DrugScope response to the Justice Committee inquiry 'Crime reduction policies: a co-ordinated approach?': May 2013

About DrugScope

DrugScope is the UK's leading independent centre of expertise on drugs and drug use, and the national membership organisation for the drug and alcohol field, with around 450 members. DrugScope also incorporates the London Drug and Alcohol Network (LDAN).

DrugScope is a member of the Criminal Justice Alliance; is involved in the Bradley Group, an independent forum advocating for the recommendations of Lord Bradley's report on diversion of people with mental health problems and learning disabilities within the criminal justice system; and is a member of the Making Every Adult Matter (MEAM) coalition, which works to influence policy and practice for adults facing multiple needs and exclusions, including many in contact with the criminal justice system. DrugScope is a partner (with the Recovery Group UK and the Substance Misuse Skills Consortium) for the Recovery Partnership, which aims to provide a collective channel of communication to Government and officials on achieving the Drug Strategy's ambition for improving treatment outcomes and recovery. DrugScope's Chief Executive is a member of the Criminal Justice Council and the Association of Chief Police Officers (ACPO) Drugs Committee.

Given the nature of our membership and expertise, our response focuses on drug and alcohol-related offending.

Overview

- There are clear links between substance misuse and offending, and robust evidence points to the significant role of drug and alcohol treatment in cutting crime. This is recognised by the national drug and alcohol strategies, as well as the Ministry of Justice documents 'Punishment and reform' (2012) and 'Transforming rehabilitation' (2013).
- The commissioning of drug and alcohol services, in prison and the community, has recently undergone significant reforms. This brings opportunities, but also risks, including possible disinvestment in substance misuse services in some areas.
- The Drug Interventions Programme, which has been the principal policy vehicle bringing together criminal justice and drug treatment services, has come to an end as a national programme, and there is concern about the survival of DIP-style interventions under the new commissioning arrangements.
- While drug treatment in prisons has improved considerably, community orders are usually more appropriate for those with drug and alcohol problems, who are often convicted of relatively low level offences. These also avoid the damaging impact of prison, including separation from what the 2010 Drug Strategy refers to as "recovery capital".
- There is, currently, limited evidence on payment by results schemes; we urge a cautious rollout of the 'Transforming rehabilitation' proposals.

What is the Government's approach to cutting crime? To what extent is the approach taken cross-departmental, and how are resources for such policies – from within and outside the criminal justice system – allocated and targeted? How reliable is the evidence on which these policies are based?

1. Successive governments have recognised the role of drug treatment in cutting crime, for which there is overwhelming evidence. The structures for planning, commissioning and delivering drug and alcohol treatment have recently undergone radical reforms, with the abolition of the National Treatment Agency in April 2013 and absorption of its functions into Public Health England, and a significant transfer of control and responsibility to local authorities. Additionally, NHS England has assumed responsibility for substance misuse treatment in prisons as part of its offender health remit. Police and Crime Commissioners (PCCs) also have a stake in drug and alcohol treatment and have inherited the Home Office funding for the Drug Intervention Programme (DIP), which has been absorbed into the Community Safety Fund (CSF) for 2013-14. The impact of these changes on drug and alcohol service provision will be profoundly important for the effectiveness of the Government's approach to cutting offending and reoffending.

2. There are clear links between substance misuse and offending, and robust evidence points to the significant role of drug and alcohol treatment in cutting crime. Official estimates point to the annual cost of drug-related crime as £13.9 billion; drug treatment prevents 4.9 million crimes annually, saving £960 million in costs to the public, businesses, the criminal justice system and the NHS.[1] These figures do not take account of the impact of alcohol-related crime, which has been estimated to be a factor in up to half of all violent crimes.

3. 55% of prisoners report committing offences connected to their drug taking, with the need for money to buy drugs the most commonly cited factor. 81% of people arrested who used heroin and/or crack at least once a week said they committed an acquisitive crime in the previous 12 months, with 31% reporting an average of at least one crime a day. 63% of sentenced men and 39% of sentenced women admit to hazardous drinking which carries the risk of physical or mental harm. Of these, about half have a severe alcohol dependency.[2]

4. The Drug Strategy 2010 and Alcohol Strategy 2012 recognise the links between substance misuse and crime and the role treatment plays in reducing offending, as do the Ministry of Justice's (MoJ) 'Punishment and reform' and 'Transforming rehabilitation' documents. From April 2013, significant reforms to the commissioning of drug and alcohol services in the community have been implemented, with responsibility shifting to Directors of Public Health (DsPH) in local authorities. These changes bring opportunities, but also risks, including possible disinvestment, and consequently increases in drug-related crime and loss of capacity to identify offenders with dependency problems in the criminal justice system, assess their needs and refer them into appropriate services.

5. The Department of Health (DoH) has estimated that 34% of the public health budget available to local authorities is derived from previous drug and alcohol funding. However, drug and alcohol services are just one of 17 areas of commissioning responsibility for DsPH. There is no ring-fencing for substance misuse services, and they are not mandated public health services that must be provided by all local authorities.

[1] http://www.nta.nhs.uk/uploads/whyinvest2final.pdf
[2] http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileNov2012small.pdf

6. In 2011, DrugScope and the Recovery Partnership first expressed concerns to Government and officials about potential disinvestment in drug treatment following the transfer of responsibility to local authorities. Last year, an assurance was given that there would be an element of protection or incentive for what was previously the 'pooled treatment budget' built into local public health budgets. However, no meaningful protection or incentive is in place.

7. Additionally, from April 2013, PCCs took control of the CSF across police authority areas, with over half this money comprised of former Home Office funding for DIP, which has been the principal vehicle for identifying offenders with drug problems in the criminal justice system, assessing and referring them into treatment. Given the links between substance misuse and crime, PCCs have an incentive to invest portions of this money in local drug and alcohol systems. However, there is no ring-fencing within the CSF for former DIP funding, and from April 2014, this money will be rolled into the main police grant. There will be pressures on PCCs, in a difficult financial environment, to divert funding from community safety services into policing budgets, and therefore from prevention to detection.

8. A further pressure on drug and alcohol treatment is evidence of reductions in funding, particularly from local authority community care budgets, for residential rehabilitation service places.

9. While there are opportunities for commissioners to pool resources, it is not clear how this will play out in practice, given the complexity of the new arrangements, which is exacerbated by a lack of co-terminosity of key bodies and structures. Moreover, DsPH and PCCs are just part of the new arrangements affecting drug and alcohol services. There are also 10 local area teams of NHS England responsible for substance misuse treatment in prisons; the 21 contract package areas (CPAs) for offender management services in the community, set out in the Government response to the 'Transforming rehabilitation' consultation, should also be taken into account. Offender management systems across the CPAs will be commissioned nationally.

10. The response to 'Transforming rehabilitation' outlines plans for effective engagement between PCCs and prime contractors. However, challenges to integrated commissioning are likely to remain – it is still unclear, for instance, how health and public health commissioners fit into the overall picture. In our response to 'Transforming rehabilitation', we proposed that budgets from prime contractors could be transferred to local commissioners of drug and alcohol services, which could protect against several commissioners paying for the same or overlapping services.

What impact have recent spending reductions had on the implementation of crime reduction policies, and the way in which resources for crime reduction are channelled at local level?

11. Spending reductions are occurring at a time of radical change in the structures for planning and commissioning drug and alcohol services, including a weakening of safeguards that have driven investment in evidence-based services. This spending has been protected, to date, primarily because of the demonstrable impact of treatment on crime reduction and community safety. While a greater focus on 'public health' is welcome, it is concerning that some key decision-making bodies within these reformed structures, including Health and Wellbeing Boards, may not include criminal justice representation. Drug and alcohol services' contribution to crime reduction and community safety must continue to be accorded appropriate weight as the 'centre of gravity' for planning and commissioning services moves to public health.

12. The risk of disinvestment is particularly concerning given budget cuts to local authorities; over the current Spending Review period, there will have been a reduction of 28% in local authority settlements. Since these reforms have only recently come into effect, however, it is unclear what the overall impact will be.

13. A further concern is the end of DIP as a national programme, and the survival of this type of intervention locally under the new arrangements. CSF money for 2013-14 includes the Home Office share of the DIP budget, which is around £32 million. The remainder of the DIP money, around £60 million, has been absorbed into the public health budget. There is no ring-fencing for DIP-style services in PCC or public health budgets; alongside local spending cuts, investment in DIP interventions may not be sustained.

14. DIP has operated in every local authority area in England and Wales, and in 2010-11 helped to manage over 62,000 offenders into treatment. The National Audit Office concluded that the overall level of crime committed by offenders receiving DIP support and in drug treatment fell by 26% compared to their frequency of offending on entering the programme.[3] DIP has also worked as part of local Integrated Offender Management (IOM) approaches. Many IOM services bring together local partners to work effectively with offenders, and it is important that these are supported within the 'Transforming rehabilitation' programme. We welcome the MoJ's commitment that potential providers will have to evidence how they will sustain partnerships, including IOM, while noting that 'Transforming rehabilitation' investment, if not carefully integrated with current local provision, could duplicate existing services, and create parallel or competing structures.

What contribution do existing sentencing, prison and probation policies make to the reduction of crime?

15. Introduced in 2006, the Integrated Drug Treatment System (IDTS) resulted in improvements in treatment provision in prisons and some improvement in continuity of care between prisons and the community. Post-April 2013, responsibility for substance misuse services in prison has transferred to NHS England. It is crucial that, under the new arrangements, what the Patel Report (2010) identified as a "menu of services" continues to be provided, including substitute prescribing for those who need this. The service specification for public health services in prison appears to acknowledge this; it will, nevertheless, be important to monitor the development of provision. Additionally, it is hoped that access to alcohol treatment in prison – which, historically, has been poor – will improve under the new arrangements.

16. Through-the-gate services provide vital support for those released from prison, and we welcome the proposal in the response to 'Transforming rehabilitation' that the MoJ and DoH will develop an "'end-to-end' approach to tackling addiction from custody into the community" in some of the new 'resettlement' prisons. However, community orders are usually more appropriate for offenders with substance misuse problems, who have often committed relatively low level offences. These also avoid the damaging impact of short custodial sentences, including loss of accommodation and employment, and separation from family and friends – what the 2010 Drug Strategy refers to as "recovery capital".

17. Since 2005, the Drug Rehabilitation Requirement (DRR) and the Alcohol Treatment Requirement (ATR) have been available as community order requirements. While DRR breach rates remain high, there has been a reduction in recent years, with 56% completing

[3] http://www.nao.org.uk/wp-content/uploads/2010/03/0910297.pdf

the order in 2011-12, compared with 28% in 2003. A 2008 UK Drug Policy Commission report[4] concluded that "those who are successfully retained on the programmes report reducing both their illicit drug use and their offending and show improvements in other domains."

18. There have been ongoing problems with availability of the ATR, hampering effective use by sentencers.[5] Given the current political enthusiasm for abstinence-based orders, set out in 'Punishment and reform', the lack of treatment-based interventions for offenders with alcohol problems may not be adequately addressed across local areas.

19. DrugScope has a longstanding interest in women with substance misuse problems, many of whom come into contact with the criminal justice system. Our recent work in this area has focused on integrated approaches: we recently published the final report of a four-year project which worked to develop a cross-sectoral network for domestic violence and substance misuse services,[6] and, with AVA (Against Violence and Abuse), we will shortly be launching a report on sex workers' experiences of drug and alcohol services. Accordingly, we would emphasise the importance of women's community services. A recent evaluation[7] highlights that they provide "an alternative to the criminogenic cycle of social exclusion, substance misuse and offending."

20. DrugScope also has an interest in offenders with a 'dual diagnosis' of substance misuse and mental health problems.[8] The Bradley Report (2009) concluded that "despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, services are not well organised to meet this need". The issue of 'dual diagnosis' is relevant to the development of liaison and diversion services, effective use of community sentencing and service provision within prisons. The new integrated offender health function under NHS England presents opportunities to improve services for offenders with a dual diagnosis, while the transformation of local commissioning arrangements creates risks and opportunities.

How cost-effective and sustainable are the Government's strategies for punishment and reform and their proposals for transforming rehabilitation?

21. There is limited evidence on payment by results (PbR) schemes, and so on the cost-effectiveness and sustainability of this approach. We urge caution, therefore, in the rollout of the 'Transforming rehabilitation' proposals. In our consultation response, we recommended that in the initial phase of implementation, no more than 10-20% of contracts should be on a PbR basis. We also highlighted that learning from other schemes, including the eight drug and alcohol recovery pilots (the evaluation of which is not expected to be completed until 2014-15), is likely to prove valuable. Gradual implementation would enable cross-governmental coordination of PbR learning and development, and adaptation of programmes in the light of emerging evidence. It is

[4] http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Reducing%20drug%20use,%20reducing%20reoffending.pdf
[5] See http://www.nao.org.uk/wp-content/uploads/2008/01/0708203.pdf; see also http://www.crimeandjustice.org.uk/opus1292/three_years_on.pdf
[6] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DVReport.pdf
[7] http://www.icpr.org.uk/media/34518/Report%20Nuffield%20final.pdf
[8] See http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf

important, too, that the experience of the Work Programme is learned from.[9]

22. We welcome the recognition in the response to 'Transforming rehabilitation' that incentivising providers' engagement with repeat offenders – which includes those with drug and alcohol problems – necessitates payment mechanisms that take into account reductions in frequency of offending. In developing the outcomes framework, the MoJ should also look at recognising reductions in severity of offending. Many of the issues involved in developing an effective PbR measure for reducing offending and reoffending were considered by the DoH's co-design group for the drug and alcohol recovery pilots, which DrugScope was involved with. We anticipate that the MoJ will want to build on this in developing an outcomes framework.

23. More gradual implementation would also mean that learning on other key aspects of successful implementation, including supply chain management, can be incorporated. This will be crucial to ensure effective engagement of voluntary, community and social enterprise sector (VCSE) agencies and their knowledge and expertise.

24. In its response to 'Transforming rehabilitation' and the Offender Rehabilitation Bill, the Government proposes a 12-month 'statutory rehabilitation' period in the community for prisoners given sentences of up to two years. We recognise the importance of support for those leaving prison. However, in the sanctioning of those convicted of criminal offences, proportionality must be maintained. We are not convinced this proposal will ensure this. Moreover, while the Bill's impact assessment highlights the potential for reduced costs through reduced reoffending, it also outlines possible costs of £25 million per year through breach of licence and supervision conditions, and £5 million through police time needed to deal with offenders who fail to comply.

25. A more cost-effective approach would be encouraging greater use of community orders in place of short prison sentences. It is important to recognise the damage that short prison sentences, in themselves, can cause. Indeed, a previous Justice Committee report noted that they may have a criminogenic effect.[10]

26. The Offender Rehabilitation Bill also introduces a 'Drug Appointment Requirement' as a licence condition or requirement during the new supervision period. The impact assessment indicates that the MoJ is not yet able to quantify the cost of this. We would suggest that there should be a careful assessment of whether the levels of provision needed to implement this requirement will, in fact, be available in the community.

27. 'Punishment and reform' points to the Government's support for abstinence-based orders for those convicted of drug or alcohol-related offences. We would highlight, once again, that these should not be developed at the expense of treatment-based interventions. Additionally, we would emphasise the importance of rigorous piloting of such measures before wider rollout begins.

For further information about this submission, please contact Gemma Lousley, Policy and Engagement Officer, on 0207 234 9735, or at gemmal@drugscope.org.uk

[9] See http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/WorkProgrammeInquiryDrugScopeHomelessLink.pdf

[10] http://www.publications.parliament.uk/pa/cm200708/cmselect/cmjust/184/184.pdf