Breaking the cycle: Effective punishment, rehabilitation and sentencing of offenders

Response from DrugScope

March 2010

DrugScope is the UK's leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs field. DrugScope is a registered charity (charity number: 255030).

DrugScope's objectives are:

- To provide a national voice for the drug sector
- To inform policy development drawing on the experience and expertise of our members
- To work with others to develop 'joined up' responses to drug and alcohol problems
- To support drug services and promote good practice
- To improve public understanding of drugs and drug policy.

DrugScope believes in drug policy that:

- minimises drug-related harms
- promotes health, well-being, inclusion and integration
- recognises and protects individual rights
- recognises and respects diversity.

DrugScope is committed to:

- promoting rational drug policy debate that is informed by evidence
- involving our membership in all our policy work
- ensuring our policy interventions are informed by front-line experience
- speaking independently, and free from any sectoral interests
- highlighting the unique contribution of the voluntary and community sector.

DrugScope incorporates the London Drug and Alcohol Network (LDAN), which works in London

- to provide independent and expert advise to member agencies, commissioners and other stakeholders
- to support member agencies in providing cost-effective, high quality services that are user focussed
- to engage with policy and decision-makers on behalf of its membership.

Introduction

1.1 Drugscope welcomes the opportunity to respond to the Green Paper *Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*. We note the opportunities for criminal justice reform to contribute to delivery of the *Drug Strategy 2010: Reducing demand, restricting supply, building recovery*, with its focus on recovery and social re-integration, and holistic responses to address the multiple needs of people experiencing drug and alcohol problems.

1.2 Our response reflects our status as a charity and our role as an independent centre of expertise on drugs and drug use and the national membership organisation for the drug field, with many DrugScope members working in the criminal justice system. It concentrates on proposals in *Breaking the Cycle* that are of most direct relevance to our members.

1.3 Our response is informed by consultation events with DrugScope members and other stakeholders. The issues were discussed at the DrugScope Drug Treatment Chief Executives' Group in March 2011, the London Drug and Alcohol Network (LDAN) Senior Managers Group in December 2010, and two consultation events on 'barriers to recovery' hosted on behalf of the Department of Health funded Drug Sector Partnership (Adfam, The Alliance, EATA and DrugScope) in London (2010) and Manchester (2011).

1.4 In 2008 we hosted an 'expert seminar' for the Bradley review, which was attended by Lord Bradley. This had a particular focus on diverting and rehabilitating offenders with co-occurring substance misuse and mental health problems (‘dual diagnosis’).

1.5 DrugScope is represented on the Department of Health's National Advisory Group for the Health and Criminal Justice Programme. Our Chief Executive, Martin Barnes sits on the Ministry of Justice's Criminal Justice Council, the Association of Chief Police Officers (ACPO) Drugs Committee and (in a personal capacity) on the Advisory Council on the Misuse of Drugs (ACMD). We are members of the Criminal Justice Alliance and the Third Sector Forum on Criminal Justice and Mental Health, hosted by the Centre for Mental Health (formerly Sainsbury Centre for Mental Health).

1.6 We are partners in Making Every Adult Matter (MEAM), a cross-sector partnership to improve outcomes for adults with multiple needs. MEAM brings together DrugScope, Clinks, Homeless Link and Mind, and is funded by the Calouste Gulbenkian Foundation. It is developing three pilot projects in Cambridgeshire, Somerset (Mendip and Sedgemore) and Derby to assess the impact of innovative, practical approaches to improving outcomes for people with multiple needs, including offenders and ex-offenders. The MEAM policy approach was set out in *A four point manifesto for tackling multiple needs and exclusions*, launched at party conferences in Summer 2009. The Making Every Adult Matter website is at www.meam.org.uk

1.7 DrugScope has a particular interest in women offenders with drug problems. In 2005 we published the report *Using Women*, as part of a two year project funded by the Esmee Fairbairn Foundation as part of its ‘Rethinking Crime and Punishment’ programme.[1] The London Drug and Alcohol Network (LDAN), which merged with DrugScope in March 2009, has been developing a network for domestic violence and substance misuse services in London with funding from London Councils, and has supported Women’s Voices, a GLA

[1] The *Using Women* report is available on the DrugScope website at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/UWreport.pdf

project to support women affected by drug and alcohol problems to voice their experiences and concerns.[2]

2. Supporting offenders to get off drugs for good: General comments

2.1 DrugScope welcomes the clear recognition in *Breaking the Cycle* that effective interventions to support offenders to address drug and alcohol problems are critical to the success of the 'rehabilitation revolution'. As is highlighted in the *Green Paper Evidence Report*, the adult Offender Assessment System (OASys) indicates that 48 per cent of adult prisoners and 37 per cent of offenders on probation have a drug misuse need (the OASys figures for alcohol needs are 19 per cent for prisoners and 32 per cent for adults on probation). Addressing substance misuse problems is not only critical for the rehabilitation of offenders, it makes good economic sense too. The National Audit Office report *Tackling Problem Drug Use* (2010) concluded that £1 invested in drug treatment saved £2.50 in subsequent social and criminal justice costs.[3] As DrugScope argued in our submission to the Spending Review, there is good evidence that increased investment in drug treatment has delivered a substantial crime reduction dividend.[4] The Home Office has reported that acquisitive crimes (such as shoplifting, burglary, vehicle crime and robbery) to which drug-related crime makes a significant contribution, fell by 55 per cent between 1997 and 2007.[5]

Building on solid progress

2.2 We believe that the Government has a solid basis on which to build the 'rehabilitation revolution'.

2.3 *Evidence and analysis*. A number of recent policy reviews have produced practical recommendations for Government based on detailed assessment of evidence and wide consultation. DrugScope supports the findings of *The Bradley Report* on diversion (2009); *The Patel Report* on 'Reducing drug-related crime and rehabilitating offenders' (2010); and *The Corston Report* (2008) on 'Meeting the needs of women with particular vulnerabilities in the criminal justice system'. We hope that Government will continue to be guided by the conclusions and recommendations of these reports. We are concerned by some indications that Government may be reconsidering the implementation of elements of the Bradley Review in a changed policy environment. We are strongly supportive of Lord Bradley's recommendations, particularly on the issue of dual diagnosis, and would urge Government to implement these in full.

2.4 *Provision of drug treatment*. There have been clear improvements in the availability and quality of drug treatment, both in the community and in prisons. The numbers of adults accessing drug treatment has more than doubled over the past 10 years to over 206,000 in 2009-10, with waiting times down to around a week on average, and the overwhelming majority of service users staying in treatment for at least 12 weeks.[6] The Patel Report states that funding for prison drug treatment is now over 15 times that of 1997, with the result that a record numbers of prisoners are engaging with treatment. Drug use in prisons - as measured

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[2] Details of the LDAN domestic violence project are on the LDAN website at www.ldan.org.uk and more information on GLADA Women's Voices is at www.avaproject.org.uk/glada-women's-voices.aspx

[3] National Audit Office (March 2010), *Tackling Problem Drug Use*, Report by the Comptroller and Auditor General HC 297, Session 2009-2010.

[4] Our submission to the Spending Review is at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SpendingReview.pdf

[5] Home Office (2010), Crime in England and Wales 2009-10 – Findings from the British Crime Survey, p 2-3 at http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1210chap1.pdf

[6] National Treatment Agency 'Statistics for drug treatment activity in England 2009-10 – National Drug Treatment Monitoring System' at www.nta.nhs.uk/uploads/statisticalrelease2009-10finalversion.pdf

by mandatory drug tests - has decreased by 68 per cent.[7] The introduction of the Integrated Drug Treatment System (IDTS) since 2006 has resulted in improvements in treatment provision in prisons and in some improvement in continuity of care between prisons and the community.

2.5 *Community interventions*. There has been progress in developing interventions for offenders with drug problems in the community. DrugScope has been a consistent supporter of the principles behind community sentences as an alternative to prison, specifically the Drug Rehabilitation Requirement (and, formerly, the Drug Treatment and Testing Order). Drugscope also recognises the role that the Drug Intervention Programme (DIP) has played in identifying offenders with drug problems and engaging them with treatment. The National Audit Office's 'Tackling Problem Drug Use' report (2010) found that the overall level of crime committed by offenders on DIP and in drug treatment fell by 26 per cent.[8] We have also followed the development of drug courts with interest and believe that specialist courts may have the potential to improve engagement with community orders and outcomes.

Some challenges

2.6 The Government is able to build on significant improvements in the range and quality of interventions and services for offenders with drug problems. However, as *Breaking the Cycle* recognises, there are a number of outstanding problems and challenges to be addressed.

2.7 *Prison numbers and conditions*. We note that the prison population grew from around 45,000 in 1993 to 85,000 in 2010, with nearly 60 per cent of prisons in England and Wales overcrowded in 2010.[9] DrugScope has consistently voiced concerns about the ability of our members and others to work effectively with prisoners to address drug problems in an overcrowded prison system. The Patel Report argued that the dramatic increase in the prison population had resulted 'in a strain on limited staff resources, disrupted regimes and some prisoners being placed further from home'.[10] It is particularly difficult to work with prisoners on short sentences or who are being moved between prisons. As the Secretary of State explained in his speech at Kings College London on 30 June 2010, 'it is virtually impossible to do anything productive with offenders on short sentences. And in the short time they are in prison many end up losing their jobs, their homes and their families'.[11] This is particularly relevant to prisoners with drug problems who tend to commit a high volume of comparatively 'low level' and non-violent acquisitive crimes to fund drug purchases, resulting in short sentences.

2.8 *Dual diagnosis and complex need.* DrugScope has a particular concern about co-occurring substance misuse and mental health problems. HM Chief Inspector of Prisons for England and Wales (2010) *Annual Report 2008-09* concluded that as many as three quarters of prisoners have some form of 'dual diagnosis'.[12] For the prison population, co-morbidity of substance misuse and mental health problems is the norm, and a 'single diagnosis' is the exception. Lord Bradley's review concluded that 'dual diagnosis … is a vital component of addressing the issue of mental health and criminal justice', and yet found that 'services are currently organised in such a way as to positively disadvantage those needing services for both mental health and substance misuse problems'.[13] In 2009, the Department of Health and Ministry of Justice published joint guidance on the management of dual

[7] Patel Report, p. 23.
[8] NAO, *Tackling Problem Drug Use*, p. .
[9] Criminal Justice Alliance (June 2010), *Criminal Justice – Areas for Action*, p. 2.
[10] *The Patel Report – Prison Drug Treatment Strategy Review Group* (2010), p. 7,
[11] Full text at www.justice.gov.uk/sp300610a.htm
[12] Cited in Prison Reform Trust (July 2010), *Bromley Briefing – Prison Fact File*, p. 41 at www.prisonreformtrust.org.uk/uploads/documents/FactFileJuly2010.pdf
[13] Bradley Report, p. 21.

diagnosis[14], and a dual diagnosis training project for criminal justice workers was initiated by the Department of Health, Skills for Health and the Pan-London Lifelong Learning Network.[15] These are welcome initiatives, but a step change is still needed to put the issue of co-morbidity at the heart of the 'rehabilitation revolution'.

2.9 *Integrated offender management – prison and community*. Too often the positive impact of prison drug and alcohol treatment has not been sustained and built on after release. The Patel Report concluded that 'there is a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money, having something meaningful to do and greater integration and co-ordination with community services'.[16] Voluntary and community sector organisations have developed effective resettlement projects. These include the St Giles Trust's 'Through the Gate' project (discussed in Breaking the Cycle as a key partner in the Peterborough Social Bond Pilot) and Addaction's Manchester Resettlement Project. However, provision of intensive and personalised post-release support is patchy, and the barriers to resettlement are formidable. The Criminal Justice Alliance (2010) states that 'on release, around 70 per cent of prisoners report having no employment, education or training in place and around 30 per cent have no accommodation, with many more only having access to temporary housing'. It is noted by the CJA that 74 per cent of prisoners with problems with both employment and accommodation reoffend during the year after leaving custody, compared to 43 per cent of those with no problem with either.[17]

2.10 *Drug-related deaths.* The unacceptably high rates of death from overdose among recently released prisoners is a tragic situation that we would ask the Government to address as a matter of urgency. A 2005 study found that drug using prisoners were 37 times more likely to die of drug overdose in the week following their release than other drug users as a result of a diminished opioid tolerance, and that women drug using prisoners were 69 times more likely to die. As the Patel report highights, a 2010 research report confirms that there is a high risk of drug-related death in the first two weeks following release, with increased risk persisting into weeks three and four.[18] We believe that lives would be saved by relatively simple and inexpensive harm reduction work with prisoners who are leaving drug detoxification programmes in prison (including appropriate use of naxolone, an opioid antagonist that is used for emergency overdose treatment). The evidence suggests that overdose deaths are often among prisoners who have achieved abstinence in prison, but who then relapse on release.

2.11 *Next steps for substance misuse treatment in prisons*. While there have been significant improvements in drug treatment in prisons, we share the concern expressed in the Patel Report that 'a multitude of funding streams, commissioning and process targets' has resulted in 'a fragmented system with the risk of a "one-size-fits-all" approach with limited choices in the type of treatment and broader social support available'. We note that the UK Drug Policy Commission's report *Reducing drug use, reducing reoffending* (2008) concluded that the quality of drug services in the criminal justice system was uneven, and 'that there appears to be considerable variation in provision between areas', with 'prison drug services frequently fall[ing] short of even minimum standards' [19]We welcome the opportunity that the

[14] Ministry of Justice and Department of Health (April 2009), *A guide for the management of dual diagnosis for prisons*.
[15] See Patel Report, p. 26.
[16] Patel Report, p. 7.
[17] Criminal Justice Alliance (June 2010), *Criminal Justice Areas for Action*, p. 3.
[18] The Patel Report, p. 21.
[19] UK Drug Policy Commission (March 2008), *Reducing drug use, reducing reoffending – Are programmes for problem drug using offenders in the UK supported by the evidence?* pp. 13 and 14.

'rehabilitation revolution' provides - in the words of the Patel Report - 'to achieve the cultural and system change needed to engage drug users and the communities in which they reside in effective drug treatment while in prison, and to maximise their prospects for recovery and reintegration on their release in the community'.[20]

2.12 *A balanced treatment system*. We are aware of the particular concerns that have been expressed about what some commentators have perceived to be an over-reliance on methadone prescribing in prison services (see, for example, 'Prisoners heroin addiction treatment undermined' in the BBC News on 9 December 2009[21]). DrugScope shares the Government's concerns about the tendency for some people in drug treatment to be 'parked' or 'warehoused' on methadone over long time periods, with little aspiration for recovery, and little help to address the causes and contexts of their drug problems. We embrace the Government's vision of a 'balanced' treatment system, as expressed in the *Drug Strategy 2010* and – more recently – the consultation document for the NTA's *Building Recovery in Communities* guidance. Equally, we believe that 'substitute prescribing' has a significant role to play in many recovery journeys, and would emphasise that methadone and buprenorphine are both recommended by the National Institute of Clinical Excellence (NICE) for treatment of opiate dependency. We are opposed to introducing 'strict time limits' on methadone prescribing, instead judgements about the appropriate use of medication should be made by trained and experienced clinicians. We do, however, support a shift in the onus of clinical justification to ensure that the suitability and need for substitute drugs is regularly assessed by clinicians, and is not simply the default option for services.

2.13 *Responding to new challenges.* Methadone prescribing is only ever appropriate for prisoners with opiate dependencies, and will have limited relevance for many offenders with drug and alcohol problems, particularly young offenders and the young adult population. DrugScope's report *Young people's drug and alcohol treatment at the crossroads* (2010) found that 'work with young people and young adults requires a wider conception of problem drug and alcohol use' as 'polydrug use creates a new challenge for services'.[22] The Patel Report concluded that 'poly drug use is common among offenders entering custody', with people arriving in prison 'co-dependent on any combination of alcohol, opiates, stimulants and benzodiazepines'.[23] Drug services need to respond to these shifts in the profiles of those presenting for drug treatment.

2.14 *Alcohol treatment*. Progress on drug treatment in prisons has not been matched by progress on alcohol treatment. The HM Inspectorate of Prisons report *Alcohol services in prison: an unmet need* (2010) states that nineteen per cent of adult prisoners had reported an alcohol problem in surveys carried out by HMIP in 2008-09, reaching 30 per cent in Young Offender Institutes and 29 per cent in women's prisons; yet many prisons had no alcohol strategy, and where strategies were in place they were often felt to be inadequate.[24] In addition, HMIP found that 'very few treatment or offending behaviour programmes have been developed or accredited specifically for alcohol misusers' and 'none were yet available in any prison inspected'.[25]

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[20] The Patel Report, p. 34.
[21] http://news.bbc.co.uk/1/hi/uk/8402944.stm
[22] DrugScope (2010), *Young People's Drug and Alcohol Treatment at the Crossroads – What it's for, where it's at and how to make it even better* is at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Publications/YoungPeopleCrossroadsReport.pdf
[23] The Patel Report, p. 19.
[24] HMIP (2010), *Thematic report by HM Inspectorate of Prisons – Alcohol Services: an unmet need*, p. 5.
[25] HMIP (2010), p. 16.

2.15 *Next steps for community orders and interventions*. DrugScope has broadly supported the use of community orders and referral through the Drug Intervention Programme. However, we recognise that their development has not been unproblematic. In 2004, the National Audit Office report, *The Drug Treatment and Testing Order: Early Lessons*, concluded that while DTTOs could be effective in tackling drug problems and reducing re-offending, the majority of orders are not completed.[26] More recently, the National Audit Office's 2010 report *Tackling Problem Drug Use* expressed concerns about the failure to evaluate the impact of DRRs, concluding that 'the National Offender Management Service should undertake an effectiveness evaluation of the outcomes of the Requirement and how to improve completion rates'. It reported that only 47 per cent of offenders completed their DRR in 2008-09, while noting that this was an increase on completion rates of 28 per cent in 2003-04. The NAO report also discusses a 2009 Home Office study which found that local implementation of the Drug Intervention Programme (DIP) has been inconsistent – and expressed particular concern that some local areas reported that 'no support was available from local authorities to help problem drug using offenders to obtain accommodation'.[27]

2.16 *Drug courts*. The Bradley Report highlights the evidence from the two English drug court pilots in Leeds and West London and concludes that the continuity of contact that they provide with the same magistrates and judges can improve outcomes. Lord Bradley praises the excellent work that he witnessed on his visit to one of the drug courts. However, he also expresses his disappointment that 'there was no formal provision of mental health services to the drug court', continuing that this raises a question about how such courts can address the issue of dual diagnosis, particularly when there are also plans to set up separate mental health courts'.[28] The Bradley Report recommended that the Ministry of Justice should examine how individuals with a dual diagnosis are served by drug courts.

Addressing the challenges

2.17 DrugScope welcomes the Government's commitment to build on the successes and to address these challenges. We comment on the specific proposals on drug treatment and recovery below, but would first like to make some general points, with particular reference to the broader financial and policy environment.

Positive developments that support the Breaking the Cycle approach to drugs and alcohol

2.18 *The drug strategy 2010.* The aims and principles that frame *Reducing demand, restricting supply, building recovery* provide a strong basis for delivering on the ambitions for the 'rehabilitation revolution'. In particular, DrugScope welcomes the commitment to a balanced treatment system (including recognising the role for substitute prescribing); emphasis on personalised and holistic approaches to recovery and reintegration; recognition of the vital role of 'recovery capital' ('social', 'physical', 'human' and 'cultural' – for example, access to accommodation and employment); and broadening the strategy to give a higher profile to drugs other than heroin and crack cocaine (including alcohol and poly-drug use). We particularly welcome the clear declaration in the section on 'offenders' in the Drug Strategy that 'prison may not always be the best place for individuals to overcome their dependence and offending behaviour'.

2.19 *Public spending and investment*.The capacity of drug and alcohol services to continue to deliver substantial reductions in offending and re-offending will depend on a commitment to invest in the sector during a period of financial austerity and public spending restraint. We welcome the announcement in February that central government funding for drug treatment

[26] At www.nao.org.uk/publications/0304/drug_treatment_and_testing.aspx
[27] NAO (2010), p. 7.
[28] The Bradley Report, p. 75-76.

will total £570 million in 2011/12 (including £68 million for prison based treatment), a reduction of only around 1.6 per cent in cash terms. The decision to continue to fund drug treatment at this level during a period when many central budgets are being cut significantly is a clear indication of the Government's commitment to drug and alcohol treatment, and the recognition of the value for public money that it delivers for individuals, families, communities and society (discussed in detail in DrugScope's response to the Spending Review[29]). At our consultation events, DrugScope members were clear that there is a corresponding responsibility for treatment services to make the best use of the public money available, to rise to the challenges of the recovery agenda, and explore ways of working more efficiently where they can.

2.20 *Joined up funding and co-ordinated commissioning*. DrugScope also welcomes the decision to transfer the budget for prison drug and alcohol services from the Ministry of Justice to the Department of Health. As the Drug Strategy 2010 explains this change in responsibility should 'support the Government's ambition for a greater emphasis on shared outcomes and provide an opportunity to promote the co-commissioning of drug services in England', with the potential 'to facilitate more coordinated support to help individuals recover from drug dependence, including those in contact with the criminal justice system'.

Potential concerns

2.21 *Future Government funding*. Following the transfer of the responsibilities of the National Treatment Agency to Public Health England in April 2012, we understand that around £1 billion of drug and alcohol treatment funding will be tranferred to the new ring fenced public health budget, amounting to a quarter of the overall budget for public health and as much as a half of the budgets controlled by Directors of Public Health at local level. There is a concern that -unless the outcome and accountability frameworks place clear and robust responsibilities on Directors of Public Health for substance misuse treatment - there could be disinvestment in drug and alcohol services in some localities. This would significantly impact on the delivery of the 'rehabilitation revolution', and would tend to increase crime and reoffending. Evidence from DrugScope members suggests that the scale and significance of the public health responsibility for substance misuse treatment is not yet fully understood or appreciated in all localities. We have real concerns that drug and alcohol treatment are not much more central to the White Paper *Health Lives, healthy people: Our strategy for public health in England* (particularly the specific consultation on *Transparency in outcomes - proposals for a public health outcomes framework*, which includes only one reference to drug treatment).

2.22 *Local co-commissioning*. We are unclear about how the co-commissioning of community and prison drug and alcohol treatment will operate locally following the NHS and health reforms. We welcome the announcement by the National Treatment Agency in February that in 2011-12 the local partnerships will have commissioning responsibility for all prison interventions 'to make the most of the pooled funding arrangements in order to jointly commission local recovery services'. From April 2012 the budget for community treatment will be controlled by the public health service, but we understand that funding for prison services would be the responsibility of the new National Health Service Commissioning Board, and might, in principle, be controlled by the GP consortia at the local level. We would appreciate further clarification of how the welcome commitment to co-commissioning and a shared outcomes framework at national level will be embodied locally. Given The Bradley Report's concern about 'dual diagnosis', we would also urge Government to identify and exploit the opportunities provided by the health reforms to improve links between substance misuse and mental health (for example, through Health and Wellbeing Boards) and to identify and to 'proof' the new health structures for any potential problems in achieving more

[29] At http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SpendingReview.pdf

effective join up for offenders and others with co-occurring mental health and substance misuse problems. It has been estimated that three quarters of drug service clients have a co-occurring mental health problem of some description.

2.23 *Local disinvestment.* Currently, drug treatment services in England are supported by over £200 million of annual local investment – predominantly from Local Authorities and Primary Care Trusts.[30] We note that the Director of the National Treatment Agency, Paul Hayes, has expressed his concerns about the threat of local disinvestment in a letter of 11 February 2011, which he suggests is the biggest threat to the Government's ambitions for creating a balanced and recovery-focussed drug and alcohol treatment system. He comments: 'With the impending abolition of PCTs and severe budgetary pressures on local authorities, there is legitimate concern across the treatment field that the vital funding provided from local sources will be squeezed. I believe this would be a grave mistake, and is clearly not what the Government's Drug Strategy aims for, nor what local Health and Wellbeing boards and Police and Crime Commissioners would wish to inherit'.[31] This concern is shared by DrugScope members, and we are aware that there has been disinvestment in some local areas, particularly for young people's services, which are perhaps the most reliant on local funding.

2.24 *Recovery capital.* It is, of course, not only the direct investment in drug and alcohol treatment that is critical to delivering the vision set out in the 2010 Drug Strategy and *Breaking the Cycle*, but also the availability of 'recovery capital' – for example, access to safe and secure accommodation, opportunities for training, employment and other forms of meaningful activity and support for family and other relationships (including services for people in abusive or violent relationships, particularly women). There is concern about the impact of the reduction in budgets in the Local Authority Financial Settlements for 2011-12 on the availability and accessibility of recovery capital, and the potential negative impact of some aspects of the localism agenda, such as the removal of the ring fencing for Supporting People and the Improving Access to Psychological Therapies (IAPT) programme. We note, for example, that a survey of 136 housing organisations by the National Housing Federation in January found that many local areas were planning cuts to Supporting People services for vulnerable people (such as the mentally ill and women fleeing domestic violence) significantly in excess of the Government's intentions, with 41 per cent of respondents expecting cuts of over 20 per cent in their area, and 18 per cent expecting cuts of over 30 per cent.[32] DrugScope has joined with other leading charities to express our concerns about this situation and to encourage local authorities not to disinvest in Supporting People services. We have produced a briefing in partnership with 13 other agencies who share our concerns: Adass, Clinks, Making Every Adult Matter, National Housing Federation, Revolving Doors, SITRA, Centre for Mental Health, Crisis, Homeless Link, Mind, Rethink, Salvation Army and St Mungo's.[33] Disinvestment in recovery capital will make it more difficult to achieve positive outcomes for people with drug and alcohol problems and to rehabilitate offenders.

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[30] See figures for 'Drug treatment budgets, activity and outcome data 2004-05 to 2008-09' in NAO (2010) *Tackling Problem Drug Use*, p. 24.

[31] Paul Hayes letter (11 February 2011), One pot, one purpose – Recovery funding for 2011-12, www.nta.nhs.uk/uploads/ptbletter11_02_2011[2].pdf.

[32] National Housing Federation (24 January 2011), 'Councils plan "disproportionate" funding cuts for services supporting vulnerable people' at http://www.housing.org.uk/default.aspx?tabid=212&mid=828&ctl=Details&ArticleID=3619

[33] This Supporting People briefing is on the DrugScope website at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/SupportingPeopleServices.pdf

2.25 *Managing and adjusting to a new policy environment .* DrugScope members are getting to grips with a whole range of policy changes that will impact on their work and service users. These include the new drug strategy, the Spending Review, the localism agenda, the transformation of the NHS and health services, welfare reform and the review of the vetting and barring system. They will, for example, be affected by the introduction of a number of distinct 'payment by results' initiatives – not only in criminal justice system, but also the NHS (particularly on mental health and alcohol), the Work Programme and the PbR pilots for drug and alcohol treatment being led by the cabinet office. By 2012 they will be operating in an entirely new local environment (for example, with the disappearance of the National Treatment Agency as a separate body and the pooled drug treatment budget, to be replaced by Public Health England, local Directors of Public Health and a ring fenced public health budget). They may be coping with local disinvestment (at least in some areas), both in drug and alcohol services and related services, such as housing. In responding to the specific proposals in *Breaking the Cycle* we would stress the importance of a joined up approach across Government that recognises the potential for unintended consequences in such a wide ranging agenda of policy change, and the support that voluntary and community sector organisations involved in the rehabilitation of offenders may need if they are to manage this period of transition effectively and deliver better outcomes.

2.26 With respect to investment in recovery capital, the Drug Sector Partnership (DrugScope, Adfam, The Alliance and EATA) has produced a consensus statement, which calls on Government to

- To maintain ring fenced funding for drug and alcohol treatment within the new public health budget. (We recognise this is unlikely, but would urge Government to ensure that other mechanisms of accountability are in place to ensure Public Health England and local Directors of Public Health maintain the levels of investment in drug treatment required if it is to continue to deliver on the Government's crime reduction and recovery objectives).
- To maintain the responsibility for ensuring that balanced treatment provision is available in every community proportionate to local need, and is of acceptable quality (including treatment for young people and young adults)
- To ensure that provision of drug and alcohol treatment meets the same clinical and ethical standards as all other NHS provision, and that practice is evidence based and to the highest professional standards
- To provide leadership and support for a national cross-sectoral workforce development strategy, to drive the recovery agenda and support best practice
- To introduce a requirement for "community impact assessments" where local decision makers and funders are proposing to refocus, significantly reduce or withdraw funding, where there may be an impact on the most vulnerable and/or the voluntary and community sector.

3. Supporting offenders to get off drugs for good: consultation questions

<u>3.1 How can we use the pilot drug recovery wings to develop a better continuity of care between custody and the community? (BtC Q11)</u>

3.1.1 *General response*. DrugScope supports the Government's commitment to invest in drug recovery wings. A prison sentence can provide a unique opportunity for offenders to address drug and alcohol problems, and we are aware of the excellent work that is being done by DrugScope members to deliver drug recovery in prisons. This is an important component of a balanced treatment system, but should not be at the expense of other forms of support.

3.1.2 *Some concerns about short sentences*. We recognise the potential benefits of drug recovery interventions for some prisoners serving sentences of under 12 months, and particularly welcome the emphasis on the need for 'join up and continuity between prison and the community'. However, there is a concern that the development of drug recovery programmes specifically for short sentence prisoners will encourage courts to sentence people with drug problems to short periods of imprisonment in circumstances where they would otherwise have passed a community sentence. In terms of continuity of care, a community order is always preferrable to a prison sentence. As *Breaking the Cycle* recognises, a prison sentence will tend to result – for example – in loss of accommodation, training and employment.

3.1.3 A key issue will be how the courts decide whether to sentence offenders either to intensive drug treatment in the community (including residential based intervention programmes) or to a short prison sentence with access to a drug recovery wing. It is our understanding that one purpose of the more intensive community orders is to provide a robust and constructive alternative to short terms of imprisonment for offenders who commit drug-related crimes. Without clear guidance, there is the potential for inconsistent sentencing practice to develop.

3.1.4 The National Treatment Agency suggests that effective treatment interventions for problem drug use require a minimum period of engagement of 12 weeks. We therefore recommend that drug recovery wings for offenders serving sentences of under 12 months should focus on prisoners with sentences of a minimum of six months. In our view, from a drug recovery perspective, it is preferable if other non-violent offenders with drug problems receive community sentences.

3.2 What potential opportunities would a payment by results approach bring to supporting drug recovery for offenders? (BtC Q 12)

3.2.1 *General response.* DrugScope is supportive of the commitment to new approaches to commissioning, funding and purchasing services with a greater emphasis on outcomes and to providing opportunities for innovative third sector providers to compete with statutory services where they can demonstrate effectiveness in reducing re-offending. Our members recognise their responsibilities regarding public investment in drug treatment services to demonstrate that they can deliver outcomes efficiently and effectively, especially in a challenging financial climate.

3.2 2 *Some concerns.* We do, however, have concerns about the pace of change in developing payment by results, given the complexity of the implementation issues, the problems in creating a level playing field for the third sector (particularly smaller charities) and the potential for unintended consequences. We favour a cautious approach to developing PbR, with careful evaluation at each stage, and a willingness to explore alternative approaches to outcome-based funding and commissioning. (We would also note the need to join up different payment by results pilots, including the criminal justice schemes, the Department of Health payment by results for alcohol treatment, the work programme approach and the drug treatment pilots that are being developed by the Cabinet Office.)

3.2.3 *Drug Sector Partnership approach*. The Drug Sector Partnership consensus statement on Funding and Purchasing applauds the intentions behind payment by results, while urging Government:

- To ensure that the development of payments by results is based on full and detailed consultation and engagement with service providers and service users, including the full range of voluntary and community sector organisations.
- To ensure that any piloting of payment by results involves robust evaluation, comparing an appropriate range of approaches and also enabling meaningful

comparison with the performance of other approaches to outcome-based commissioning.

3.2.4 It specifically calls on Government to ensure that all payment by results pilots meet the following key criteria:

- That outcomes are specified in a way that reflects the complexity and multiplicity of individual recovery journeys, the significance of "small steps" and the tendency for relapse to be part of "cycles of change".
- That the welcome focus on recovery and re-integration is not seen as an alternative to harm reduction services, which save lives, prevent disease and reduce crime.
- That a national standards and regulatory function is clearly maintained to ensure that practice is of the highest professional standards and does not include approaches where there is evidence that they may be ineffectual or harmful.
- That results should be measured through objective and verifiable mechanisms that minimise the amount of paperwork and bureaucracy.
- That service users should have a role in negotiating outcomes with service providers that reflect their priorities and motivation and help to built therapeutic relationships, as well as in a robust qualitative evaluation of the pilots.
- That payment by results is developed in a way that enables small local organisations to compete, and is not weighted disproportionally towards large organisations, including private companies.
- That outcomes and payments are developed in a way that prevents 'cherry picking', which has the perverse consequence that those most in need - including people with multiple needs - find it the most difficult to get help.
- That outcomes and payments are developed in a way that incentivises and rewards co-operation and partnership between different sectors (including mental health, housing, education, training and employment, criminal justice and family support) and reflects local conditions (for example, the accessibility of homes or jobs in a particular locality at a particular time).
- That outcomes for families and carers who are affected by drug and alcohol problems are fully understood and provided for.

3.3 How best can we support those in the community with a drug treatment need, using a graduated approach to the level of residential support, including a specific approach for women? (BtC Q 13)

3.3.1 *General response*. DrugScope supports the diversion of offenders with drug and alcohol problems from prison to appropriate community orders, which challenge and support them to address their substance misuse, to stop offending, and to get their lives back on track. We recognise the potential value of high intensity residential (and other) options for some offenders coming before the courts for drug-related crimes, as part of a balanced treatment system. We have concerns, however, about how the courts will make informed decisions about the suitability of particular treatment interventions for particular individuals – to ensure, in the words of the NTA's *2010-11 Business Plan* that they get 'the right treatment and support at the right time', and therefore that the system delivers 'good value for money'.[34]

3.3.2 *Collecting the evidence*. It is important to build on the lessons of Drug Treatment and Testing Orders and Drug Rehabilitation Requirements in further developing community sentencing options. We endorse the conclusion of the UK Drug Policy Commission's *Reducing drug use, reducing reoffending* (2008) that 'community punishments are likely to

[34] NTA *2010-11 Business Plan*, p. 3.

be more appropriate than imprisonment for most problem drug using offenders'.[35] We are aware of the National Audit Office's concerns (2010) about limited evaluation of DRRs. The NAO noted that the Ministry of Justice is reviewing DRRs as part of a wider offender community cohort study, but concluded that 'without an effectiveness evaluation, the Ministry is not able to assess the impacts of the Requirement, such as any change in offenders drug use and criminal activity. Nor will it be able to understand how to improve the percentage of drug users who comply with, and complete, the requirement, or the value for money provided'. DrugScope would emphasise the value of research to identify factors that affect breach rates - these have improved significantly, but remain high.

3.3.3 *Assessing treatment need.* A critical question is how the courts determine the appropriate level of intervention for particular offenders, whether 'high' (residential based), 'medium' (structured treatment, potentially with a residential element) or 'low' (outpatient treatment).

3.3.4 *Proportionality and need.* The courts must balance the requirement to punish offences proportionately and to rehabilitate offenders by addressing the causes and contexts of their offending. In principle, this may mean that only offenders convicted of more serious crimes can access the most intensive treatment through the criminal justice system. It is undesirable for offenders to be up-tariffed onto intensive community sentences where this is disproportionate to the offence, particularly given the potential consequences of breach and the high rates of non-completion. Equally, it would appear unfair to give offenders convicted of more serious offences privileged access to more intensive treatments where the need is the same. This is less problematic if equivalent services are accessible to less serious offenders and non-offenders on a voluntary basis through the community, of course. However, if the Department of Health does commit to funding treatment-based accommodation specifically to support the *Breaking the Cycle* proposals this will potentially mean that less investment is available to fund residential places for other populations.

3.3.5 *Treatment requirements should be based on clinical assessment.* DrugScope takes it to be a fundamental principle for NHS and health care services that decisions about treatment should be based on clinical considerations (and should be compliant with the principles of the NHS Constitution 2009). There is a distinction between (1) sentencing an offender to a community order which includes a requirement to comply with treatment, and (2) specifying the precise nature of that treatment. DrugScope believes that decisions of the first kind fall within the legitimate jurisdiction of the courts, but decisions of the second type do not (or, at least, should be based on an independent assessment of treatment need conducted in the appropriate way). We do not underestimate the benefits of intensive treatment, including residential services, for many offenders. However, there is a real risk of high breach rates and disruption to therapeutic environments if these decisions are not based on a careful assessment of need and suitability for a particular individual at a given point in the 'cycle of change'.

3.3.6 *Co-occurring substance misuse and mental health problems.* DrugScope would also urge the Government to take this opportunity to consider how community sentencing could be more effectively developed for offenders with 'dual diagnosis'. (We have noted above Lord Bradley's concern that drug courts are not addressing drug diagnosis.) Our understanding is that the introduction of the new Community Order in 2005 (implementing the Criminal Justice Act 2003) was intended to enable the courts to respond to the profile and needs of offenders by selecting from a range of twelve requirements - including the Drug Rehabilitation Requirement, Alcohol Requirement and Mental Health Treatment Requirements (MHTR). A report by the Centre for Mental Health (2008) found that Mental Health Treatment Requirements accounted for less than one per cent of all requirements

[35] UKDPC (2008), p. 14.

issued, with only 725 issued in England and Wales in 2006.[36] Anecdotal evidence from DrugScope members suggests that offenders with mental health problems are often not considered suitable for drug rehabilitation requirements. We would urge the Government to look at dual diagnosis as a key issue in its plans to develop new community sentencing options. In this context we note the discussion of 'more effective and robust community sentences' on pages 58 to 60 of *Breaking the Cycle*, and the proposals for a more generic health treatment requirement, which could have particular relevance for this group. The comments in this section of our response are therefore relevant to Q37-Q41 of *Breaking the Cycle.* We believe that a generic health treatment requirement could provide additional flexibility for the courts where people have both substance misuse and mental health problems, although consideration would need to be given to the balance between providing appropriate treatment for offenders and proportionality between the requirements of the order and the seriousness of the offence.

3.3.7*Taking the issues forward.* We are aware that these comments raise some complex practical and implementational issues, and we would welcome an opportunity to work with the Ministry of Justice to develop solutions.

3.4 In what ways do female offenders differ from male offenders and how can we ensure that our services reflect these gender differences? (BtC Q 14)

3.4.1 We applaud the recognition of the need for a distinct approach for women offenders building on the development of community provision since the Corston Report in 2008.

3.4.2 *Women offenders.* The arguments for diverting women offenders with drug and alcohol problems onto community orders are exceptionally strong. A 2009 Ministry of Justice report found that women prisoners were significantly more likely than men to be serving very short sentences, with 61% sentenced to custody for six months or less in 2008.[37] This reflects the fact that women are more likely to be imprisoned for low level, non-violent crimes. DrugScope's *Using Women* report (2005) revealed that a high proportion of women prisoners were serving sentences for drug offences, acquisitive crime and prostitution. Women in prison for drug offences are typically operating on the lowest rungs of the supply ladder. Many women get involved in drug use and/or supply and other criminal activity only after entering into violent and exploitative relationships with men.

3.4.3 *Dual diagnosis and complex need.* Drug and alcohol problems among women in the criminal justice system are strongly linked to other issues, many of which have a strong gender component. In a 2011 report, Baroness Corston observes that 48 per cent of women prisoners have drug or alcohol problems, 40 per cent have experienced domestic violence, sexual abuse or rape and 8 per cent are involved in prostitution.[38] A University of Oxford report concluded that: 'women in custody are five times more likely to have a mental health concern than women in the general population, with 78 per cent exhibiting some level of psychological disturbance when measured on reception to prison, compared with a figure of 15 per cent for the general adult female population'.[39] There are high rates of self harm and suicide among women prisoners. Any proposals for developing intensive community-based treatment options for women will have to address these complex needs, and recognise that

[36] Linda Seymour and Max Rutherford (2008), *The community order and the mental health treatment requirement*, p. 6.
[37] Ministry of Justice (2009) *Offender Management Caseload Statistics 2008*, London: Ministry of Justice.
[38] All-Party Parliamentary Group on Women in the Penal System chaired by Baroness Corston (2011), *Second report on women with particular vulnerabilities in the criminal justice system*, p. 2.
[39] Cited in Prison Reform Trust (2010), *Bromley Briefing 2010,* p.25.

for many women it is unrealistic to address substance dependency problems in isolation. For that reason, it may be better to develop high intensity services that build on the multi-faceted, one stop women-centred approach advocated by the Corston Report, with a strong focus on substance misuse, rather than to develop 'free standing' community drug treatment options.

3.4.4 *Better outcomes*. The *Bromley Briefing 2010* also found that women are more likely to complete community sentences successfully than men and cites New Economics Foundation research that concluded that every £1 invested in support-focused alternatives to prison for women generates £14 worth of social value for women and their children, victims and society generally over ten years**.**[40]

3.4.5 *DrugScope's approach.* In *Using Women* (2005) we recommended that prison custody for women should be replaced by a 'network of local women's supervision and support centres to provide an effective supervision and rehabilitation service to women offenders serving a community sentence', an approach that was also advocated by the Prison Reform Trust and the Fawcett Society. We welcome the recommendation in *The Corston Rep*ort (2008) that traditional women's prisons should be replaced with a limited number of small, multi-functional custodial centre.

3.4.6 *Building on progress.* DrugScope notes that the Minister of State for Prisons, Crispin Blunt, has told parliament that '*short sentences for men have proved pretty ineffective, and …short sentences for women are even more ineffective and deleterious'.* We welcome the Government's support for the Corston Report and investment in developing women-only community provision to support robust community sentences. We note the commitment to reduce the women's prison estate by 300 places by March 2011 and 400 places by March 2012, and to invest in one-stop shop support services, bail services, improvements to improved premises and diversion of women from the criminal justice system as discussed in the 2011 All-Party Parliamentary Group report. [41]

3.4.7*Some concerns.* We note, however, that this report also expressed concerns that the number of women in prison increased by 236 between January 2010 and January 2011, despite the target to reduce the number of women in custody to 400 by March 2012. The statement in *Breaking the Cycle* that the Government is 'committed to tackling all forms of domestic violence' is welcome, but we are concerned that domestic violence services are vulnerable to cuts and closures in the current financial environment. Real concern was expressed by some front-line providers at a meeting of the LDAN Domestic Violence Network (a pan-London group funded by London Councils) in February 2011 about the future of domestic violence services (including refuges), as well as other services that support vulnerable women facing sexual violence, including sex workers. It was also stressed at this meeting that Women's Community Projects (where probation services are often co-located with other women's services) play a vital role in diverting women from custody. These Centres currently have no dedicated funding beyond March 2011 – while some centres have secured funding from other sources, there is an anxiety that others may face closure. DrugScope urges the Government to address these issues in developing the Violence against Women and Girls Action Plan, and would be pleased to contribute to policy development in this area, drawing on our work with the LDAN Domestic Violence Network.

[40] PRT 2010, p. 26 (source New Economics Foundation (2008), *Unlocking value: How we all benefit from investing in alternatives to prison for women offenders*).
[41] All-Party Parliamentary Group on Women in the Penal System (2011)*, Second report on women with particular vulnerabilities in the criminal justice system*.

4. Other key points

4.1 *Employment and the working prison.* DrugScope shares the Government's concerns about the lack of meaningful activity in prisons and would stress the role of training and employment in recovery, as highlighted in the Drug Strategy 2010. We therefore welcome the focus on work in *Breaking the Cycle*. However, we have concerns about the largely punitive tone in these sections of the Green Paper, with, for example, regular working hours described as 'tough discipline' with little reference to the rehabilitative benefits of employment. We would welcome a greater emphasis going forward on the role of training and employment in recovery. It is important that training and work regimes within the criminal justice system provide offenders with more positive experiences of the benefits of employment and improve their prospects of work on release from custody or following completion of a community order. They should not be narrowly or exclusively punitive. We know, for example, that 48 per cent of prisoners are at or below the level expected of an 11 year old in reading, 65 per cent in numeracy and 82 per cent in writing and would welcome a focus on forms of training and employment that will help to address these deficits.

4.2 *Criminal records.* DrugScope welcomes the proposals in *Breaking the Cycle* to review the Rehabilitation of Offenders Act to further limit the circumstances under which ex-offenders are required to disclose a criminal record to a potential employer. Stigma and negative expectations are a barrier to employment for people with a history of drug and alcohol problems, particularly where they have criminal records. The UK Drug Policy Commission report *Working towards recovery: getting problem drug users into jobs* (2008) states that two third o employers interviewed said they would not employ somebody with a history of heroin or crack cocaine problems under any circumstances, even if they were satisfied they were otherwise qualified for the job (although employers who did employ from this population reported positive experiences). Drugscope has recently secured funding for a second phase of a Trust for London funded project to run in the capital from 2011-2013 to improve pathways to employment for people with a history of drug and alcohol problems, with a particular focus on working directly with employers. We would welcome opportunities to share the findings from this work with Government.

4.3 *Using wages to support families.* We note the proposals to make deductions from prisoners' wages for uses including reparation to victims and communities. We would strongly urge the Government to make provision from prisoners' wages to support prisoner's families. Families are often the victims of a family members drug or alcohol problems and can provide vital recovery capital and support rehabilitation. They often suffer significant hardship when a family member is serving a prison sentence. The prisoners wages could also supplement the costs of families travelling to prisons for visits. (DrugScope also supports the comments and recommendations in Adfam's submission to the Breaking the Cycle consultation, and work closely with Adfam, including as participating organisations in the Department of Health funded Drug Sector Partnership.)

4.4 *The mental health liason and diversion service.* DrugScope welcomes the commitment to continuing to develop mental health liaison and diversion schemes. We would emphasise the need for these projects and their staff to be supported to work with offenders with co-occurring mental health and substance misuse problems. A review of court diversion schemes by Nacro in 2004 found that only 17 per cent of schemes had a protocol or policy for dual diagnosis and only three schemes had a dedicated dual diagnosis worker.[42]

4.5 *Foreign national prisoners.* DrugScope notes the concern about the rising population of foreign national prisoners in *Breaking the Cycle*. According to the *Bromley Briefing 2010*, the

[42] Nacro (2005), *Findings of the 2004 survey of Court Diversion/Criminal Justice Liaison Schemes for mentally disordered offenders*, p. 12

majority of foreign national prisoners (47 per cent) have committed drug offences – including four out of every five sentenced women (79 per cent), with 58 per cent of foreign national women in prison serving sentences for drug offences.[43] DrugScope's *Using Women* report (2005) showed that a significant proportion of these women are in UK prisons for importing relatively small quantities of drugs into the UK (so-called drug mules). The Fawcett Society's Commission on Women and the Criminal Justice System (2009) highlighted the reality that these women often come from very poor backgrounds, are coerced into participation in drug smuggling and operate at the lower rungs of the supply ladder. The financial rewards for carrying drugs are typically small, the risks very high. These women receive some of the longest prison sentences handed down by British courts for any offences, including most violence offences.[44] DrugScope's Using Women report recommended that serious consideration should be given to a lower tariff offence for coerced drug couriering of this type. It is also important for policy approaches to address the risks that these women and their families (including children) can face from the criminals who recruit them into drug trafficking where they are unsuccessful in importing drugs.

4.6 *Sentencing and the law*. DrugScope supports calls for a review of the *Misuse of Drugs Act 1971* as promised by the previous Government in 2006, but subsequently abandoned. Criminal sanctions for comparatively low level drug offences contribute to the pressures on the criminal justice system. In particular, we would like to see a review of the approach to the policing of low-level drug offences, primarily possession for personal use. Research from the Joseph Rowntree Foundation has roughly estimated that in the first year after police moved to issuing street warnings for most cannabis possession cases in 2004, nearly 270,000 officer hours were saved across the 43 forces of England and Wales, with savings of over three and a half million pounds.[45] DrugScope does not believe it is necessary or cost-effective to deal with the majority of low level drug offences through the criminal justice system, and would welcome a review of the law and/or approaches to enforcement in this area.

4.7 *Policing and harm.* DrugScope also notes the conclusions of the UK Drug Policy Commission's 2009 report, *Refocusing drug-related law enforcement to address harm.*[46] The UKDPC argued that increased enforcement beyond a certain point will not necessarily reduce the availability of drugs because established drug markets are resilient and adaptable. There are opportunities, however, to target enforcement activities in ways that are more effective in reducing drug-related harm. Enforcement should target particularly violent and harmful activity (for example, drug markets involving gangs and gun crime, sexual exploitation or using children as lookouts and couriers) and markets that are most damaging in their impact on communities (for example, open drug markets in residential areas).

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[43] Prison Reform Trust (2010)*, Bromley Briefing 2010,* p. 28*,*
[44] See Fawcett Society, May 2009, *Engendering Justice – from policy to practice – Final report of the Commission on Women and the Criminal Justice System*,
[45] Tiggey May, Martin Duffy, Hamish Warburton and Mike Hough (2007), *Policing Cannabis as a Class C Drug*, Joseph Rowntree Foundation: 'It is difficult to estimate accurately the financial savings of reclassification through using street warnings instead of arrests. However, during the first year of street warnings the research team crudely estimated that reclassification is likely to have saved just over three and a half million pounds or 269,327 officer hours across the 43 forces of England and Wales.
[46] http://www.ukdpc.org.uk/resources/Refocusing_Enforcement_Full.pdf