First test for the DTTO

Drug treatment and testing orders now spearhead the drive to cut drug-related crime. But our analysis of the study used to justify nationwide implementation reveals that urine test results, the orders' key indicator, failed to demonstrate their effectiveness.

by **Mike Ashton**
Editor, Drug and Alcohol Findings

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In September 1998 Cabinet 'enforcer' Jack Cunningham signalled a government on the offensive against drug problems. Drug-related crime was the target and drug testing the major new weapon.[1] Rather than waiting for drug users to opt for treatment, those identified through the criminal justice system would be given a Hobson's choice: risk prison, or stay free but submit to regular urine testing. Treatment and supervision would help offenders produce the drug-free urines which would show that prison was not the only way to tackle crime.

Before nationwide implementation, these new 'drug treatment and testing orders' (DTTOs) were first to be piloted in three locations, but the evaluation was less about *whether* to go ahead than *how*.[1 2] Nevertheless, it could shape the new initiative in ways which would determine whether it delivered worthwhile crime reductions. With just the interim results before them, ministers committed to implementation in every court in England and Wales.[4 5] In Scotland too, treatment and testing regimes have been piloted and the results have led to their being introduced in 11 regions.[6 7 8]

DTTOs are just one manifestation of the government's conversion to drug testing. Their apparent success reinforced the case for testing suspects arrested for offences involving or potentially related to class A drugs.[9] Those who test positive will not be forced into treatment, but they will be offered it through arrest referral schemes.[10] In practice, the incentive to at least go through the motions will be compelling. To enforce abstinence courts will also be able to order testing of offenders thought likely to misuse class A drugs. Completing the package is the ability to subject the same target group to drug testing when they leave prison.[5] Convicted or not, before, during and after prison, and whilst serving a non-custodial sentence, class A drug users will be tested. The ambitious objective is to halve their repeat offending by 2008.[5]

In short, testing is arguably the single most important innovation in current drug policies and an important anti-crime tool. The study examined here is not just a plank in the evidence base for testing; it is practically the whole floor. A large, inverted policy pyramid rests on the 132 offenders interviewed for the study, more narrowly on the 24 who came out the other end, and yet more narrowly on the five who had completed their orders.

THANKS We thank Paul Turnbull of South Bank University's Criminal Policy Research Unit, Professor Philip Bean of the Midlands Centre for Criminology and Criminal Justice and Anita Nichols of Milton House for comments on this article in draft. While they have enriched it, they bear no responsibility for the final text.

Results from the pilot schemes

The orders were piloted in Croydon, Gloucestershire and Liverpool. Researchers from Southbank University evaluated these schemes over their first 18 months. To widen the experience base, the three were allowed to be run on very different lines ◤ *DTTO schemes not all the same*. In each area specially assembled teams of probation officers and health and drug workers assessed offenders referred to them and decided whether to propose a treatment and testing order to the court. From 554 referrals, 288 proposals were made ending in 210 orders.

Interviews with 132 offenders shortly after they started their orders revealed that despite being deeply involved in drug use for many years, three-fifths had never received formal help. Typically young white men unemployed for several years, they averaged 31 previous convictions and four-fifths had been in prison, on average five times. Before arrest, 91% had been using heroin daily and three-quarters had been using crack. A typical weekly drug spend of £400 was funded largely through shoplifting, burglary and selling drugs.

Typically orders were made for 12 months. For half the offenders the teams opted for detoxification or a reducing prescription and for a third residential rehabilitation. Just a fifth received maintenance treatment. This mix varied; two-thirds of the offenders in Croydon received maintenance but none in Gloucestershire.

Sentencers reported that (as intended) in many cases the testing element of the order gave them the confidence to use it instead of prison. When an order is revoked the offender is re-sentenced for the original offence. At least two-thirds then received a custodial sentence, confirming that the orders did act as an alternative to prison. The intention that the sentencing court would also review the offender's progress was achieved in only a minority of cases at two of the sites but in four out of five in Liverpool. Arrangements there were aided by a set time for the hearings and by their being heard mainly by two magistrates. In 8 out of 10 reviews the court did not amend the order but staff did see reviews as important motivators for the offender.

Outcomes good in parts

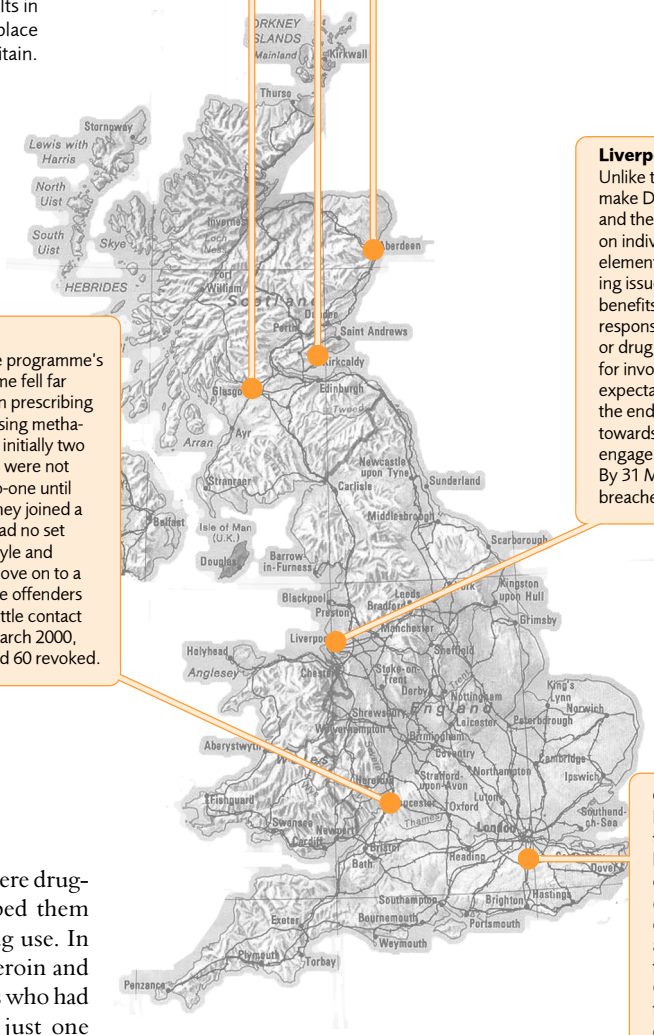
Interviews with three samples of offenders were the main means for determining the orders' effectiveness. One had been on their orders for about six weeks, another for six months. 'Exit' interviews were conducted with a third sample nearing the end of their orders or who had come out the other end (completed or revoked). In each case, current crime and drug use were compared with levels before arrest.[11] Broadly, offenders' responses indicated that they had dramatically cut drug use and crime. However, urine test results were equivocal and there was a large gap in the data: between a third and two-thirds of prisoners were not interviewed because they had dropped out of contact or been thrown off the order. As the report made clear, overwhelmingly data came from people *still actively participating in their orders.*

◤ **Early progress** 132 of the 210 offenders placed on orders attended the schemes long enough to be interviewed about six weeks later. The proportion using heroin in the past four weeks had fallen by 30% and the proportion using crack by 35%. A third were no longer buying illicit drugs and the typical drug spend of the remainder had fallen to £70. Two-thirds had stopped committing acquisitive crimes and a further fifth had substantially reduced their offending. Interviewees who reported selling drugs also fell by almost two-thirds.

◤ **Mid-term** Six months into their orders 48 offenders were interviewed. They felt helped by the structure and intensity of the programmes, support from staff, and access to detoxification and residential rehabilita-

DTTO schemes not all the same
The three English pilots reported on in the main text each ran on different lines. Later pilots have begun to produce results in Scotland. Soon schemes will be in place across Great Britain.

Scotland
By September 2001 the Glasgow pilot scheme had processed 96 orders and the Fife pilot 70 orders. A pilot scheme in Aberdeen was about to open. Initial results were encouraging enough to lead to announcements that schemes would be implemented in another eight areas.



Gloucestershire
Severe implementation difficulties led to the programme's temporary suspension. The actual programme fell far short of original plans. Beyond detoxification prescribing (sometimes much delayed and mainly not using methadone), the programme was drug-free. After initially two (later six to eight) weeks, positive drug tests were not tolerated. Offenders were to be seen one-to-one until they provided a clean urine sample, when they joined a daily induction group for four weeks. This had no set programme but addressed motivation, lifestyle and offending. Offenders who did well would move on to a 'core group'. Very few did so. Nearly half the offenders attended residential rehabilitation and had little contact with the team and its programmes. By 31 March 2000, 100 orders had been made, 63 breached and 60 revoked.

Liverpool
Unlike the other schemes, Liverpool asked courts to make DTTOs without a concurrent probation order and the programme was based not on group work but on individual programmes assembled from a range of elements, many offered by partner agencies addressing issues such as employment, accommodation and benefits or providing ancillary treatments. Allocation of responsibility within the team for offence-based work or drug treatment seemed unclear as did the criteria for involving partner agencies. There was no clear expectation of frequency or intensity of contact. By the end of the pilot period the team had moved towards initially providing a weekly in-house group to engage offenders in treatment and build motivation. By 31 March 2000, 68 orders had been made, 29 breached and 19 revoked.

Croydon
DTTOs were made alongside probation orders to provide a legal basis for offering support beyond drug treatment. An individual package of care was negotiated with each offender drawing on Prochaska and DiClemente's model of change. The intensive programme required attendance at five half-day group work sessions for 12 weeks plus one-to-one appointments. Offenders then attended a group which focused on entitlement beliefs and impulse control. By 31 March 2000, 42 orders had been made, 28 breached and 17 revoked.

tion services. Though under 40% were drug-free, most felt the order had helped them stop (30) or reduce (17) illicit drug use. In the past month just 15 had used heroin and five cocaine or crack, three-quarters who had been injecting had stopped, and just one (compared to most before arrest) had shared injecting equipment. 19 were still buying illicit drugs but typically spending only £50 a week. Very few (three or four) were still committing acquisitive crimes.

Exit 'Exit' interviews were conducted with 31 offenders who had completed or nearly completed their orders. Between them they had committed over 3000 acquisitive crimes in the month before their arrest. All said they were no longer committing acquisitive crimes and only four admitted using illicit drugs apart from cannabis. If their claims are valid, these 31 represent the schemes' successful 'graduates'. Another 19 offenders whose orders had been revoked were interviewed on average eight months later. Compared to when they were still subject to the order, crime and drug use had increased, but both remained far less than before their arrest. Five (down from 11) were still using crack and 12 (down from 18) heroin, but their weekly drug spend was typically £53 rather than £420. An average monthly tally of 190 acquisitive crimes before arrest had fallen to 48.

Urine tests required by the orders provide only a partial check on offenders' reports. Such tests do not reflect *reductions* in drug use unless urine levels fall below the threshold for a positive result. However, tests are, in the Home Office's words, "essential to the credibility of the order".[4] Over the whole study 4 in 10 tests were positive for opiates and about the same proportion for cocaine. In the first four weeks 128 out of 157 offenders tested positive for opiates, typically two to three times. But as offenders progressed through their orders the proportion of opiate positives fell from over half to under a third at around the mid-term. Largely due to persistent high rates in Croydon, cocaine positives remained high.

Failure to comply with the order was common, usually in the form of not attending for treatment or supervision or continued use of illicit drugs. Breach proceedings potentially leading to revocation were mainly initiated for failure to attend. By the end of the study, 96 orders (46%) had been revoked, a proportion which was bound to rise further. The high rate was largely due to the 60% rate in Gloucestershire, where the project insisted on offenders becoming drug-free within weeks without the support of a methadone prescription, and where long distances and travel times made it harder for offenders to keep appointments. There and in Croydon offenders had to attend at least every weekday, but in Liverpool intensity of contact was set individually, sometimes just once a week. At the same site urine testing was once a week or less compared to several times a week at the other sites. In Liverpool, just 28% of orders were revoked.

Often teams in name only

The combination of probation, health, and drug staff in a criminal justice context is not new, but in the DTTO pilots the togetherness had been dictated from above. Clashing professional traditions and values were a serious obstacle, contributing to "considerable conflict" at one, where the quality of the work suffered, and to high staff turnover at another, which derailed initial plans. A recurring issue was how to engender un-

What are drug treatment and testing orders?

Drug treatment and testing orders are community sentences which combine court-ordered treatment for drugtaking offenders with regular mandatory testing to check for continued drug use and periodic review by the courts (preferably the court which imposed the sentence) to assess whether the offender's progress or lack of it requires a change in the order. Probation officers may start breach proceedings against offenders thought not to be complying with their order, having them re-arrested and taken back to court. Ultimately courts can revoke an order and re-sentence the offender for the original offence(s).

The orders can be applied to offenders aged 16 or over who are eligible for a community sentence and whose drug misuse or dependence is considered to require and be amenable to treatment. The intention is to reduce the offending of high-rate property offenders whose crimes are committed largely to finance drug use.[52] Another key objective is to make the orders tough enough to be credible to magistrates and judges yet not so onerous that offenders will refuse to consent to them; both can opt for alternative punishments even when the requirements for a drug treatment and testing order are fully met. Orders can last from six months to three years. They became available to courts throughout England and Wales from October 2000 but are still being piloted in Scotland.

derstanding and respect for the different disciplines' methods and goals without unrealistically wasteful duplication of roles. However, one of the schemes showed that many of the issues could be resolved sufficiently to build an effective team. That site was characterised by a professional attitude from high calibre leadership and staff, energetic engagement with the issues, sufficient management time devoted to their resolution, and regular, well conducted liaison between lead agencies prepared to devolve operational matters to the team's leader.

Promising ...

For the researchers, the results outlined above showed that DTTOs were "promising but not yet proven". First we explore why they are 'promising', then why this has to be qualified by an 'unproven' verdict.

Sufficient quantity

To dent the national burden of drug-related crime, DTTO schemes must process a substantial *quantity* of targeted offenders. Do the pilots suggest throughputs of at least of the right order of magnitude?

Early intake rates can be discounted as too vulnerable to teething problems. More significant is that in the last half of the study schemes averaged the equivalent of 59 orders a year.[12] One such team in each probation area in England and Wales implies a yearly intake of under 3200 offenders, barely half government expectations.[5 13] However, the researchers expected intakes to rise to 80–100 a year, implying at least 5000 a year nationally. Funding is sufficient for this workload. Over a full year £40m is ring-fenced for the schemes,[4] enough for about 6700 orders at an estimated cost of £6000[14] each or 5000 at £8000.[15]

Throughput of this order could make a substantial impact on drug-driven crime. About 1 in 10[16] of the guesstimated 200,000 dependent heroin/cocaine users in Britain[17] are high-rate offenders of the kind targeted by the orders, suggesting 20,000 potential targets. If 5000 a year are processed by DTTO schemes, a high proportion will be subject to DTTOs during their drug using careers. A caseload of this magnitude would rival that of prison and voluntary treatment. British treatment services probably see about 80,000 people a year with primarily opioid or cocaine use problems,[18 19] of whom 8000 might be of the type targeted by the orders. At any one time in 1999, prisons in England and Wales probably held about 11,000 inmates previously dependent on opiates.[20 21]

But numbers are not everything. The offenders must be of the right kind: high-rate, drug-driven offenders. In the pilots, this appears to have been the case. Pre-sentence offending rates were comparable to those seen at arrest referral schemes[22] and several times higher than among criminally active voluntary treatment clients,[23] but reduced along with drug use. Reductions in crime among such offenders account for most of the cost savings due to treatment.[24] Unwillingness of courts to allow prolific offenders to stay on the streets is unlikely to prove a blockage – as long as the orders retain their credibility: courts accepted three-quarters of the teams' recommendations for orders.

Sufficient quality

Having captured an appropriate caseload, the schemes must achieve acceptable improvements. One way to benchmark 'acceptability' is whether DTTOs save more than they cost. The study provides enough evidence to suggest that the orders do create net savings for society.

A bottom line estimate can be reached by making the most pessimistic assumptions: that schemes reach only the throughputs seen in the pilots; that offenders who don't stop drug use and crime make no reductions at all; and that improvements do not outlast the orders. Even on these assumptions, cost estimates derived from NTORS suggest schemes would need to process just 3000 offenders a year to cover their costs, well within their probable capacity. Lasting effects[25 26] and sub-total reductions in crime should mean the orders comfortably net considerable cost-savings. For example, if offenders not entirely free of crime or drug use still made changes which reduced the cost burden on society by just one-tenth, a throughput of under 2000 would be needed to cover costs.[27]

Better than the alternatives?

One key assumption in these calculations is that improvements attributed to the orders *would not otherwise have occurred*. Without a comparison group processed through a non-DTTO system, this remains just an assumption – but it is a reasonable one.

Prosecution and imprisonment[28 29 30 31 32] generally have little lasting effect on dependent drug users.[33] In the DTTO study, all the offenders had previously been convicted and most imprisoned, yet all were still criminally active. Had they been imprisoned again, probably most would have served sentences too short for coherent treatment in prison or to qualify for post-release supervision. Standard probation and treatment orders without testing are associated with reductions in crime and drug use of the order seen on DTTOs.[34] However, many pilot DTTO offenders would not have been considered for these 'softer' options. Over long drug careers when they could have received treatment, just 2 in 5 had done so, and on average they had been out of treatment for 16 months. Most offenders said they accepted the order at least partly to avoid prison. The implication is that many would not have entered treatment without legal pressure.

... but unproven

The wide margin for error means some cost-savings are almost inevitable from DTTOs – but, as the researchers acknowledged, there is no escaping the width of the margin left by gaps in the evidence.

Large gaps in the data

Very little is known about people whose orders were revoked or who participated so little in the schemes that they could not be interviewed ▸ *The problem of missing data*, p. 19. These missing offenders are likely to be doing less well than those who were interviewed. Assuming that improvements among interviewees would be replicated across all DTTO offenders is almost certainly being far too optimistic.

At the first interview, data was missing for over a third of the relevant intake, at the second, for over two-thirds. Representativeness of the 'exit' interviews is limited by the

fact that so few reached this point – the reason why 26 *nearing* exit had to be added. Just five interviewees had actually completed their orders. The additional 19 whose orders had been revoked were only a fifth of all revokees. Interviews with these 24 people (of the original 210) were the only means of assessing changes in offending or drug use which outlasted the orders.

The finding of improvements even in those whose orders had been revoked is based almost entirely on a sample from Gloucestershire, the scheme most likely to have revoked people who were fundamentally doing well. The report does not indicate how many at the time of the interview were free to commit crimes and use drugs and how many were still subject to legal constraint. For revokees above all, those the researchers were able to contact are likely to be doing uncharacteristically well.

Can the results be **believed**?

Baseline data was crucial, forming the benchmark against which the degree of improvement could be assessed. However, there were no pre-order interviews; instead offenders already six weeks into their orders were asked to recall what they had been doing not just before their orders started, but before their arrest.

Neither can there be great confidence in the offenders' accounts of their improvements. If they failed to improve they faced possible imprisonment. Where drug users (and the rest of us) believe we have something to lose from telling the truth, selective recall becomes common.[35] Assurances of confidentiality from unknown researchers may not have been enough. Though trust may have built up in later interviews, at the initial stage this cannot yet have occurred. Even if they did believe the researchers, offenders who thought this far would have realised that their interests lay in exaggerating the degree to which they had cut drug use and offending since being on a DTTO.[36]

From urine tests it's known that at the start of their orders over 1 in 6 offenders falsely claimed no longer to be using opiates. More may have lied but not been caught out. Others may have said they were using less than they actually were, a claim which could not be contradicted by the tests. Reports of criminal behaviour (given the offenders' legal status, a highly sensitive issue) could not be corroborated.

Urine tests **unconvincing**

Doubt over offenders' reports and testing's centrality to the orders make test results an important indicator. Unfortunately, these provide no solid evidence of improvements in drug use. Only in Liverpool did the proportion positive for cocaine fall as offenders progressed through their orders. There *was* a drop in the proportion positive for opiates, but this might have been due to the winnowing out of offenders who continued to use heroin.[37] Rather than indicating success, it could just be that 'failures' were diverted out of the schemes.

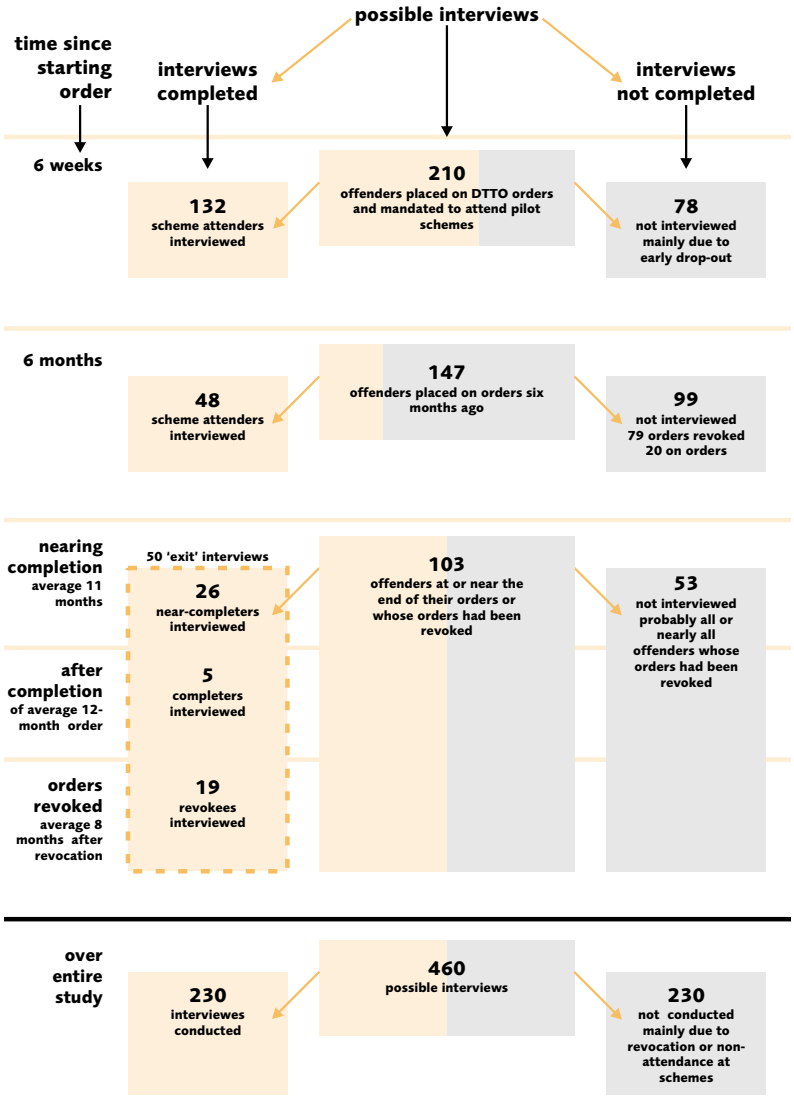
The most fail-safe strategy is to assume that tests missed for whatever reason were positive for illegal drugs. The number of *tests* missed is not recorded, but we do know how many *offenders* could not be tested due to revocation. Assuming they would have been positive for opiates sees an encouraging downward trend evaporate. The remaining glimmer is a drop right at the start, but even this is in doubt; 29 offenders whose tests were counted as occurring in the first four weeks were actually tested *before* their orders *Uncertainty over fall in opiate use*, p. 20.

More important are the proportions of *all* the offenders who started orders who tested positive. On this basis, in the first four weeks the possible opiate positive rate was between 47% and 61%.[38] At six months it might have reached 55%,[39] at best a very small improvement. The true picture lies somewhere between this and the more optimistic impression gained by focusing only on offenders who attended for testing, and ignoring the fact that some tests were done before orders started.

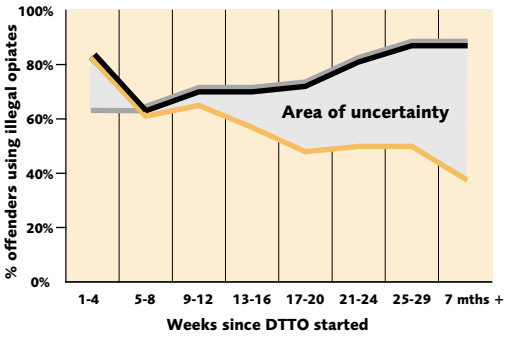
Optimising carrots and sticks

Evidence of effectiveness might have been less equivocal had schemes and sentencers had been able to fully profit from research and experience elsewhere. The mainly US evidence on non-residential programmes for drug using offenders is unconvincing, but does suggest that without also intensifying treatment, more intense monitoring (including drug testing) does not improve outcomes over standard probation or parole, and that the quality of the treatment determines whether it improves outcomes.[40 41]

More relevant is the experience of drug courts in the USA and elsewhere which spe-



The problem of missing data
As many interviews and interviewees were missed from the study as were included. Very few interviews were conducted after completion or after orders had been revoked.



Uncertainty over fall in opiate use
The % of tested offenders positive for opiates ▬ drops over the life of a DTTO. But take into account the number who might still be using but were not tested because their orders had been revoked ▬ and all that remains is a drop after the first four weeks. Even this could evaporate because many tests nominally in this period were actually done before orders had started ▬. The result is uncertainty ▬ over whether there was a drop at all.

cialise in drug-related offences. These emphasise rewards as well as punishments, see offenders often enough to respond swiftly and sensitively to their progress, and maintain continuity in the sentencer dealing with the case. Typically drug courts have available to them a range of minor sanctions and terminate treatment or community sentences only as a last resort.[3 42 43] This pattern of rewards and punishments is more likely to influence behaviour than the all-or-nothing punishments available to British courts.[41 44] Procedures which do not respond to lapses until these have cumulated to an unacceptable degree, and then deliver the irretrievable penalty of a prison sentence, are not the best way to change behaviour.[45 46]

Neither was the pilot schemes' focus on abstinence-oriented non-residential treatment consistent with evidence that most heroin addicts do better in maintenance programmes,[47 48 49 50] including offenders coerced into treatment.[51]

There were positive elements. Despite heightening the risk of breach, the requirement for regular, frequent attendance seems to have been appreciated by offenders as helping to prevent relapse. For some, access to previously denied residential rehabilitation was an important plus, one schemes were able to deliver by side-stepping local authority community care budgets and acceptance criteria.

Addicts can be **expected** to use drugs

The biggest obstacle to the schemes' success was their failure to persuade so many offenders to comply with the programme, despite the threat of prison. Non-compliance undermines the orders' potential to reduce crime and social costs, and the resulting high revocation rate reduces the extent to which they relieve the prison system.

Insistence in Gloucestershire on reaching abstinence within weeks ran counter to evidence that the more realistic goal for addicts coerced into treatment is *reduced* use and crime.[51] Individualised treatment and less frequent attendance requirements in Liverpool provided fewer and lower hurdles for offenders to trip over, probably helping reduce the revocation rate there to well below the other sites. One result should have been that Liverpool retained more offenders who continued to regularly use illegal drugs. Yet reductions in opiate positives were steeper there than at the other two sites, and only at Liverpool did the proportion of cocaine positives also fall, suggesting that the relaxation in requirements helped retain offenders without adversely affecting their progress. Current guidance recommends testing two or three times a week and daily attendance, closer to the regimes in Croydon and Gloucestershire and likely to lead to the same high rate of revocation if national probation guidelines are followed.[4]

Shaky, but still a foundation

Many of the lessons from the study have already been incorporated in new guidance.[4] Here we concentrate on what seem the most significant obstacles to progress and how they might be addressed.

Outcomes might improve if each scheme deployed a range of treatments matched to individual need. One impediment is the fixed length of the order, which encourages use of fixed length treatments rather than indefinite maintenance. To overcome this, local arrangements might be made for transfer of stabilised maintenance patients from DTTOs to GP-based shared care prescribing programmes – assuming these are available and can cope with the burden.

Amendments to laws and procedures to allow rewards and sanctions short of revocation could also elevate performance. A related issue is the degree of tolerance for drug use and other failures to comply. National probation standards stipulate that offenders must be returned to court on the second unacceptable failure to comply; normally the court must then impose a custodial sentence.[9 10] The pilots avoided wholesale rapid breaching only by relaxing the guidelines they were given[52] and reserving breaches for offenders whose serious and persistent non-compliance suggested they would not benefit from the order. Latest DTTO guidance accepts that reductions in drug use can take months and that requiring abstinence after a set time is counter-productive. Though still suggesting that "as a general rule" two unacceptable absences should lead to breach proceedings, they add that each case should be "examined on its merits".[4]

Even these concessions leave offenders who are fundamentally doing well at high risk of being breached because the intensity of the intervention and the closeness of the supervision provide so many opportunities to fail. Teams could be encouraged to concentrate mainly on offending rather than drug use, a focus from which urine tests tend to divert attention. For those genuinely addressing their drug problems, continued positive tests undermine motivation and jeopardise progress if they trigger a breach.

However, testing is the only objective way to check on what may be misleading claims by offenders and, if the results are seen to be disregarded, sentencers may turn away from the orders. This inherent conflict seems likely to interfere with the development of open and therapeutic relationships between offenders and DTTO teams and treatment providers. The researchers' recommendations that testing be individualised in line with goals agreed between the team and the offender, and that relapse be seen as a reason to increase rather than withdraw treatment inputs, can only be implemented to a limited degree without the credibility of the orders suffering.

Could prove a good buy

A policymaker taking a disinterested view of the data from the DTTO pilots might conclude that while those who stay the course do improve, the only objective data (urine tests) does not support the view that overall the orders reduce drug use, and that reports from offenders are seriously compromised by missing data and by an unusually persuasive incentive to exaggerate their progress. Such an observer would have been more likely to put nationwide implementation on hold than to rush it through before the final evaluation report.

But their more optimistic colleague (again hypothetical) who signed the order committing to nationwide implementation would not necessarily have been wrong to do so. Given the very high cost imposed on society by offenders of the kind captured by the schemes, even a very modest impact

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would tip the cost-benefit ratio in their favour, and there was enough evidence to suggest this was the case. Wider implementation provides the opportunity to improve this ratio in the light of more experience than can be gained from just three schemes.

As long as the schemes remain open to evidence, experience and change, rather than tied to counter-productive rules and expectations, they could yet prove to have been as good a buy for £40m per year as the extra voluntary treatment slots this could otherwise have funded.

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33 However, whilst in prison, social cost-savings would have accrued. Prison costs £25,096 per prisoner per year (Charles Clarke. *Hansard*: 28 February 2000, col. 128W).

34 Hearnden I. "Problem drug use and probation in London: an evaluation." *Drugs: Ed., Prev. and Policy*: 2000, 7(4), p. 367–380.

35 Chermack S.T., *et al*. "Comparison of patient self-reports and urinalysis results obtained under naturalistic methadone treatment conditions." *Drug and Alc. Dep.*: 2000, 59, p. 43–49.

36 DTTO teams might be less ready to to believe offenders if anonymised data fed back to them by the researchers revealed continuing high levels of offending and drug use, yet they got a different story from offenders.

37 Offenders who persisted in pre-arrest patterns of opiate use are also the ones most likely to have been left out of the dataset because they were not tested due to revocation of their orders, failure to attend for testing, and/or reconviction for further offending.

38 Depending on whether its is assumed that all those tested before their order tested positive or negative.

39 During the study period 147 offenders had been placed on orders for about six months. Of these 81 either tested positive for opiates or were not tested because their orders had been revoked.

40 Chanhatasilpa C., *et al*. "The effectiveness of community-based programs for chemically dependent offenders." *J. of Subst. Abuse Tr.*: 2000, 19, p. 383–393.

41 Harrell A., *et al*. *Evaluation of the D.C. Superior Court drug intervention programs*. US Nat. Inst. of Justice, 2000.

42 Walker J. *International experience of drug courts*. Scottish Executive, 2001.

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46 Given their average nine minutes duration, there must also be question mark over the depth of assessment and the degree to which offenders were motivated by the courts' reviews of their progress

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49 Bell J., *et al*. "Investigating the influence of treatment philosophy on outcome of methadone maintenance." *Addiction*: 1995, 90(6), p.823–830.

50 Broers B., *et al*. "Inpatient opiate detoxification in Geneva: follow-up at 1 and 6 months." *Drug and Alc. Dep.*: 2000, 58, p. 85–92.

51 Ashton M. "Force in the sunshine state." *Drug and Alcohol Findings*: 2000, 4, p. 21–25.

52 Home Office. *The Crime and Disorder Act. Guidance for practitioners involved in drug treatment and testing order pilots*. 1998.

SECOND SIGHT

Inherent conflicts led to inevitable failures

by **Philip Bean**

Director of the Midlands Centre for Criminology and Criminal Justice

Though drug treatment and testing orders were piloted in England and Wales and evaluated, inexplicably they were introduced nationally before the evaluation was complete. In itself that was ominous, especially as the results were not heartening. At best the failings could be attributed to teething troubles, at worst to a lack of training and defects in the basic concept. Presumably DTTOs were continued for political reasons – why else would we persist with them? Eire got rid of the DTTO two years ago and Scotland will change it irrevocably when it brings in drug courts in December 2001.

The problem stems from a failure to ask basic questions – such as what are DTTOs trying to do? Are they directed at harm reduction or abstinence? If harm reduction (and this seems the most likely), how can that fit into a criminal justice system? For example, if a heroin addict stops taking heroin but continues to take cocaine in lesser amounts, that may be a therapeutic advance, but can it meet the demands of a criminal justice system whose aim is to stop offenders breaking the law? Clearly not. Or take the review hearings. DTTO guidelines say these are to examine progress during treatment. What does 'progress' mean? From the evaluation, it seems no one knows.

Other problems concern procedures. Drug testing, inter-agency working and supervision need to be integrated if they are to be effective. Each on its own has little impact. Yet the evaluation revealed many failings: frequency of testing varied markedly between the areas and the procedure was not always carefully monitored; DTTO teams struggled to develop effective inter-agency working; the three sites had different approaches to supervision, including the use of warnings, breaches and revocation.

All of which was and remains a recipe for failure. Making the probation service responsible for DTTOs compounded the problem. They were ill-prepared, poorly trained, and lacked the necessary ideological commitment. Urine testing is a highly skilled exercise, involving ethical and jurisprudential questions affecting all concerned, issues not addressed in the DTTO guidelines. Supervision must be certain with clearly defined aims. Again not addressed. As for the 'team' approach, if the agencies cannot work together, the offender will take advantage of any defects, of that we can be certain.

Sadly, in England and Wales we seem unwilling to put the matter right. In the meantime we, unlike others nations, continue with an outmoded and inefficient system.

LINKS **Nuggets 5.6 4.12 3.12 3.11 2.10** • *Pressure pays*, issue 2. *Force in the sunshine state*, issue 4.