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## **SU Drugs Project**

### **Phase 2 Report: Diagnosis and Recommendations**

**Project aim:**

**To identify the mix of policies which  
will substantially reduce the harms  
caused by drugs to users and others**

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## Summary (1)

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- The current system has had a limited impact on reducing the massive crime, health and social harms caused by high harm causing users (HHCUs) because
  - it has failed extensively to identify, capture and grip HHCUs when they encounter the criminal justice system, or are being treated in the community
  - the treatment regime has not coped with the formidable difficulty of treating chaotic and constantly relapsing problem drug users, and has not borne down holistically on the harms they cause
  - the organisational responsibility for dealing with HHCUs has been highly fragmented: accountability, responsibility and funding have not been aligned
- The greater attack, ministerial focus and additional resources of recent years have brought – and will continue to bring – improvements; but the changes do not address the fundamental flaws of the historic system, and will not have a transformational impact, particularly on crime harms

## Summary (2)

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- This review recommends a long-term strategic vision for drugs which could halve the cost of drug-motivated crime, saving up to £8b pa. It would be focused on
  - radically improving the system's ability to capture and grip HHCUs through the criminal justice system, and to place them in a more fit-for-purpose treatment regime
  - introducing more coercion, criminalising heroin use and creating a register for HHCUs, alongside enhanced case management
  - placing organisational responsibility for HHCUs with a new National Drugs Service (NDS) located within the new National Offender Management Service (NOMS), and with the Home Office responsible and accountable for bearing down on all drug harms
- There are two options for moving towards the long-term vision
  - gradual movement, with full implementation in 2009/10, allowing piloting and further evidence to be gathered, particularly on the impacts and practicability of criminalising hard drug use, and building in key decision points
  - the alternative would be to move to full implementation within about three years, thereby maximising the prospect for substantially reducing harms
- The review further recommends that free prescription of heroin should be more extensively piloted
  - to build on the experience of other countries
  - and to identify how heroin prescription could benefit some users as one part of a treatment regime bearing down on crime and other harms

## Summary (3)

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- Intervention in the drug supply chain - from the producing countries, through trafficking, to wholesale and retail distribution - is expensive. Supply interruption has been ineffective world-wide in reducing the overall availability of drugs; and it has had little or no impact on reducing harms in the UK. Intervention in the future should focus on reducing harm by driving users and dealers into registration and treatment
- Some interventions in the illicit drugs industry should continue, however, for reasons other than reducing drugs harms
  - to eliminate social nuisance (e.g. dealing on the streets, closing crack houses)
  - to punish criminality, particularly the low thousands of major importers and wholesalers of problem drugs in the UK
  - to aid failing states, where drug production can foster corruption and weaken government, and thus create conditions where poverty grows and terrorism is incubated

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## Scale of the problem: summary of the analysis from phase 1 of the review

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- Around 280,000 high harm causing users (HHCUs), consuming heroin and/or crack, are responsible for an estimated £21bn of harms in the UK each year
  - there are £16bn of crime harms and £5bn of health and social harms
  - each user causes on average £75,000 of harm per year, nearly £60,000 of which are crime harms
- High harm causing users
  - commit 56% of all crime
  - are responsible for around 30% of all crime costs
  - commit the majority of acquisitive crime
    - 80% of domestic burglary
    - 54% of robbery
    - 45% of fraud
- During the course of the year, two-thirds of HHCUs will come into contact with either the treatment or the criminal justice systems
  - but many do not move into treatment, or remain long in it, as a result of those contacts
  - at any one moment, the vast majority of HHCUs, 80%, are not in treatment
  - and most of them are offending to fund their habits

Note: Phase I analysis generally used the last year for which full data is available. Latest figures from DoH suggest that at any one moment 75% of HHCUs are not in treatment.

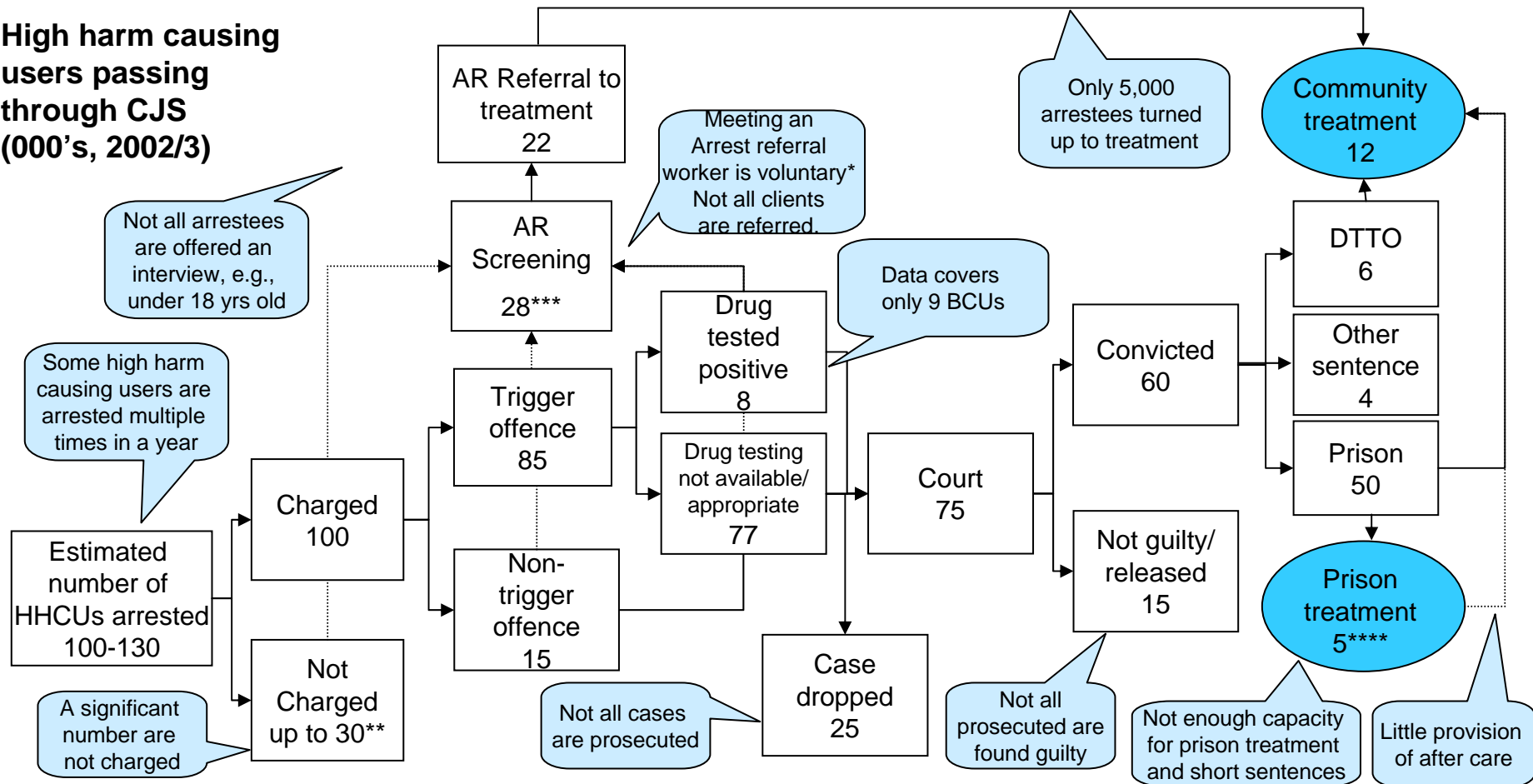
Source: Team analysis, NEW ADAM 'economic and social costs crime'; DoH statistics

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# In 2002/3, up to 130,000 HHCUs entered the criminal justice system but, after leakages, only 17,000 ended up in treatment

High harm causing users passing through CJS (000's, 2002/3)



\* but action may affect sentence and, in the future, bail decision \*\* assumes higher charge rate than normal population \*\*\* 41 all screened, 28 assumed HHCUs

\*\*\*\* the figure of 5,000 for the flow of HHCUs into prison treatment is an estimate based on latest Prison Service data

Note: HO 2003/4 estimates suggest that numbers going into community treatment may rise to 18-21,000. Dotted lines are used where precise flows are unknown

Source: Team analysis, HO Statistics

# Major leakages of HHCUs have occurred right across the criminal justice system

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Identify and grip

- The key leakages in the criminal justice system each year have been caused by
  - a failure to identify that an arrestee is a HHCU. In 2002/3
    - although up to 130,000 of HHCUs were charged, only 28,000 were assessed by an Arrest Referral worker
  - a failure to place the HHCU in the treatment system. In 2002/3
    - although up to 130,000 HHCUs were arrested, up to 55,000 were not charged or will have had their case dropped
    - although 22,000 HHCUs were referred to treatment by an Arrest Referral worker, only 5,000 HHCUs entered treatment in the community as a result
    - although 60,000 HHCUs were convicted, only 6,000 were given a sentence that dealt with their drug use
    - although 50,000 HHCUs were sent to prison, only 5,000 received treatment there
- In total, around 100,000 HHCUs have been leaking out of the criminal justice system each year
  - moreover, of those who were not convicted or who were not directly referred to treatment via the CJS, it is estimated that only 15-25,000, ended up in treatment from a non-CJS referral route (predominantly self-referral or NHS referral)

# Reasons for the leakages of HHCUs from the criminal justice system

Identify and  
grip

Leakages	Reasons
<ul style="list-style-type: none"> <li>Up to 130,000 HHCUs were charged, but only 28,000 were assessed by an Arrest Referral worker</li> </ul>	<ul style="list-style-type: none"> <li>Too few Arrest Referral workers</li> <li>Decision to see an Arrest Referral worker is voluntary</li> </ul>
<ul style="list-style-type: none"> <li>Although up to 130,000 HHCUs were arrested, up to 55,000 will not have been charged or will have had their case dropped</li> </ul>	<ul style="list-style-type: none"> <li>Although HHCUs commit a high volume of crime, individual cases may be of low value, and police and CPS may not drive to the case to court</li> </ul>
<ul style="list-style-type: none"> <li>Although 22,000 were referred to treatment by an Arrest Referral worker, only 5,000 HHCUs entered treatment in the community as a result</li> </ul>	<ul style="list-style-type: none"> <li>User is not shepherded to treatment</li> <li>Treatment is voluntary for users</li> </ul>
<ul style="list-style-type: none"> <li>Although 60,000 HHCUs were convicted, only 6,000 were given a sentence that dealt with their drug use</li> </ul>	<ul style="list-style-type: none"> <li>Historically, drug treatment-specific sentencing has not been a widespread option for the courts</li> <li>Courts often deal with the offence, not the drug using cause</li> </ul>
<ul style="list-style-type: none"> <li>Although 50,000 HHCUs were sent to prison, only 5,000 received treatment there</li> </ul>	<ul style="list-style-type: none"> <li>Many HHCUs only serve short terms in prison</li> <li>Prisons lack the capacity to provide appropriate treatment for all HHCUs</li> </ul>

# What happens to HHCUs outside the criminal justice system

Identify and  
grip

- 120,000 HHCUs entered treatment in the community in 2002/3, and were thus identified as heroin and/or crack users, though not necessarily and explicitly as HHCUs
  - 10% were referred from the criminal justice system (through Arrest Referral workers and via DTTOs)
  - 90% entered treatment via a non-CJS route (including self-referral)
  - over half of those who entered treatment in the community (65,000 HHCUs) had previously been arrested or had spent time in prison
  - 40,000 quit or failed treatment
- 95,000 HHCUs were **neither** in contact with the treatment **nor** the criminal justice systems in a year, and were thus not identified by any part of the system
  - most of the unidentified HHCUs had probably already been in contact with the criminal justice system in previous years, or would be in the future
  - those HHCUs not identified during a 12 month period may be
    - either good at offending and have not been caught
    - or are early in their high harm causing career
    - or are causing significant health harms - e.g HIV - but are in the tiny minority not funding their habit via crime
- So although 120,000 HHCUs may have entered treatment in the community, the system as a whole has not been effective in identifying them as HHCUs
  - or in placing and keeping them in treatment

Note: Latest data, which incorporates a stock and a flow, suggests that 140,900 participated in treatment during 2002/3; this figure will include those being treated for drugs other than heroin or crack. Latest data also suggests that 20% of referrals are directly from the CJS. Of the remainder, 41% self-referred and 25% were NHS referrals

Source: Team analysis based on Regional Drug Misuse Database and others

## In sum, for HHCUs the system is a revolving door

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Identify and  
grip

- Individual HHCUs in the course of a drug career are likely to have
  - constant relapses
  - multiple treatment experiences from multiple providers
  - multiple encounters with the CJS
  - a number of spells in prison
    - sometimes involving treatment
    - sometimes not
- During the course of multiple treatment episodes for the HHCU, there will be
  - no single point of contact for the user with the system
  - no continuity of treatment and support
- The CJS and treatment services will encounter the same user on different occasions taking up police, court, probation and medical resources, but in an uncoordinated and unsystematic way

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# Treatment of HHCU addiction: summary

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Effective  
treatment

- Most heroin and crack use results from deprivation and is often an escape from multiple difficulties in users' lives
- Heroin and crack are highly addictive substances
  - even those who become abstinent may relapse in days, weeks, months or even years
  - many heroin users may remain addicted forever
- Although weaning individuals off drugs is difficult, treatment can, nonetheless, still be effective in reducing some crime, health and social harms
  - evidence suggests that the benefits can be nine times greater than the costs
- Overall, however, because the treatment system in England has failed to grip the HHCU population, at any one time only 20% of HHCUs have been experiencing treatment. The treatment system itself has
  - failed to keep track of HHCUs and maintain them in treatment
  - focused insufficiently on crime harms
  - been unresponsive to new needs, particularly speed or crack
  - performed variably

# Heroin and crack are highly addictive, and long term abstinence is achieved by only a minority

Effective  
treatment

- Heroin and crack are highly addictive because of the speed and intensity of their effect
  - heroin is additionally addictive because of the severe adverse impact when it is withdrawn
- The combination of the high addictiveness of the drugs and the vulnerability of the users, who are most likely to be in or from deprived areas, and to have poor skills and other problems, make HHCUs particularly chaotic and difficult to treat
- Most users reach the point, however, when the impact of drug-taking on their lives (the strain of committing crime; the pain of deteriorating partner and family relationships) creates a desire to lose their habits. BUT, whatever the intention, problem drug use is, unfortunately, a chronic relapsing condition
  - most users experience a continuing cycle of treatment, followed by relapse, followed by a return to treatment
  - nearly half of all HHCUs engage with treatment each year, but most do not stay for long
  - even the minority of users who achieve long term abstinence have on average 4-5 treatment episodes before becoming abstinent
  - long term abstinence rates world-wide are broadly similar to the UK rate of around 20%

# The nature of heroin treatment

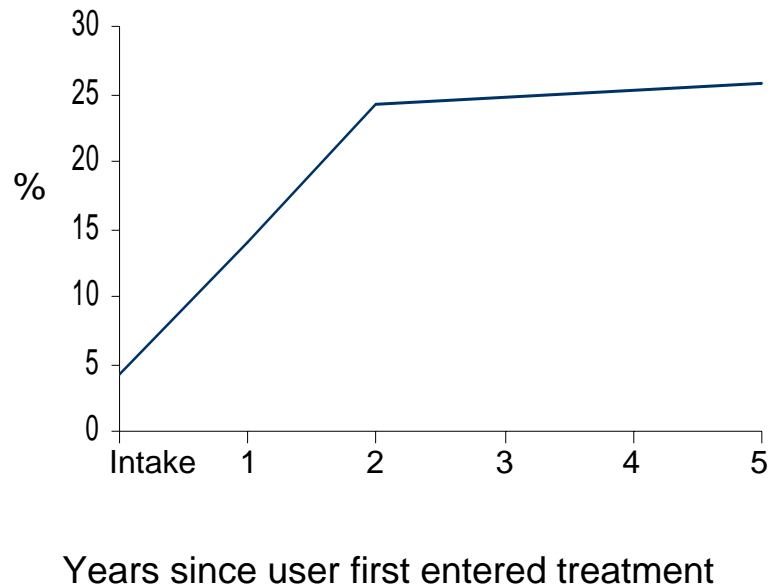
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- Heroin treatment in the UK broadly reflects world-wide practice. Current treatment interventions typically include
  - needle exchange programmes: designed to provide clean needles and advice on injecting practices
  - structured counselling: individual and/or group sessions involving discussion of drugs and other lifestyle issues
  - structured day programmes: sessions of different activities including counselling but also complementary therapies, art and skills training
  - community prescribing: prescription of substitutes for heroin, mostly methadone, or blockers such as naltrexone, to prevent relapse
  - inpatient detoxification programmes: designed to support users while ceasing use altogether
  - residential rehabilitation: group and individual activities including counselling, skills training, etc
- Heroin prescribing is also included in the above range of treatments for opiate dependence, but in practice it is rarely utilised. This is due to
  - a reluctance of doctors in general to prescribe heroin
  - the lack of availability of doctors who are licensed to prescribe heroin
  - the high cost of heroin maintenance treatment

# Evidence of heroin treatment effectiveness (1)

Effective  
treatment

## Heroin users achieving abstinence from all drugs

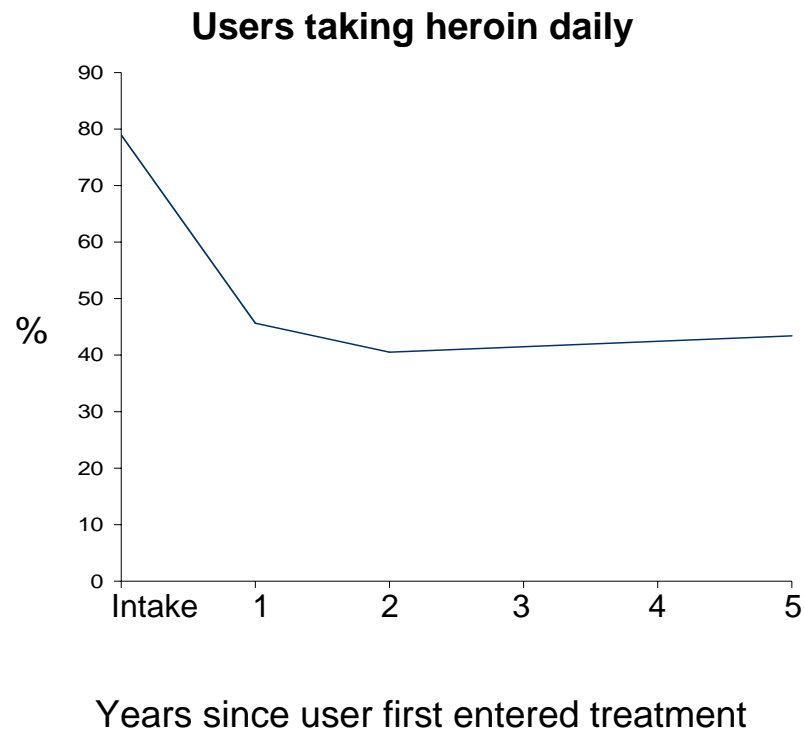


## The difficulty of achieving abstinence

- Around 25% of users who **enter community treatment** become abstinent from heroin over 5 years
- The path to abstinence or less frequent use may be accompanied by multiple treatment episodes
- **BUT**
  - after 10 years the abstinence rate is closer to 20%
  - a quarter of users who have become abstinent still relapse after 15 years
  - for many individuals, heroin addiction may be a life-long condition
- These figures may **overstate** serious drug abstinence because they do not capture those who substitute crack or other serious drugs for heroin

## Evidence of heroin treatment effectiveness (2)

Effective  
treatment



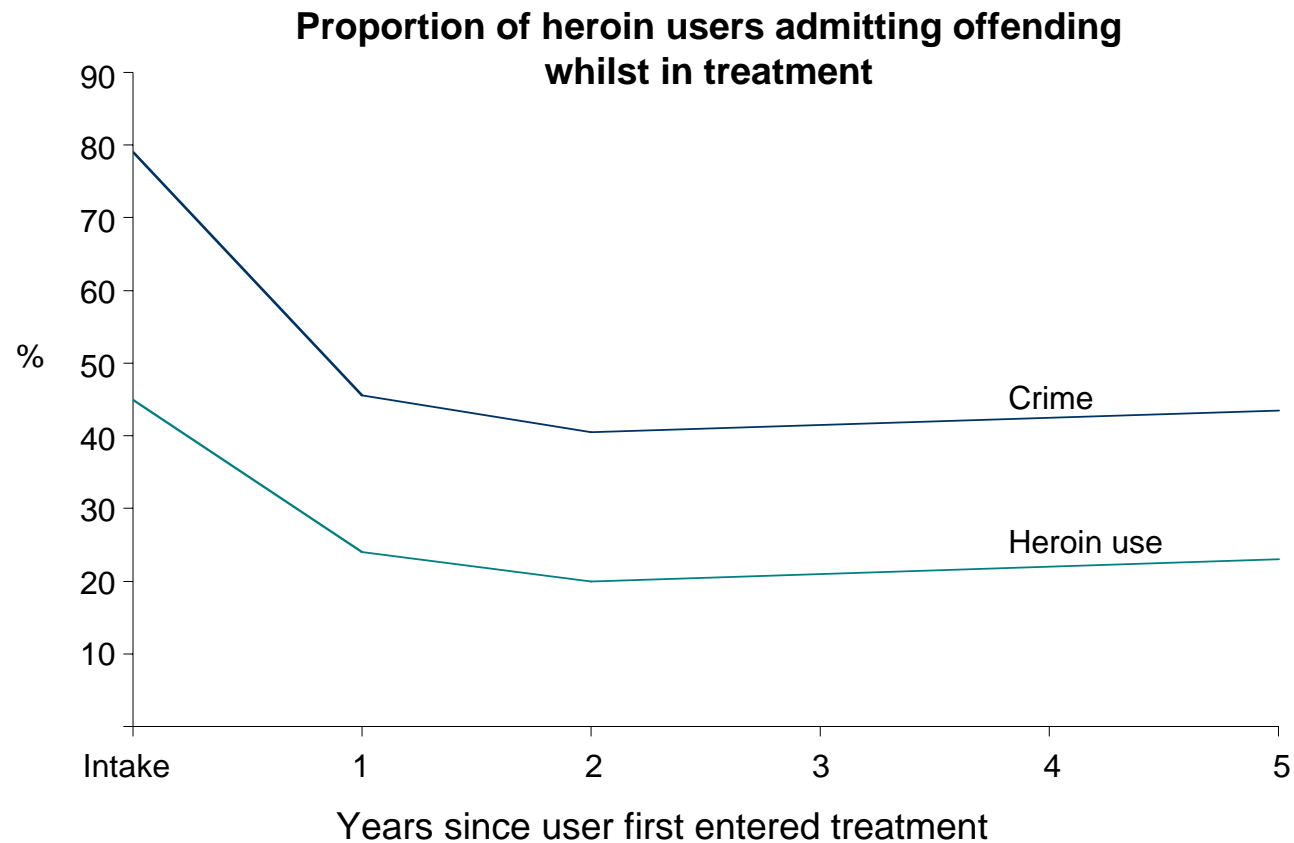
### The impact of treatment on heroin use

- Treatment is typically effective in reducing the frequency and level of heroin use
- The number of users taking heroin daily reduces over 5 years
- **BUT**
  - most once-daily users still take heroin frequently or occasionally
  - one-time frequent users under treatment still take heroin occasionally
- **AND** most heroin users in treatment are probably still continuing to fund (lesser) habits through crime

# The impact of heroin treatment on crime harms

Effective  
treatment

- Crime drops during treatment in line with reduced heroin consumption



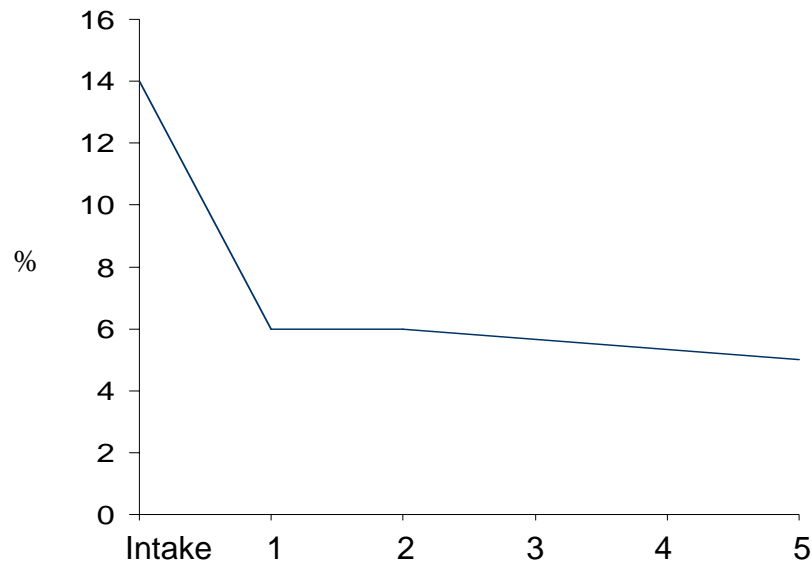
Note: The level of crime committed by heroin users in treatment is likely to be higher than admitted

# The impact of treatment on health harms

Effective  
treatment

- Following treatment, the proportion of heroin users **sharing needles** fell by half in one year

**Proportion of users sharing needles over time following treatment**

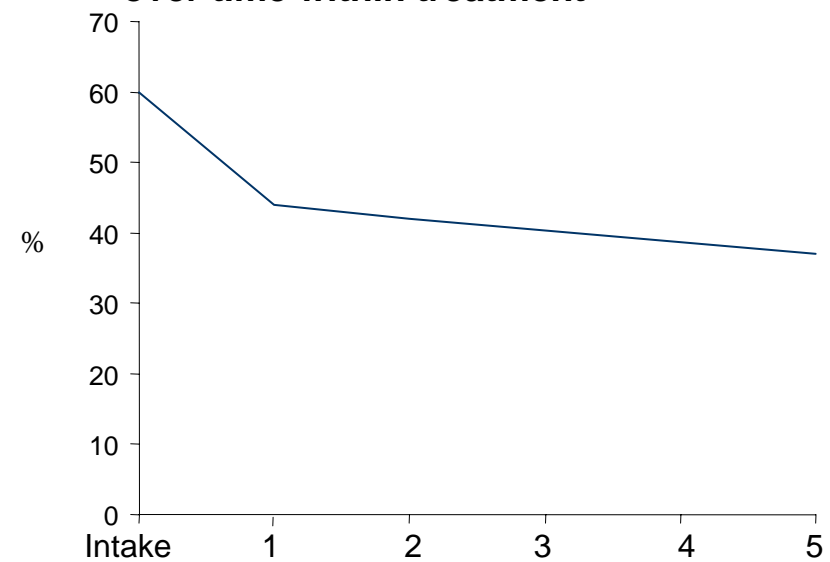


Years since user first entered treatment

- Reducing the sharing of needles reduces the incidence of HIV and hepatitis C among drug users

- Following treatment the proportion of users **injecting heroin** fell by around 25% over 4-5 years (users moved to smoking heroin)

**Proportion of users injecting heroin over time within treatment**



Years since user first entered treatment

- Reducing injecting will lessen the risk of blood-borne infections and other health harms caused (e.g. collapsed veins)

# The nature of crack treatment

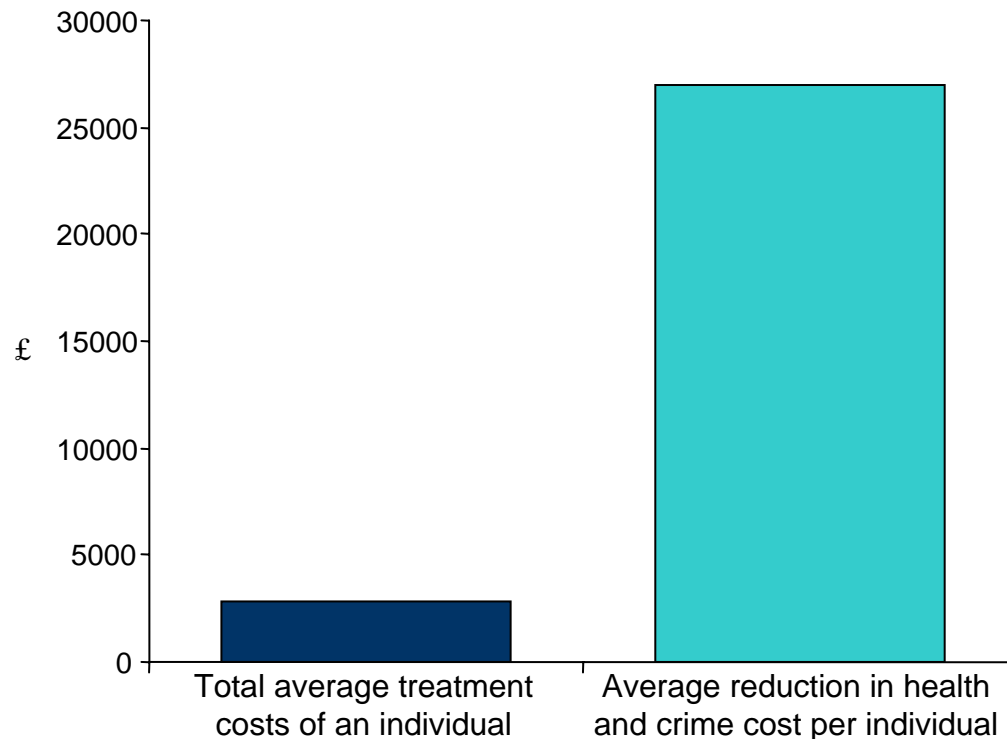
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- Most HHCUs who use crack also use heroin
  - 120,000 use both crack and heroin
  - 22,000 use crack alone
- Crack users are responsible for significant crime harms
  - the pharmacological effects of the drug cause many crack users to commit more violent crime than heroin-only users
- Crack use has been growing more rapidly than heroin use
  - crack has not yet reached some areas of the country, but may spread more widely in due course
- Crack use is treatable
  - drug-free psychological interventions such as counselling are cost effective for users with few complicating problems
  - for more dependent users, cognitive-behavioural approaches can have a positive impact
  - clients with multiple needs, ranging beyond their specific drug problem, respond best to services offering group support and therapeutic activities
  - the severe crack cocaine epidemic has not however been of sufficient duration to produce significant longitudinal evidence on abstinence rates

# Treatment of individual heroin users both in the UK and world-wide appears to produce substantial benefits

Effective  
treatment

Comparison of treatment costs with reduction in harms after two years of treatment



- Although treatment brings abstinence only for a minority, it does reduce crime, health and social harms
- Recent re-analysis of NTORS\* demonstrates that treating addicts in the UK produces a harm reduction nine times greater than the cost of the treatment
- Academic research in the US\*\* and Australia\*\* has produced broadly similar results

Source: Economic analysis of costs and consequences of drug misuse and its treatment: two year outcome data from the National Treatment Outcome Research (NTORS), Godfrey, C., Stewart, and Gossop, M.(\*); Cost-benefit analysis of drug treatment services: review of the literature, Cartwright, W (2000) (\*\*)

## The treatment regime in the UK, however, has not overall had a substantial impact on reducing harms

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Effective  
treatment

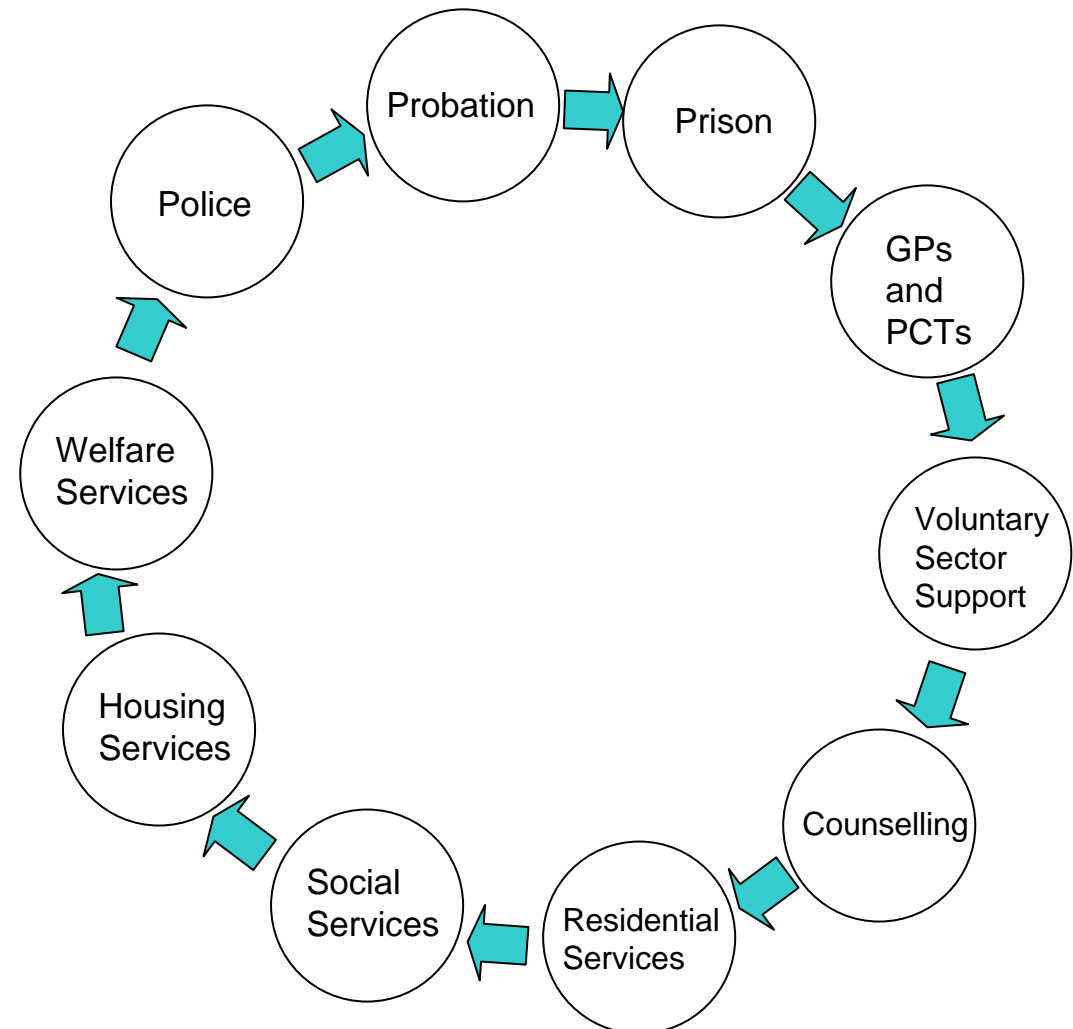
- Treatment in the UK has had a limited impact on reducing harms overall because
  - only a small proportion of HHCUs, 20%, are in treatment at any one time
  - even when HHCUs are in treatment, the regime does not bear down sufficiently on crime harms, the biggest category of harm
  - performance across the system as a whole has been variable
- Limited numbers of HHCUs are in treatment at any one time because
  - no one part of the system has gripped and steered chaotic individuals through the multiple services they need
  - individual HHCUs have had themselves to deal with multiple treatment providers
  - there has been insufficient capacity in the system to cope with total need
  - there has been under-provision of critical services, particularly crack treatment

# HHCUs are likely to encounter many different agencies or services during the treatment cycle

Effective  
treatment

## The treatment cycle

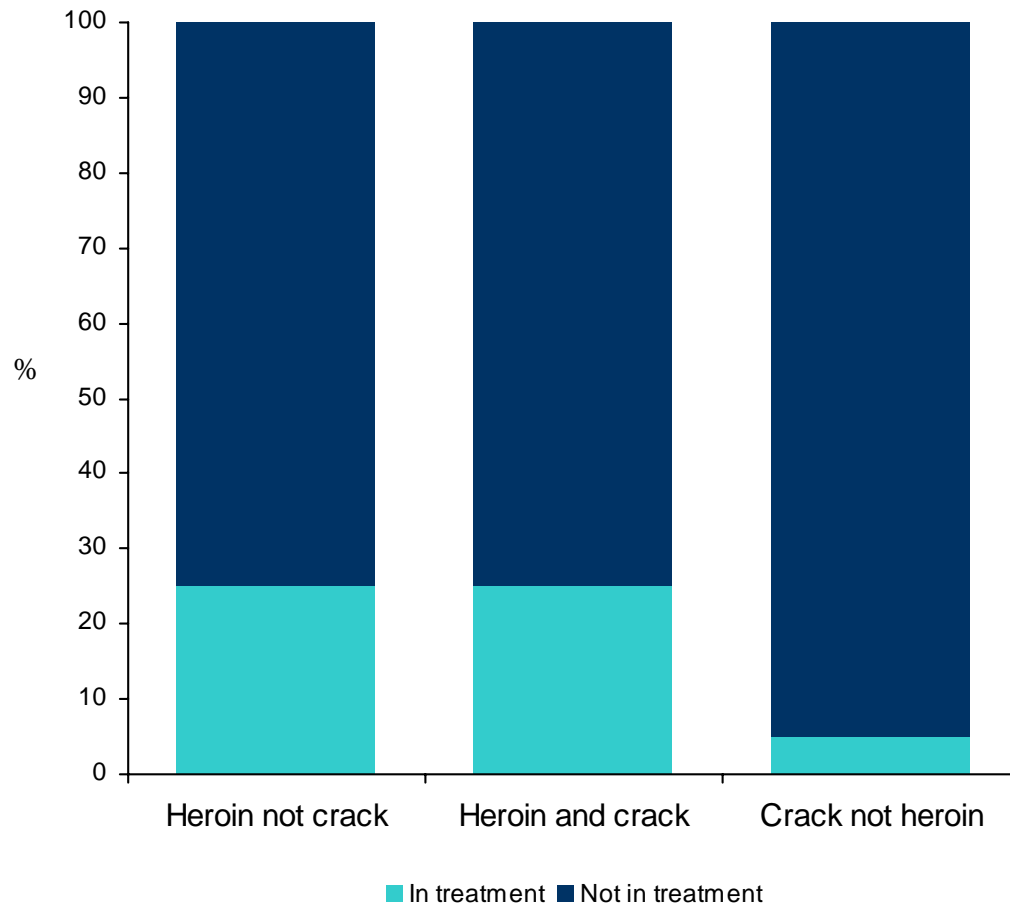
- HHCUs may come into contact with many different agencies and services whilst their treatment and other needs are being provided for
- Within the current treatment system
  - no-one has steered HHCUs through the whole system, ensuring individual user needs are met
  - no-one has been tracking and retrieving HHCUs who have fallen out of the system
  - no one has been responsible for overall outcomes



# There is a severe under-provision of treatment for crack users

Effective treatment

Percentage of users in treatment at any one time, according to drug/s used



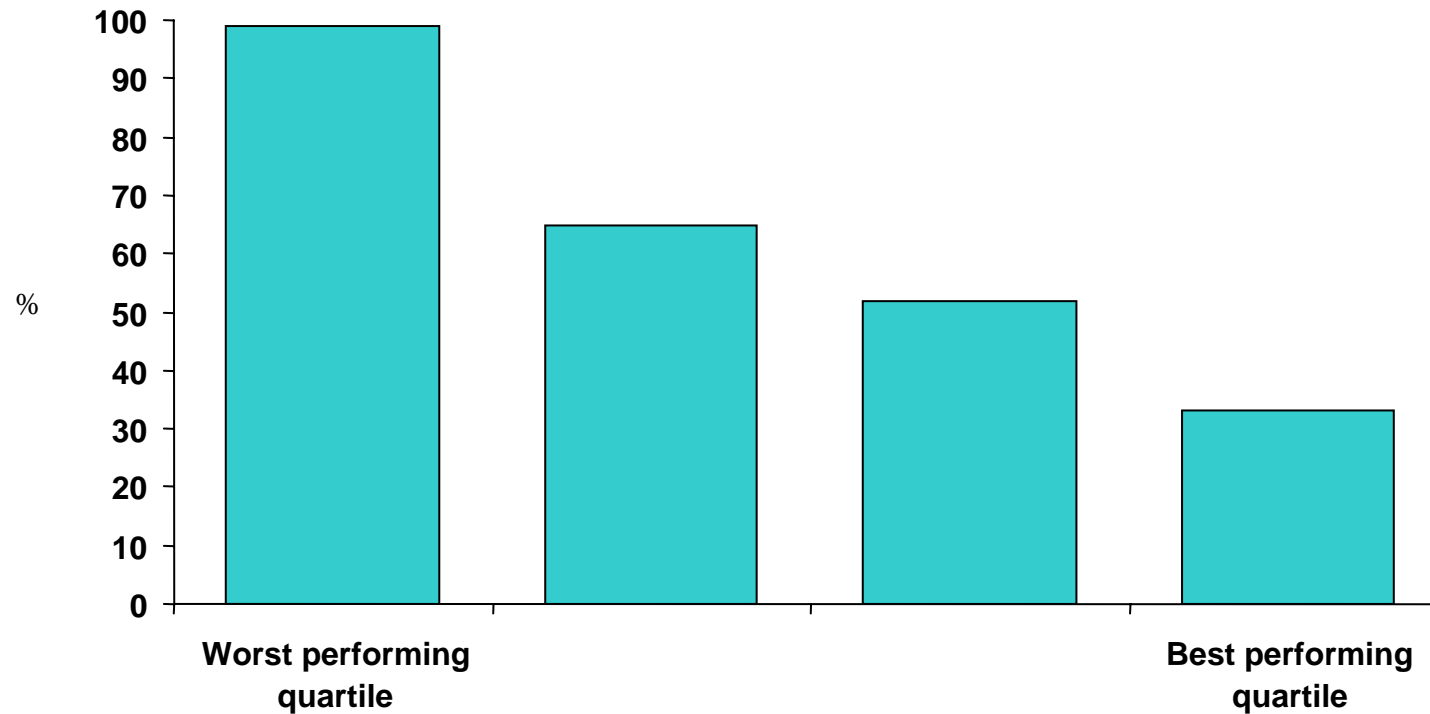
## Crack users

- The treatment system in the UK is mainly configured for opiate users
- Only 5% of those who only use crack are in treatment at any one time

# There is a substantial variation in the success of treatment across the system

Effective treatment

Variation among residential treatment programmes: percentage still taking heroin after one year of treatment



Note: Statistics on agency performance are not kept nationally  
Source: NTORS at One Year 1998

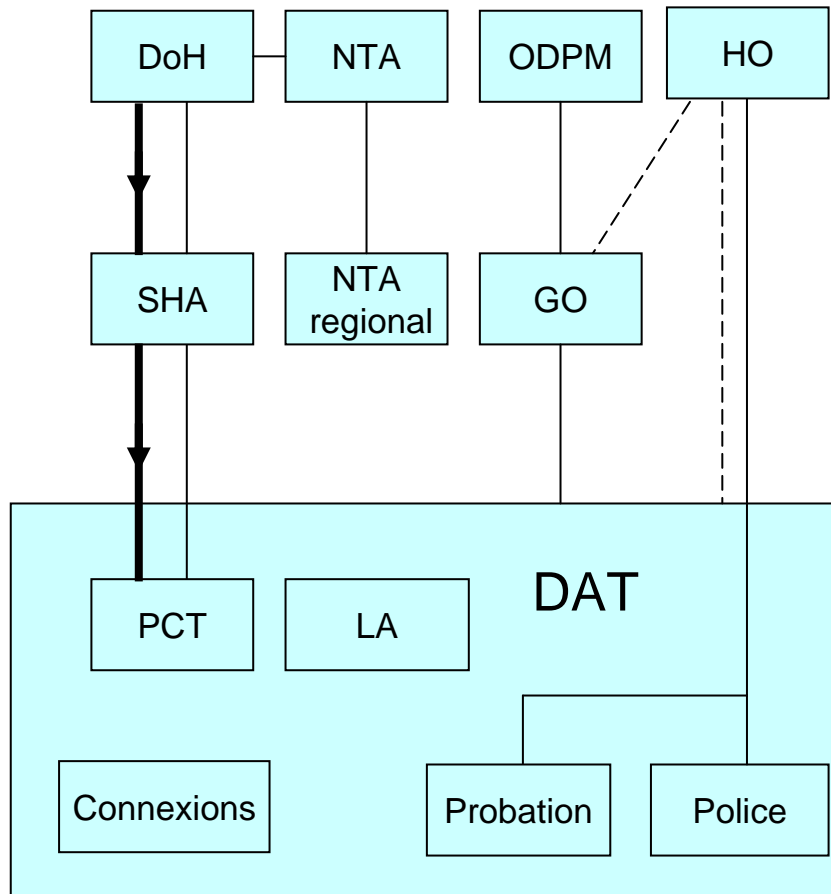
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# The current system has not enabled a clear focus on reducing the harms caused by HHCUs

Organisational focus

## Map of current system



— Main funding route

— Direct accountabilities

- - - Indirect accountabilities

## Difficulties with the current system

- Accountability, responsibility and funding in the current system are not aligned
  - Home Office (HO) is responsible for leadership and outcomes, but has had weak control over funding delivery mechanisms
  - Department of Health (DoH) manages the funding but has had little responsibility for bearing down on the key crime harms
  - the accountability for directing the mainstream health budget towards problem drug users is unclear
- There is no single point of responsibility in the system
  - for achieving outcomes at an operational level
  - for focusing on, capturing, gripping, tracking and providing integrated services for the HHCUs
- There is no single strategic overview of drug treatment, supply interventions and spending decisions. Although HO has overall responsibility
  - targets across the system do not cohere to bear down on harms
  - performance management is conducted by Government Offices
- The NTA has had insufficient leverage to ensure compliance with best practice

## Current targets do not link clearly to user outcomes or harm reduction

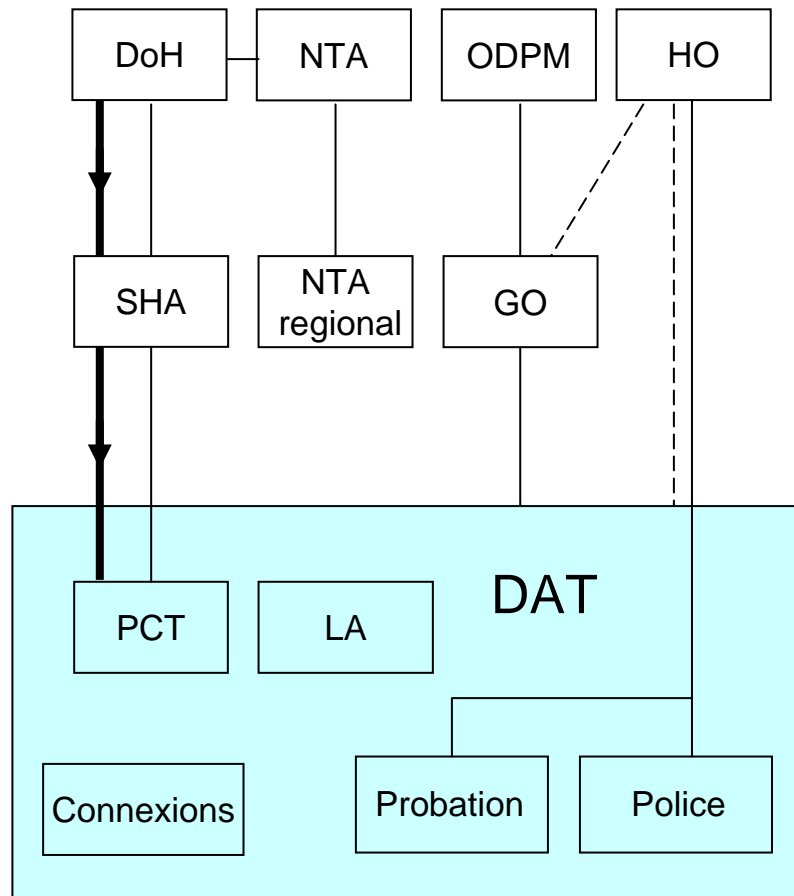
Organisational  
focus

PSA	Responsibility	Assessment
Reducing the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25	Home Office Supported by DoH, DfES and HMT	Target places heavy emphasis on <i>use</i> of drugs by young people rather than a focus on the harms caused
Reduce drug related crime	Home Office	Target is focused on one aspect of harm outcomes, albeit the most important one
Increase the participation of problem drug users in drug treatment programmes, and increase year on year the proportion of users successfully sustaining or completing treatment programme	Department of Health	Target is designed around the throughput volume rather than based on a holistic assessment of harm reduction
Reduce the availability of illegal drugs	HMCE Supported by Home Office	Target focuses on supply side interventions rather than their impact on drug harms

# Accountabilities and funding in the system have not been well-aligned at a regional or local level

Organisational focus

## Map of current system



— Main funding route

— Direct accountabilities

- - - Indirect accountabilities

- The ability of Drugs Action Teams (DATs) to drive performance at a local level is impaired by a lack of clarity of accountability and funding at national level
  - DATs have multiple accountabilities to partner organisations, including the police, probation, local authorities, PCTs, and Connexions
  - DATs do not hold funding directly, and therefore must commission services through partner organisations. It can be difficult for DATs to exert leverage, particularly over treatment provision in the NHS
  - DATs spend much time managing relationships with partners

## Summary diagnosis of the existing system

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- The system has been weak at identifying, capturing and placing HHCUs in treatment when they come into contact with the criminal justice system
- The treatment system has not been designed to grip chaotic drug users; to bear down holistically on all the harms for which they are responsible; and to maintain effective contact with HHCUs throughout their drug career
- There has been no clear organisational focus on the HHCUs or clear accountability for bearing down on the substantial harms they cause

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## Recent and planned changes to the current system

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Current  
changes

- There has been a significant change in recent years in the Government's focus on the problem drug user
  - the 2000 Spending Review brought a big increase in treatment spending; the creation of a pooled budget on treatment; the formation of the National Treatment Agency (NTA); and a new strategic Planning Board in Whitehall
  - in 2001, HO took over responsibility for the overall delivery of the drug strategy. The Cabinet sub-committee DA(D) was established; and, at local level, planning for young people's substance misuse services was integrated and Communities Against Drugs created
  - following the 2002 Spending Review, new targets were framed with an overall focus on problematic use and reducing harm; and spending on treatment increased. CJIP was created, and DPAS moved into GOs which picked up regional responsibility for delivering the drug strategy; pooled budgets for young people were piloted
- The updated Drugs Strategy of 2002 built on this progress. Priorities were to increase the focus on key target groups and outcomes; to embed delivery within mainstream services; to improve performance management; and to remove unnecessary bureaucracy

## Improvements are being made both to capturing users and to treatment services

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Current changes

- The Criminal Justice Interventions Programme (CJIP), which has been established in 25 areas, is focused on capturing HHCUs as they pass through the criminal justice system
  - within CJIP, Arrest Referral workers are being brought together with workers from other local statutory service providers to form Criminal Justice Integrated Teams
  - the number of HHCUs placed in treatment in 2003/04 is expected to increase by between 6,000 and 9,000
  - the HO's best-case scenario for full development of CJIP suggests that up to a further 40,000 users may be placed in treatment in the community by 2007/8
- Treatment services are improving
  - in 2002/3 140,900 drug users participated in treatment, a 10% increase on the previous year
  - average waiting times have progressively fallen to 2-5 weeks by October 2003
  - steps are being taken to ensure that PCTs and other service providers act in line with NTA guidance
  - there is a focus on improving the information base, including consideration of a follow-up to the National Treatment Outcomes Research Study

# CJIP Assessment

Current changes

Best case scenario estimated by the Home Office at full potential of CJIP	What the HO aspirational scenario for CJIP implies	Strategy Unit assessment of forecast CJIP improvements
<ul style="list-style-type: none"> <li>The number of HHCUs who enter community treatment through the CJS would be expected to increase to 61,000 per annum from 12,000 in 2002/3</li> <li>This would be achieved by:                             <ul style="list-style-type: none"> <li>- increasing arrest referral screening numbers from 41,000 to 55,000</li> <li>- increasing the percentages referred to treatment from 68% to 76%</li> <li>- doubling the 2003/4 figures of treatment take up to 74%</li> <li>- increasing the number of HHCUs accessing treatment via community sentencing from 9,000 to 30,000</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>With full rollout of CJIP the HO estimate that the number of HHCUs entering treatment via the CJS will triple</li> <li>The overall impact, if CJIP achieved these objectives, would be to reduce crime harms by up to £2.3bn per annum by the time the scenario reached steady state</li> </ul>	<ul style="list-style-type: none"> <li>Given SU diagnosis of the system overall, we are sceptical about whether it is likely that treatment take up will increase by more than double the rate achieved by the best performing DATs. Raising performance to current best practice levels may be more realistic</li> <li>It may also be more realistic to forecast a growth rate for generic community sentences more in line with the growth rate for DTTOs, leading to a forecast of around 23,000 rather than 30,000</li> <li>The overall SU assessment is that the full roll out of CJIP would be more likely to reduce crime harms by £2bn per annum by the time the scenario reached steady state</li> </ul>

# Steps are currently being taken to improve organisational focus

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Current changes

- A range of measures are being taken to improve delivery
  - Key Performance Indicators will be introduced to reinforce the accountability of individual agencies
  - a new senior Whitehall group has been set up under Home Office leadership to drive progress forward
  - the burden of bureaucracy for partnerships is being addressed
  - funding streams are being simplified by creating young people and CJIP pooled budgets, bringing down the overall number of funding streams handled by local partnerships from 19 to 4
  - drug treatment is being prioritised within the DoH star-rating system by ensuring that a target on treatment for drug misuse is included in the PCT Performance Ratings process for 2003/4
  - PCTs are being made a responsible authority (along with local authorities, police and others) under the Police Reform Act with duties to produce agreed local crime and drugs audits and strategies
  - integrated drugs teams are being formed in Government Regional Offices to performance manage partnerships across the strategy
  - the role and accountabilities of the NTA will be reviewed

# Overall assessment of current initiatives

Current  
changes

Issue	Plan	Likely impact
Improved capture	<ul style="list-style-type: none"> <li>• CJIP</li> </ul>	CJIP will improve capture and is also likely to improve outcomes from treatment and other interventions. However, there are serious limitations on how far CJIP can plug the range of leaks identified in the SU analysis
Improved treatment	<ul style="list-style-type: none"> <li>• Increase capacity</li> <li>• Improve compliance with guidance</li> <li>• Reduce waiting times</li> </ul>	Numbers entering treatment have increased year on year while waiting times have fallen. Participation rates appear low. Although capacity has been increasing, there remains significant unmet need.
Organisational focus	<ul style="list-style-type: none"> <li>• Key Performance Indicators</li> <li>• Reducing bureaucracy</li> <li>• Simplifying funding streams</li> <li>• Star-ratings for PCTs</li> </ul>	Activities underway will help embed drugs objectives in mainstream services and a lot of good work is going on within many DATs. However, accountabilities and funding are not aligned to drive the system, and successes are often driven by personal relationships

## Overall assessment

Recent and planned initiatives are likely to bring improvements and to reduce harms, but are unlikely to be transformational

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Current initiatives do not address the fundamental problems the review has identified and are unlikely to bring substantial change. If we seek a transformational improvement in reducing drug harms, a more radical long-term strategic vision needs to be considered

# Achieving transformational change

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- Drug harms will only be substantially reduced by a system which
  - **Identifies and grips** the HHCUs
    - Achieving a step-change in capturing HHCUs, and in placing them in treatment
    - Monitoring and tracking and keeping HHCUs in treatment, addressing the problem of the revolving door
  - Provides an **effective treatment regime** which bears down all the harms arising from problem drug use
    - Achieving an individual and continuing focus on users, ensuring that they receive treatment and services meeting all their needs, and bearing down on the full range of harms
  - Brings clear **organisational responsibility and accountability** for reducing drugs harms
    - Ensuring that accountability, responsibility and funding are appropriately aligned
    - Avoiding unnecessary confusion and overlap between organisations

**We set out a vision that meets these criteria, and identify two options for achieving it**

# Vision of a future drug regime




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## Identify and grip the HHCU

- Combine enhanced case management with making heroin use an offence
- Create a Drug Treatment and Registration Order (DTRO)
- Introduce compulsory registration of heroin users
- Allow voluntary registration
- Give the Police Service and a new National Drugs Service (NDS), part of the newly proposed National Offender Management Service (NOMS), a statutory duty to monitor HHCUs and to increase the number entering treatment

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## Effective treatment

- Introduce a new case manager system for every user, with case managers working for the new NDS
- Create a statutory duty for Local Authorities to provide support services for registered users

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## Organisational focus

- Create a National Drugs Service (NDS) as a division of the newly proposed National Offender Management Service (NOMS)
- Channel all drug-related funding, including relevant mainstream health funding, to the National Drugs Service acting as a purchaser
- Make NTA, possibly to become a division of CHAI, responsible for identifying and monitoring compliance with best healthcare practice
- Make HO directly accountable and responsible for driving down all drugs harms, and for achieving targets on harm reduction

# Identify and grip the HHCUs

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Vision

- Summary of difficulties to overcome in the long-term if the system is to improve its ability to identify and grip HHCUs
  - HHCUs are generally arrested for committing a non-drugs offence, and the focus of the criminal justice system has often been on the offence rather than on the drug-motivated cause
  - very few HHCUs enter treatment as a result of this interaction with the criminal justice system, and have their drug use focused on
  - half of HHCUs are not arrested each year, though most are known to the police
  - the needs of HHCUs are complex and long-lasting, and existing mechanisms do not allow continuing long-term supervision after sentencing

# Implementing this vision would transform the system's ability to identify and capture HHCUs and to place them in treatment



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## Making heroin use an offence

- Enables police to target, arrest and test HHCUs in the community
- Enables the criminal justice system to focus directly on drug use

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## Drug Treatment and Registration Order

- Provides a sentence for the court which
  - focuses on drug use
  - enables the long term registration of HHCUs

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## Compulsory registration

- Allows a continuing focus on HHCUs after the sentence
- Enables tracking and monitoring by NDS case workers of individual users and the harms they cause
- Becomes the passport to methadone maintenance or heroin prescription

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## Voluntary registration

- Enables HHCUs and other problem drug users to enter the system directly and to circumnavigate a criminal justice system intervention

**The increase in coercion must be accompanied by enhanced case management to maximise the effectiveness of the treatment regime and to keep HHCUs in treatment**

# Making heroin use an offence (1)

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## Heroin use as an offence

- Heroin use would be made an offence on a par with heroin possession (which currently carries a maximum seven year sentence)
- HHCUs who test positive would be required to face an assessment from a National Drugs Service case worker; refusing the test or the assessment would be an offence
- Those HHCUs who have tested positive but who have not been arrested for another offence would face a choice
  - either go to court and have a Drug Treatment and Registration Order (DTRO) imposed on them
  - or register voluntarily with the National Drugs Service and commit to a standard regime, thus avoiding a conviction: a breach of voluntary registration would be reported to the police
- Those HHCUs who test positive and who have been arrested for another offence would, if convicted, receive a DTRO alongside any other sentence
- Breach of a DTRO
  - should first attract a community penalty e.g. tagging or tracking
  - and should only attract a custodial penalty as a last resort

## Police

- The police would be tasked to capture all HHCUs, including drug-using dealers
  - they would need to have a reasonable belief that an individual was taking heroin before arresting and testing them
  - they would have new performance targets to reflect this change of focus

## Making heroin use an offence (2)

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### Crack users

- There is currently a test for cocaine, but not for crack; present drug tests cannot distinguish between cocaine and crack
  - a test for cocaine would pick up a large number of recreational cocaine users, and would not be effective in targeting HHCUs
  - if a test for crack were to be developed, crack use should also be made an offence alongside heroin
- However, a high proportion of crack users - around 85% - also use heroin, so will be picked up in any case under the regime
  - a smaller number of crack users - 22,000 - do not take heroin, and would escape the net
- Making heroin use an offence would require careful framing to avoid the perception that Government considered crack less serious than heroin
  - a primary power could be taken to make use of hard drugs an offence
  - secondary legislation would set out the detail; regulations would initially specify heroin use as an offence, but would be amended if/when a test for crack were developed
- It is highly unlikely that HHCUs will switch to crack in response to making heroin use an offence, as crack and heroin are pharmacologically different drugs. Moreover, most HHCUs already break the law on a daily basis to fund their heroin habit, and to buy the drug - so it must be doubted that criminalisation of heroin use would really affect their behaviour

## Making heroin use an offence (3)

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Vision

### Impact on recorded crime

- Making heroin use an offence would lead to an increase in recorded crime. However, this would be offset
  - by encouraging those testing positive to register voluntarily
  - by the large drop in crime that should result from the more effective grip on HHCUs that making heroin use an offence would allow

# For heroin use to be made an offence, it would need to be compliant with the ECHR

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Vision

## Compliance with the European Convention of Human Rights (ECHR)

- The compatibility with the ECHR of making heroin use an offence would need to be established. The rationale for compliance would be
  - the enormous scale of harms that are caused by HHCUs
  - the established link between heroin addiction and the need to fund that habit through crime
  - the precedents set by France, Sweden and Finland

# A key test for ECHR compliance would be whether the new offence was proportionate

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Vision

## Potential challenges under ECHR to making heroin use an offence

- It may be suggested that it is disproportionate to have a sanction of a custodial sentence for refusing a drug test. However
  - refusing a drug test currently attracts a £2,500 fine or 3 months spell in prison, which will rise to 51 weeks under the Criminal Justice Bill
  - failure to take an alcohol test on suspicion of drink driving is also an offence attracting a fine of up to £5,000, a sentence of up to 6 months, and/or compulsory disqualification from driving
  - anecdotal evidence from police suggests that refusal to participate in a drug test is currently extremely rare, though that may change if heroin use were made an offence
- It may be suggested that compelling users into treatment would also be disproportionate. However
  - as now, with DTTOs, HHCUs could refuse to sign up to a DTRO and could opt for prison
  - other HHCUs might not comply with DTROs - as now with DTTOs - and repeated breaches may also lead to prison
- When and if Departments identify a detailed template of how the mechanics of registration and use as an offence would work, the case for ECHR compliance would need to be established

# The consumption of heroin and other illicit drugs is already illegal in three EU member states

Vision

<b>France</b>	<b>Sweden</b>	<b>Finland</b>
<ul style="list-style-type: none"> <li>• Drug use has been a criminal offence since 1970</li> <li>• Suggested punishment: one year in prison and a fine of euros 3000</li> <li>• Compulsory treatment can be by a 'therapeutic order', aimed at addicts arrested by the police following criminalisation of use. However, this has been criticised for its non-uniform application and because it was not intended to deal with recreational users</li> <li>• Imprisonment is used as a 'last resort'</li> <li>• No evidence of ECHR challenges</li> </ul>	<ul style="list-style-type: none"> <li>• Drug use has been a criminal offence since 1988</li> <li>• Suggested punishment: six months imprisonment</li> <li>• Police empowered to undertake urine or blood specimen to verify consumption</li> <li>• Those testing positive are fined and referred to a social worker who makes a decision on appropriate treatment (take-up is compulsory)</li> <li>• No evidence of ECHR challenge</li> </ul>	<ul style="list-style-type: none"> <li>• Consumption of all illicit drugs has been a criminal offence since 1966</li> <li>• Suggested punishment: a fine or maximum six months imprisonment</li> <li>• Public opinion consistently supports strict measures to control drugs</li> <li>• Prosecution &amp; punishment can be waived if the offence is to be considered insignificant or if the suspect seeks treatment (1994 amendment, revised 2001)</li> <li>• A person suspected of drug use will undergo harsher treatment in comparison to other criminals in the Finnish legal system, but powers to coerce users into treatment are rarely used</li> <li>• No evidence of ECHR challenge</li> </ul>

# Compulsory and voluntary registration of heroin users (1)

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Vision

- A Register of all heroin users would be kept by the National Drugs Service (NDS)
  - all users with DTROs or custodial sentences would be automatically registered
  - registration could also be **voluntary** following arrest and testing, or via self-referral by an individual, possibly prompted by a healthcare professional
  - crack users would also be able to self-refer and to register voluntarily to access treatment
- The purpose of the Register would be
  - to allow a continuing focus on individual HHCUs
  - to enable tracking and monitoring of users and the harms they cause
  - to allow targeted follow-up activity by either the NDS or the police
  - to enable the NDS to forge an overview of the cohort, and to measure whether national policies are successfully bearing down on harm
- As part of the assessment process, NDS case managers would make recommendations on appropriate treatment and on an appropriate period of registration
  - for example, a 16 year old who self-refers early in their drug career might be registered for just two years, whereas a more problematic user might be registered for up to ten years
  - where registration was imposed as part of a DTRO, a breach would lead to the period of registration being renewed

# Compulsory and voluntary registration of heroin users (2)

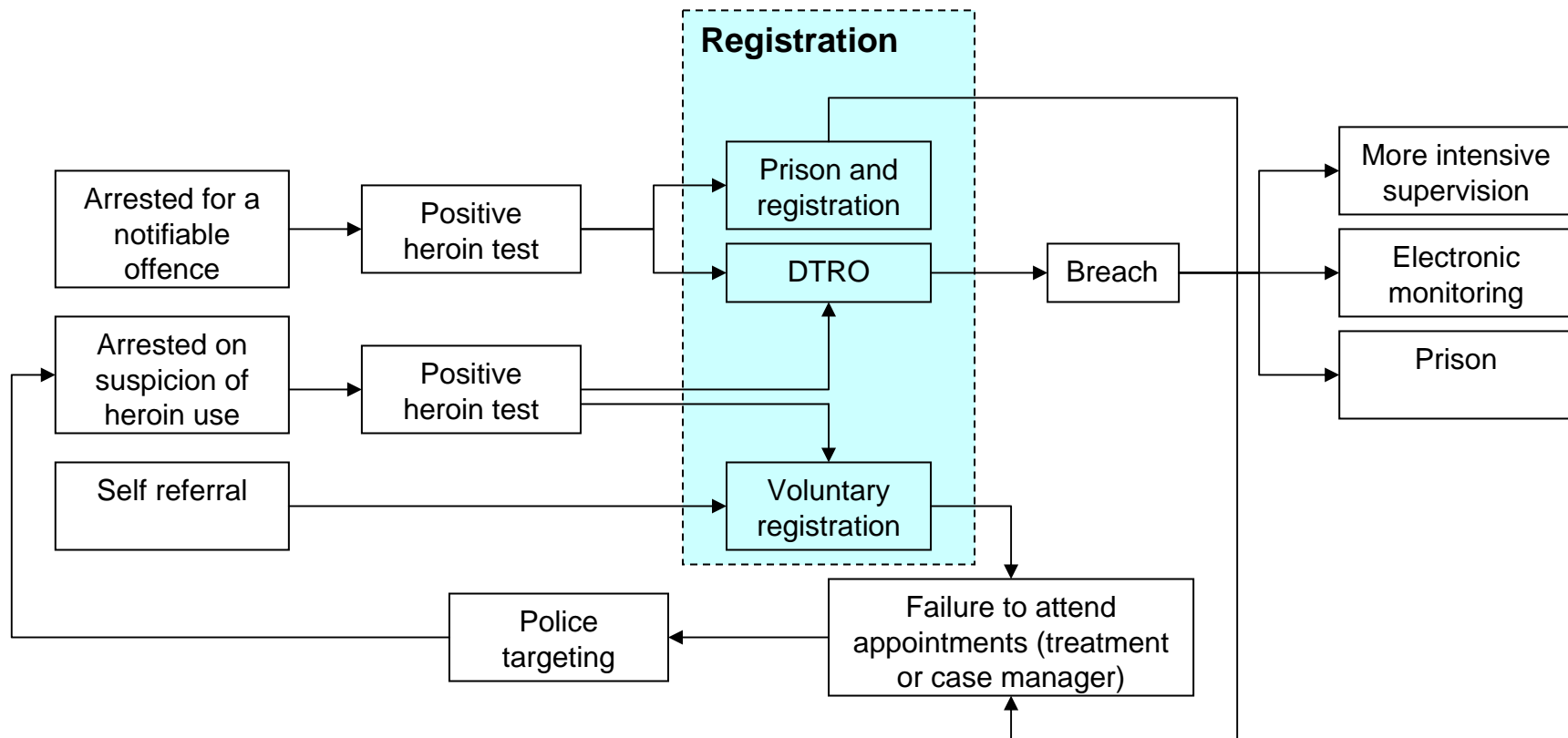
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Vision

- Individuals on the Register would come under the care of a case worker from the National Drugs Service with responsibility for all aspects of their care and for bearing down on all the harms associated with the particular pattern of their habit, including health and social harms. The register would entitle the user
  - to all modalities of treatment (prescription of methadone or indeed heroin would not be lawful without registration)
  - to all the services provided by the local authority
- The Register would be accessible only to National Drugs Service staff and would record
  - the current drug-using status of users
  - the treatment they are receiving
  - their offending behaviour
  - their whereabouts (users would be required to notify a change of location)
- A register of a special offender group currently exists in the criminal justice system – the Violent Offender and Sex Offender Register (ViSOR) – which is jointly managed by police and probation

# Implementing the vision would transform the ability of the criminal justice system to grip HHCUs

Vision



# Why coercion is a critical feature of a regime designed to transform the system's ability to grip offenders

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Vision

- Coercion
  - enables the targeting and capture of HHCUs known to the police, but who have not been caught for the offences they are committing
  - enables those encountering the CJS to have their drug use dealt with, rather than relying on conviction for another offence
  - enables HHCUs to be registered and kept in treatment under a case manager regime, and to benefit from a continuing focus of attention on their many needs
- Modelling work and analysis shows that a system **without** coercion, which does not allow a stronger grip on the chaotic relapsing drug user, would be far less effective in reducing harm
- But coercion alone is not enough
  - it must also be accompanied by enhanced case management to sustain users in treatment
  - an emphasis on case management is likely to be important for achieving the active involvement of practitioners on the ground

# A new system would interact with different categories of heroin users in different ways

Vision

Category of user	How the current system views and deals with the user	Possible actions in the new regime
Using heroin, offending and arrested for a non-drugs offence	<ul style="list-style-type: none"> <li>Likely to be known to the police as a HHCU</li> <li>Arrested/charged or convicted of a notifiable offence</li> <li>Assessed by an Arrest Referral worker and referred to treatment where necessary</li> </ul>	<p>The HHCU is</p> <ul style="list-style-type: none"> <li><b>either</b> convicted and given a DTRO (in the community or in custody dependent on the nature of the offence)</li> <li><b>or</b> not convicted of original offence but convicted of heroin consumption and given a DTRO</li> <li><b>or</b> not convicted of original offence but voluntarily registers</li> </ul>
Using heroin and offending but not arrested for any offence	<ul style="list-style-type: none"> <li>Likely to be known to the police as a HHCU</li> <li>Could be targeted through one of the pre-arrest initiatives available in some areas</li> </ul>	<p>The HHCU</p> <ul style="list-style-type: none"> <li><b>either</b> voluntarily registers</li> <li><b>or</b> is targeted by the police and is placed in treatment either via voluntary registration or through a DTRO</li> </ul>
Using heroin and not offending (likely to be a very small number)	<ul style="list-style-type: none"> <li>Unlikely to be known to the police</li> </ul>	<p>The problem drug user</p> <ul style="list-style-type: none"> <li><b>either</b> is highly unlikely to be targeted</li> <li><b>or</b> could register voluntarily</li> </ul>

Under a new regime, HHCUs who encounter the CJS would be gripped and retained in treatment longer; those who offend but escape arrest would be targeted by police and placed in treatment; those who do not offend would be unlikely to be known to police, and may escape targeting

Note: those who use heroin and do not offend are likely to be HHCUs early in their drug career, or users who fund habits through family and friends, or those who are able to fund their habit through personal wealth

Source: Team analysis

# An effective treatment regime for the HHCU

Vision

- The National Drugs Service case manager would
  - be the first, main and continuing point of contact with the drug user
  - take responsibility for the assessment of treatment needs after arrest or self-referral
  - manage the treatment programme, whether in the community or in prison, designed to bear down on the full range of harms: crime, health and social functioning
  - have responsibility for purchasing appropriate treatments and programmes from the public, voluntary and private sectors: the purchasing role would give the case manager greater grip over providers as well as the user
  - work with the local authority, which would be required by statute to provide support services for the user
  - maintain a long-term relationship with the drug user beyond treatment

## Case managers and methadone maintenance

- Despite clear NTA guidance, methadone is consistently under-prescribed across the UK
- In consequence, many HHCUs use methadone simply as a baseline, and top up with other drugs funded by crime
- A clear purchasing role for case managers should improve their ability to acquire appropriate treatment for the drug user in line with best NTA-defined practice

# Impact of the vision from a user perspective

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- A new regime would bring increased benefits for the user
  - there would be a central contact point for dealing with the breadth of the user's needs
  - the case manager could be contacted by the user at any point of crisis: for example following re-arrest, relapse into drug use, breach of DTRO, or loss of social security benefits
  - users would be able to use their case manager to help navigate their way through the system: they would find it easier to access secondary health care or other medical and support services
  - users would retain the support of their case manager beyond treatment and beyond prison; case managers would facilitate provision of the full range of aftercare services
  - there would be more certainty for users about how they would be dealt with by the system
- So, although many users might be coerced into treatment, they would also see significant benefits from the new focus on case management

# Effective treatment: piloting of heroin prescription (1)

Vision

- In principle, there is a strong rationale for a more widespread use of heroin prescription in the treatment system
  - around 260,000 heroin users have serious habits which are predominantly funded through crime
  - it is better to draw those users into an environment
    - where they can inject safely
    - where they can be persuaded to move down the pathway towards abstinence
  - it is also better to provide heroin freely to those users than to have them commit crime to buy it
  
- In the UK, there is general consensus among clinicians on the role that heroin prescription can and does play for older heroin users who have failed other treatments. But
  - expert opinion is divided:
    - some clinicians argue that heroin prescription may, with benefit, attract new users to treatment who would not have attended treatment otherwise
    - other clinicians argue that heroin prescription might increase long-term dependence and reduce motivation to proceed to abstinence
  - the role that heroin prescription might play in reducing harm amongst different groups of users has not been properly researched or evaluated in the UK

## Effective treatment: piloting of heroin prescription (2)

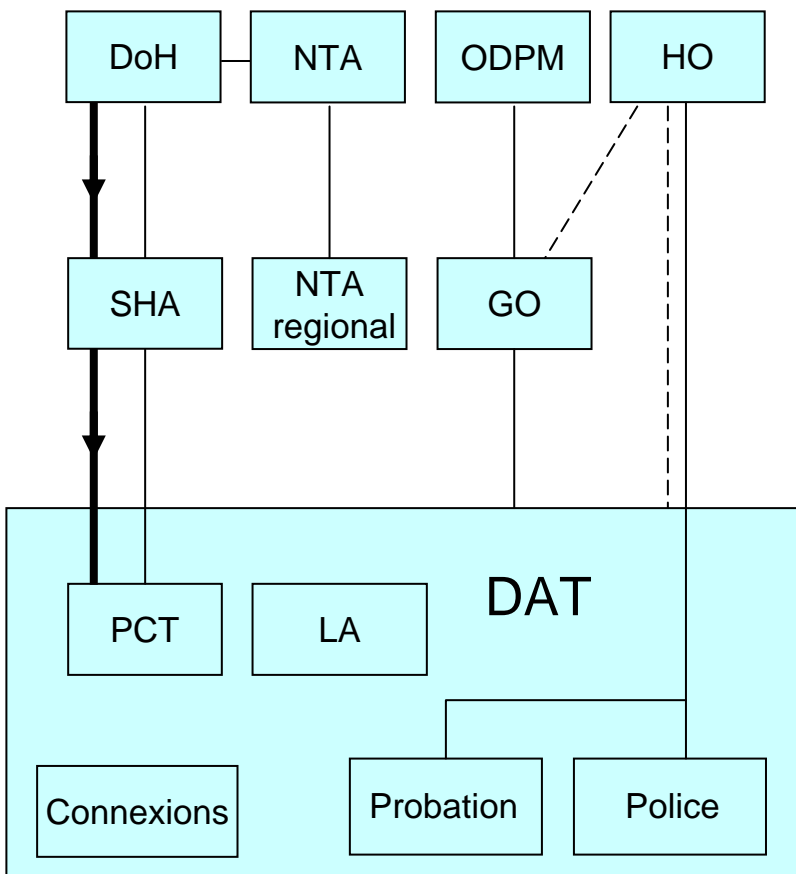
Vision

- Elsewhere in Europe, there are a number of trials to gather evidence on the potential impact of heroin prescribing
  - **Switzerland:** to participate, users must have failed at least two other treatment episodes; evidence suggests a decrease in crime, infection, death, mental health disorders and an increase in employability, and possibly abstinence
  - **Netherlands:** a trial to dispense heroin to “untreatable addicts” (ie a treatment of last resort for highly problematic users); evidence showed significant improvements in physical and mental health, and in social functioning
  - **Germany:** introduction of a trial for heroin users who have not yet been reached by treatment services (as such, a treatment of first rather than last resort); evidence not yet available
- DoH, NTA and HO have taken steps to improve the evidence base, including pilots, and to disseminate new guidance. It is recommended that these pilots, should be made more extensive, at an estimated cost of £2.1m per annum, particularly focusing on
  - which groups might benefit most from heroin prescribing
  - whether there is a significant role that heroin prescription might play in reaching users early in their high harm causing career
  - in what circumstances heroin prescription might be cost effective (heroin prescription may be expensive and could cost £12 -£15,000 per annum per patient)

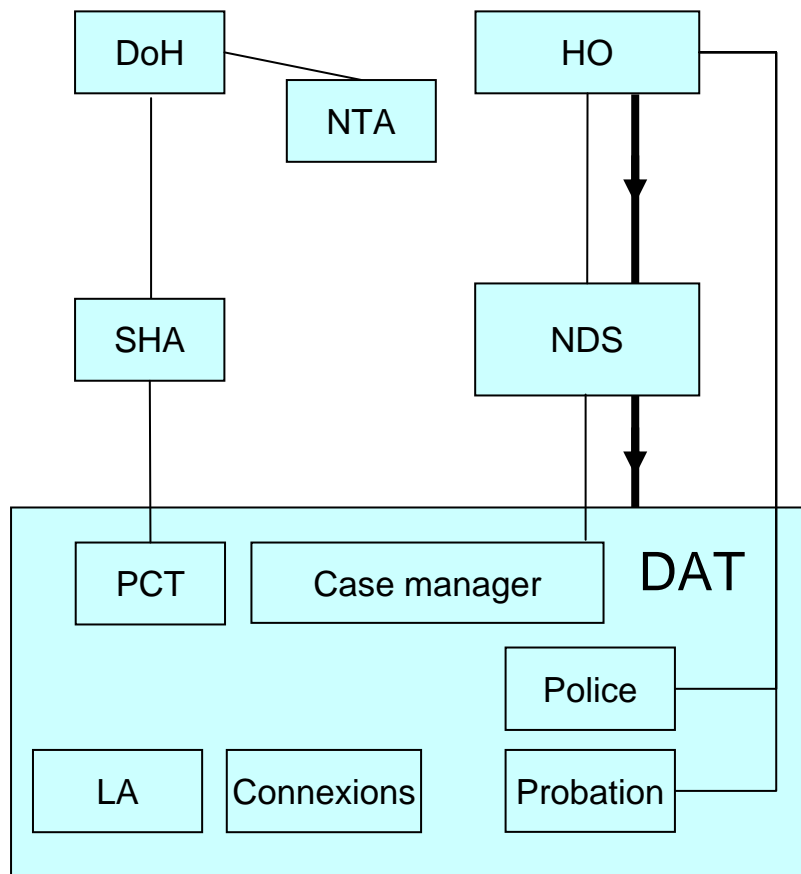
# A more powerful organisational focus for bearing down on drugs harms

Vision

Map of current system



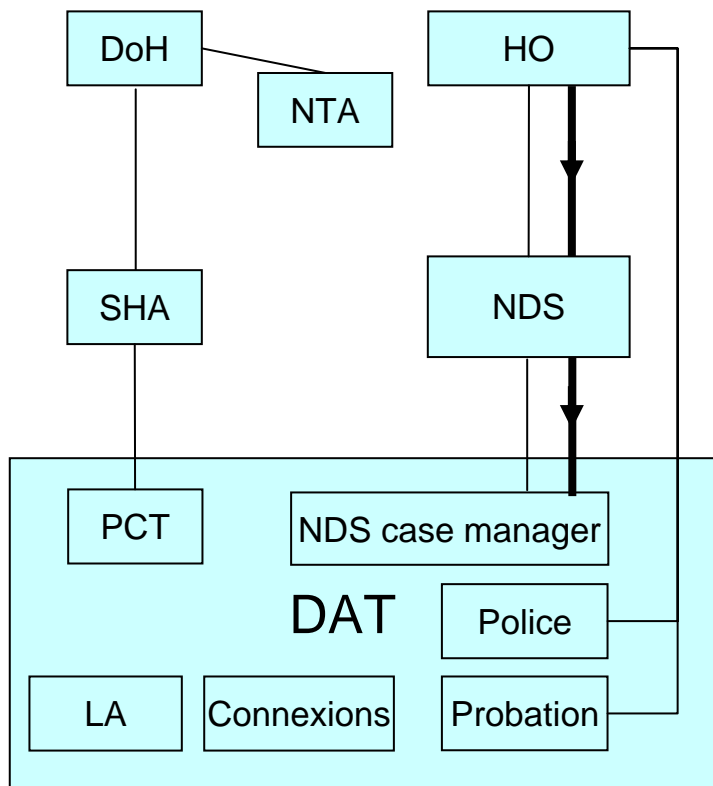
Map of system: Vision





- Main funding route
- Direct accountabilities
- - - Indirect accountabilities

# Rationale for a new organisational system

## Map of new system



 Main funding route  
 Direct accountabilities

## Long-term organisation of the system

The organisational system proposed would

- make the primary focus crime harms
- give the National Drugs Service (NDS) prime responsibility for reducing harms, and bring a close alignment between accountability, responsibility and funding
- make the criminal justice system the main mechanism for dealing with HHCUs
- bring clear leadership to the DATs, with an NDS appointed case manager co-ordinator, holding the budget for treatment and other interventions with the user
- assign the performance management role to the NDS

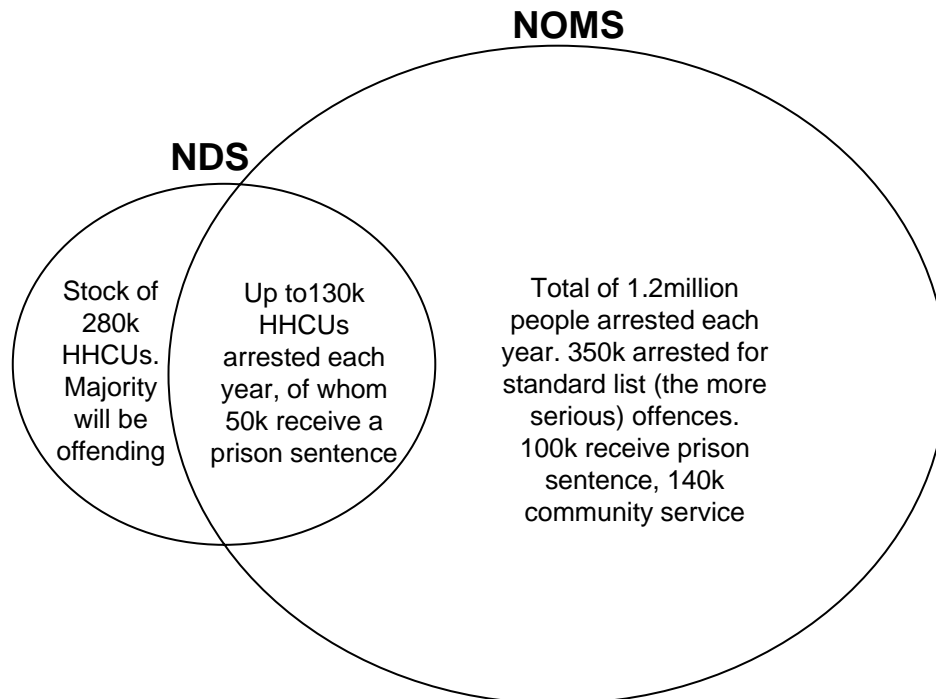
The boundaries between drug treatment, provided and purchased by NDS/NOMS, and secondary health care, provided in the NHS, would need careful policing.

Responsibility for best treatment practice and inspection would be assigned to DoH, discharged by NTA/CHAI

# The National Drugs Service should be an integral but separately branded part of the new National Offender Management Service



## Overlaps in the customer base of the National Drugs Service (NDS) and NOMS



The overlap between the NDS and NOMS would increase still further were heroin use made an offence

- Both the NDS and the NOMS would be dealing with the same cohort of people - offending HHCUs - so it makes sense for NDS to be incorporated within NOMS: dealing with criminality and the causes of criminality in one organisation
- The NDS would retain separate additional branding from NOMS to encourage users to self-refer and to register voluntarily, and not be deterred by an 'offender' label
- If the organisations were not merged, their overlapping case management roles would lead to confusion and to difficulties of co-ordination with the same drug-using offender population

## Performance targets: long-term vision

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- Implementation of the long-term vision should substantially reduce harms caused by HHCUs
- Targets for the system would be agreed between the HO and the centre
  - a% of HHCUs on the Register
  - b% of Registered Heroin Users (RHUs) kept under active NDS supervision
  - c% of RHUs not offending
  - d% of RHUs without HIV/ Hepatitis/ other
- Subsidiary supporting targets would need to be set for other agencies e.g. police and local authorities, such as
  - e% increase in number of unregistered HHCUs becoming registered

## Vision: Pros and Cons

Vision

<b>PRO</b>	<b>CON</b>
<ul style="list-style-type: none"> <li>• Most effective course of action for gripping HHCUs, and containing them in a tight treatment regime</li> <li>• Brings clear responsibility for outcomes</li> <li>• Enables clear alignment of HO interest in key outcomes with ability to control the main levers</li> <li>• More effective case management would offer a greater treatment focus on the holistic needs of the HHCUs</li> <li>• Likely to produce a substantial reduction in crime and other harms</li> </ul>	<ul style="list-style-type: none"> <li>• Possible political and legal difficulties of making heroin use an offence</li> <li>• Difficulty of persuading clinicians to engage with an enforcement regime</li> <li>• Risk of other DAT partners (e.g. LAs, PCTs) disengaging from CJS-driven system</li> <li>• Difficulty of moving currently largely voluntary sector case-manager workforce into public sector case management role</li> <li>• Risk of a loss of focus on health harms</li> <li>• Risk of driving some HHCUs underground</li> <li>• Uncertain impact of breach rates and consequential impact on prison numbers</li> <li>• As the most radical approach, also the most disruptive</li> </ul>

# Option 1: a graduated approach to improving grip through the criminal justice system

Option 1

## Identify and grip the HHCUs

- Roll out pre-arrest initiatives across all police forces
- Make full use of new powers from the Criminal Justice Bill to persuade users into treatment
- Legislate to allow testing at arrest
- Assess ECHR compliance of making hard drug use an offence, and take powers to pilot; full implementation in 2009/10 if pilot is successful

## Effective treatment

- Introduce a new case manager system for every user, with case managers working in the NDS
- Create a statutory duty for Local Authorities to provide support services for registered users

## Organisational focus

- Create a case management organisation for HHCUs - the NDS - within NOMS
- Move responsibility for CJIP into NDS/NOMS, and as a first step pull into NOMS (initially) all CJS-related treatment spending
- Make NTA, possibly to become a division of CHAI, responsible for identifying and monitoring compliance with best healthcare practice
- Make HO directly accountable and responsible for driving down all drugs harms for those captured and dealt with by the criminal justice system, and for achieving targets on harm reduction
- Bring together responsibility and funding for all HHCUs within NDS/NOMS in 2009/10 if piloting is successful

## Option 1: building the evidence base, and inserting key decision points

---

Option 1

- Option 1 would focus on improving the evidence base, and on building in key decision points on whether to proceed to full implementation. Option 1 would
  - continue to build on current initiatives and to focus on delivery, with an increase of focus on improving capture of HHCUs as they pass through the criminal justice system
  - bring together delivery of services for offending drug users within a National Drug Service (NDS) - a division of the new National Offender Management Service (NOMS)
  - assess the impact of making hard drug use an offence through piloting, testing the likely impacts on prison numbers and the engagement of healthcare professionals
- Decisions on full implementation would be taken as part of a 2008 Spending Review, and would be considered against the following criteria
  - the likely improvements to capture
  - the likely engagement of clinicians
  - the likely impact on prison numbers
  - the robustness of NDS/NOMS in taking on the new challenge
  - the growth in treatment capacity to meet new demand
  - the extent to which self-referral may reduce the need for such a strong focus through the criminal justice system

## Option 1: an increasing focus on capture (1)

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Option 1

- While the criminalisation of hard drug use would be piloted, other steps would be taken to improve capture in the meantime
- Pre-arrest initiatives would be rolled out across all police forces
  - targeting HHCUs earlier than they would otherwise be caught - and actively encouraging them into treatment
  - focusing on street level dealers to periodically disrupt local availability, and thus encourage HHCUs into treatment, and shift open markets to closed markets
    - similar programmes have been set up in some Basic Command Unit (BCU) areas with positive results: close to 95% of those targeted in these programmes have accepted the treatment offered, and their offending has decreased by around 30%
- Other measures could be taken to improve the capture and placement of HHCUs in the criminal justice system. For example
  - using new powers from the Criminal Justice Bill to persuade users to take up treatment
  - legislating to allow testing at arrest, as against testing when charged as now, and assessing compliance with ECHR
  - extending supervision post-sentence of HHCUs who have committed higher tariff offences

## Option 1: an increasing focus on capture (2)

---

Option 1

- Introducing drug testing on arrest and not just, as now, when charged
  - would require primary legislation
    - ECHR compliance would need to be established to demonstrate that testing on arrest did not amount to random testing
  - would enable the identification of more HHCUs as they encounter the CJS
    - in any one year up to 30,000 HHCUs are arrested but not charged
  - would, however, only be likely to increase the numbers entering treatment by around 5,000
    - if the current translation rate from testing positive to entering treatment were maintained
- Extending supervision for HHCUs
  - would require primary legislation
  - would work in a similar way to extended sentencing for sex offenders and violent offenders
    - courts can add a period of post-release supervision to the custodial sentence. Sex offenders can be given an extended sentence for a maximum of 8 years. Violent offenders imprisoned for more than 12 months can be given an extended sentence for a maximum of 5 years
  - would be unlikely, however, to have a significant impact in retaining users in treatment
    - the average custodial sentence for HHCUs is 4 months, and applying extended sentencing to them would most likely be disproportionate. Few are sentenced for the 12 months that applies for violent offenders

Note: refusal to take a drug test is currently an offence carrying a maximum £2,500 fine or a 3 month custodial sentence

Source: Team analysis

## Option 1: a focus on case management

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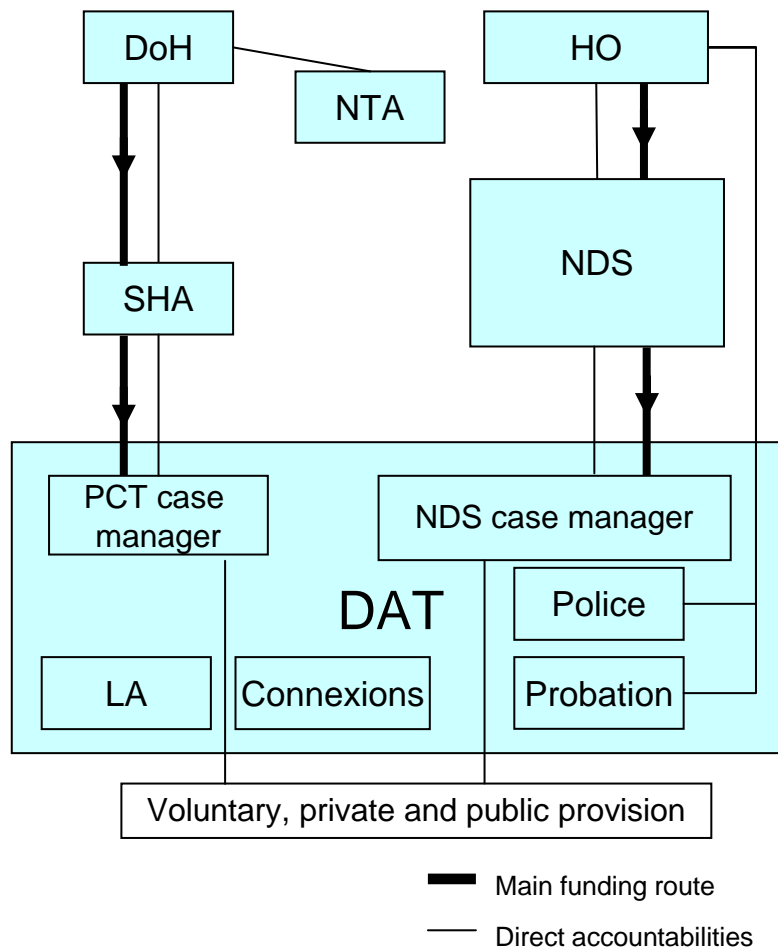
Option 1

- A new focus would be placed on case management: all HHCUs would have a case manager
- During the transitional period, HHCUs within the criminal justice system would be dealt with by NDS/NOMS. HHCUs outside the criminal justice system would be dealt with by PCTs
- The case manager would
  - be the central contact point for the user, with responsibility for assessing needs
  - manage the programme of interventions to bear down on all harms, with a strong focus on aftercare services
  - have responsibility for purchasing services, and for agreeing the commissioning framework with DAT partners. Case managers in NOMS and PCTs would effectively purchase services from the same pool of voluntary, private and public providers
  - be focused on improving self-referral rates by building links with other service providers
  - be responsible for ensuring access to other support services
- Unless and until heroin use was made an offence, however, case managers would not be responsible for maintaining a Register and enforcing compliance with recommended treatment regimes

# Option 1: map of transitional organisation

Option 1

## Transitional organisational map



- Initially, case management of drug-using offenders would be brought together within the NDS as part of NOMS
  - first steps to achieve this would take place quickly, with integration of CJIP within NOMS from its target launch date of July 2004
  - DTTO funding would also be brought together within NDS in 2004/5
- PCTs would continue to be responsible for purchasing services for those who self-refer, and would be funded, as now, to do so
  - both PCTs and the NDS would purchase treatment services from the same range of voluntary, private and public providers
- The NTA would retain responsibility for best practice and for inspection of treatment services provided both inside and outside the criminal justice system

# Option 1: phasing and pathway to implementation

Option 1

2004/5	2005/6	2007/8	2009/10
<p align="center"><b>Phase One</b></p> <p align="center"><b>Prepare the ground and legislate</b></p>	<p align="center"><b>Phase Two</b></p> <p align="center"><b>Pilot and appraise increased coercion</b></p>	<p align="center"><b>Phase Three</b></p> <p align="center"><b>Full implementation</b></p>	
<p>Continued rollout of CJIP. Responsibility for CJIP moves into NDS/NOMS in shadow form with the launch of NOMS</p> <p>Pull into NDS/NOMS DTTO funding from pooled treatment budget</p> <p>Development of cadre of specialist case managers within emerging NDS/NOMS</p> <p>Legislate to allow testing on arrest. Legislate to allow for piloting of hard drug use as an offence and for registration</p> <p>SR agreement to focus on capture and grip via NDS/NOMS, and funding for piloting of increased coercion and mainstreaming of pre-arrest initiatives for police</p>	<p>Pilot hard drug use as an offence and registration to test impact on capture, treatment retention, and engagement of healthcare professionals</p> <p>Roll out pre-arrest initiatives across all police forces and devise new performance indicators for the police</p> <p>Emerging NOMS organisation to take on responsibility for residential rehab places</p> <p>Implement extended sentencing for those with high tariff offences</p> <p>Consider national rollout of increased coercion against a number of key tests</p> <ul style="list-style-type: none"> <li>• likely improvements to capture</li> <li>• likely engagement of clinicians</li> <li>• likely impact on prison numbers</li> <li>• robustness of NOMS in taking on new role</li> <li>• growth in treatment capacity to meet new demand</li> <li>• extent to which self-referral may reduce the need for criminal justice focus</li> </ul>	<p>Agreement to funding as part of the 2008 Spending Review</p> <p>Affirmative regulations to allow national rollout of hard drug use as an offence</p> <p>All funding streams pulled together and channelled through NDS/NOMS</p> <p>New funding and performance indicators for the police</p>	

Note: precise timing of integration with NOMS would need to be considered by the NOMS implementation team

Source: Team analysis

# Option 1: likely impacts on harm during the phases towards full implementation

Option 1

	2004/5	2005/6	2007/8	2009/10
	<b>Phase One</b> Prepare the ground and legislate	<b>Phase Two</b> Pilot and appraise increased coercion	<b>Phase Three</b> Full implementation	
<b>Activities</b>	Continued rollout and delivery of CJIP	Embedding of enhanced case management Rollout of pre-arrest initiatives Potential implementation of testing on arrest and extended sentencing Piloting hard drug use as an offence	Full implementation of hard drug/heroin use as an offence, combined with enhanced case management	
<b>Likely harm impacts</b>	With associated improvements to case management, likely to reduce harms by <b>c.£2bn</b> per annum by steady state if there were no further changes	Pre-arrest initiatives likely to increase numbers moving into treatment Testing on arrest would increase positive tests, and is likely to increase numbers entering community treatment by c.14,000 Overall, harms likely to be reduced by <b>c.£3bn</b> per annum by steady state if there were no further changes	Full benefits of increased coercion likely to be realised, reducing harms by <b>c.£8bn</b> per annum by the time steady state is reached	

The phasing in Option 1 would allow Government to test how far grip can be improved without criminalisation and evaluate the additional costs and benefits of making hard drug use an offence

# Option 1: Pros and Cons

Option 1

<b>PRO</b>	<b>CON</b>
<ul style="list-style-type: none"> <li>• An evolutionary approach which allows a continued focus on delivery and rollout of CJIP before planning more radical change</li> <li>• Brings some improvement to the alignment of central government responsibilities for HHCUs inside and outside the CJS</li> <li>• Allows case management of offending drug users to be brought clearly within NOMS, and for the case management workforce to be grown over time</li> <li>• Enables growth of the evidence base, and the delivery/implementation risks to be addressed over time</li> <li>• Tests the acceptability and the likely impact of criminalisation of hard drug use</li> <li>• Builds in a break point to decide whether to increase coercion within the system</li> </ul>	<ul style="list-style-type: none"> <li>• Delays main savings to be generated until full implementation in 2009/10</li> <li>• Delays ability to clarify and bring together accountabilities and funding</li> <li>• Although almost all HHCUs will be offending, the transitional structure would continue to deal with some HHCUs inside the CJS and some outside</li> <li>• Creates complicated overlaps of case management functions between the NDS and the PCTs during the transitional period</li> <li>• Risk of other DAT partners (e.g. LAs, PCTs) disengaging from NDS/PCT-driven system</li> </ul>

## Option 2: rapid implementation of the vision

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Option 2

- Modelling of the vision suggests that it could generate benefits of c.£8bn per annum in avoided crime harms, including £1.2bn in cash savings to the Exchequer. Option 2 would focus on driving through those improvements as quickly as possible
- The key elements of option 2 would be
  - early agreement that all aspects of the vision should proceed
  - bringing together responsibility for dealing with drug users within NDS/NOMS from the establishment of NOMS in 2004/5
  - agreement to funding within the 2004 Spending Review
  - legislation in 2004/5 to make heroin use an offence
  - full rollout by 2006/7
- By bringing organisational responsibility and funding together immediately, there would be no need for a transitional organisational structure

# Option 2: rapid implementation would be sequenced to minimise disruption

Option 2

2004/5 <b>Phase One</b> Prepare the ground	2005/6 <b>Phase Two</b> Begin the transition	2006/7 <b>Phase Three</b> Full implementation
<p>Implementation team set up and detailed plan drawn up</p> <p>National Drug Service (NDS) set up in shadow form as part of NOMS</p> <p>Detailed workforce planning</p> <p>Future roles of NDS and NTA agreed</p> <p>ECHR/legal issues resolved</p> <p>Detailed planning to inform SR decisions on funding</p> <p>Legislate to allow for national rollout of criminalisation of heroin and registration</p>	<p>Transition to NDS begins in earnest</p> <ul style="list-style-type: none"> <li>• GO and NTA regional roles absorbed</li> <li>• funding channelled through HO</li> <li>• infrastructure and IT for register set up</li> <li>• detailed targets agreed</li> </ul>	<p>National rollout of vision, including criminalisation of heroin use and the new register</p> <p>Full benefits of increased coercion likely to be realised, reducing harms by c.£8bn per annum by the time steady state is reached</p>

## Option 2: Pros and Cons

Option 2

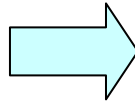
<b>PRO</b>	<b>CON</b>
<ul style="list-style-type: none"><li>• Likely to produce biggest gains in reducing crime and other harms through accelerating the implementation of the vision</li><li>• Grips and contains HHCUs in a tight treatment regime as quickly as possible</li><li>• Brings clear responsibility for outcomes from the outset</li></ul>	<ul style="list-style-type: none"><li>• Likely to be more risky than a graduated approach</li><li>• Difficult to predict the extent to which clinicians might fail to engage with a coercive regime</li><li>• Uncertain impacts on breach rates and consequential impacts on prison numbers</li><li>• Most disruptive option</li></ul>

# Key choices for Ministers

Options

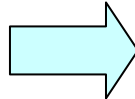
There are 3 options

– The status quo



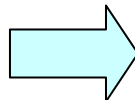
- Further rollout of CJIP, with improvements to case management, will reduce crime harms by c.£2bn per annum in the long run

– An increased focus on capture



- Capture can be improved through rolling out pre-arrest initiatives nation-wide, by tightening the ability of the CJS to push users into treatment, and by improving case management
- This would improve the effectiveness of the system, reducing crime harms by c.£3bn per annum in the long run

– Criminalise hard drug use



- By combining increased coercion with enhanced case management, the system's ability to capture HHCUs, and place and keep them in treatment would be dramatically enhanced. SU estimates that this could reduce crime harms by c.£8bn per annum in the long run

**Criminalising hard drug use offers considerable benefits over the alternatives. But it also carries greater risk. The graduated option would allow evolutionary changes to be made to increase the focus on capture before a decision was taken to criminalise use.**

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# The role of supply-side interventions in reducing harm: summary

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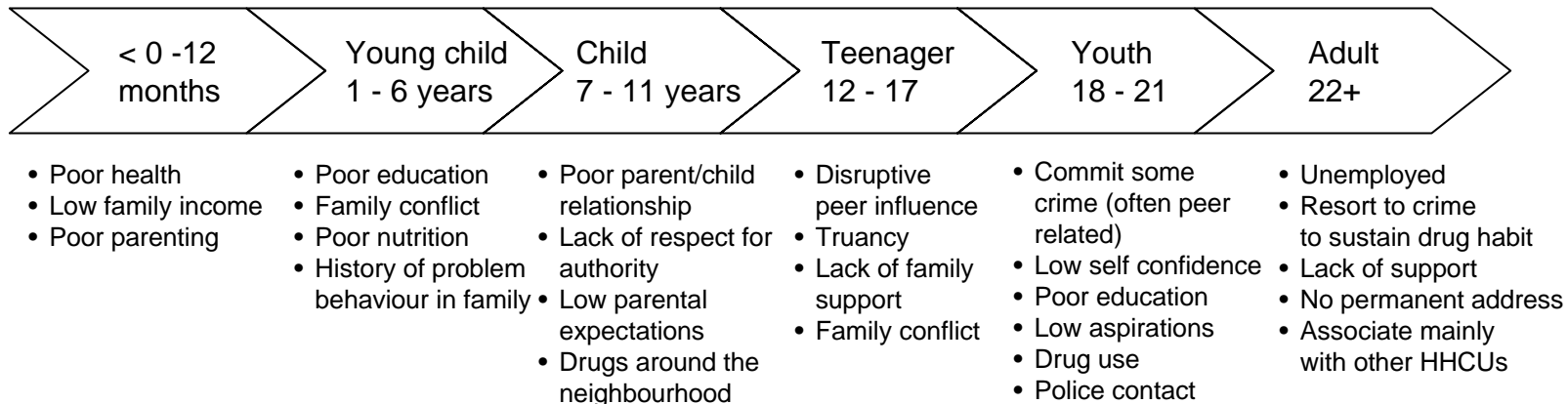
- Supply-side interventions have a limited role to play in reducing harm
  - initiation into problematic drug use is not driven by changes in availability or price
    - risk factors - particularly relating to deprivation - are the prime determinant of initiation into problematic drug use; price and availability play a secondary role
    - there is no causal relationship between availability and incidence; indeed, prices and incidence often fall or rise at the same time
    - incidence of heroin use in the UK may be levelling out, though crack use is increasing
  - supply interventions have had little impact in reducing harm
    - no-one has ever succeeded in sustainably disrupting the supply of drugs to the UK
    - the scale of disruption required to reduce supply sustainably has never been achieved anywhere
    - even if supply could be sustainably reduced, consequent price increases would increase the harms caused by existing HHCUs
  - the focus of supply-side efforts should be on how they can best reduce harm
    - the police have a key role to play in pushing users into treatment and in focusing on local availability
    - while upstream interventions may not impact on drugs harms, there are other good reasons to intervene: to address state failure, to tackle organised crime, and to deal with nuisance

# The flow into problematic use is primarily determined by risk factors

Supply

- HHCUs are a distinct and separate group from recreational users
- It is well documented in the UK and abroad that risk factors play the key role in determining problematic drug use and not the price and availability of drugs
- The key risk factors are: coping skills not developed in first few years of life; low parental income; low parental education; family conflict; poor parenting; low parental expectations; peer group influence
- Because initiation into HHCU is primarily driven by risk factors, prevention should be considered as part of wider government early intervention programmes such as Sure Start, Connexions or initiatives coming out of the Children at Risk Green Paper

## Example of a typical risk factor cycle



\* Not everyone exposed to the risk factors becomes a HHCU, the main difference being development of coping skills when very young  
 Source: Health Promotion Agency; Children at Risk Green Paper; Team analysis

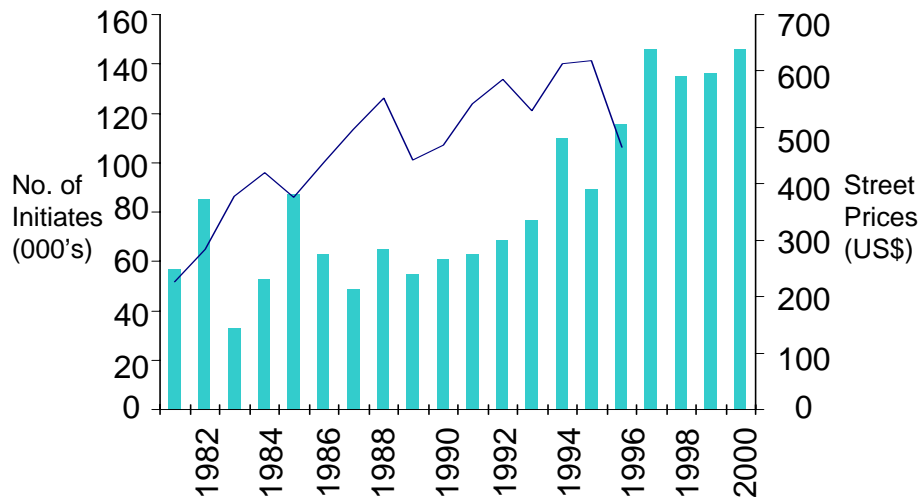
# There is no causal relationship between drug availability and incidence

Supply

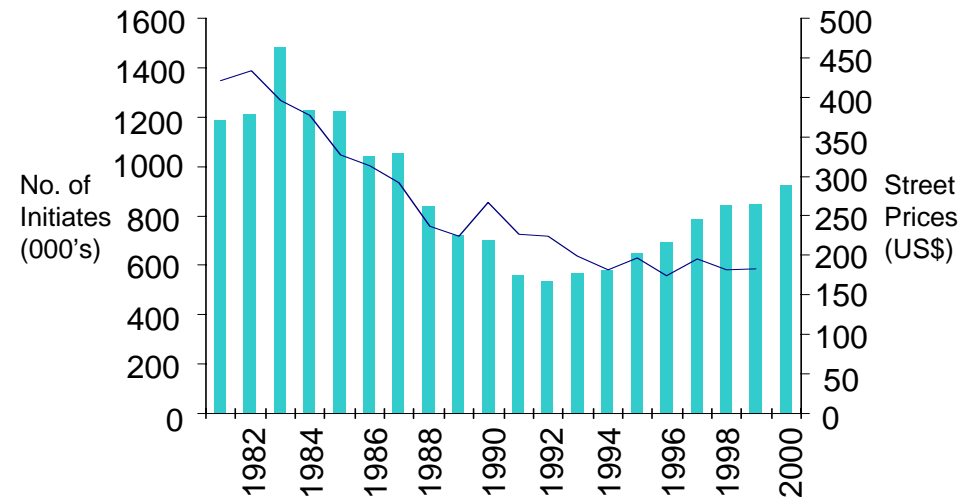
- Street price is the best proxy for measuring the availability of drugs
- If there were a strong causal relationship between initiation and price, we would expect to see initiation increase as prices fall, and initiation decrease as prices rise
- However, the US experience suggests that such a causal relationship cannot be established, and that therefore risk factors play the major role
- The graphs below show that heroin initiation in the US *increased* three fold while street prices *doubled* (1981-2000), while cocaine initiation *decreased* by 22% while prices *decreased* by more than half (1981-2000)

American Initiates (000's) and Street Prices (US\$)

Heroin



Cocaine

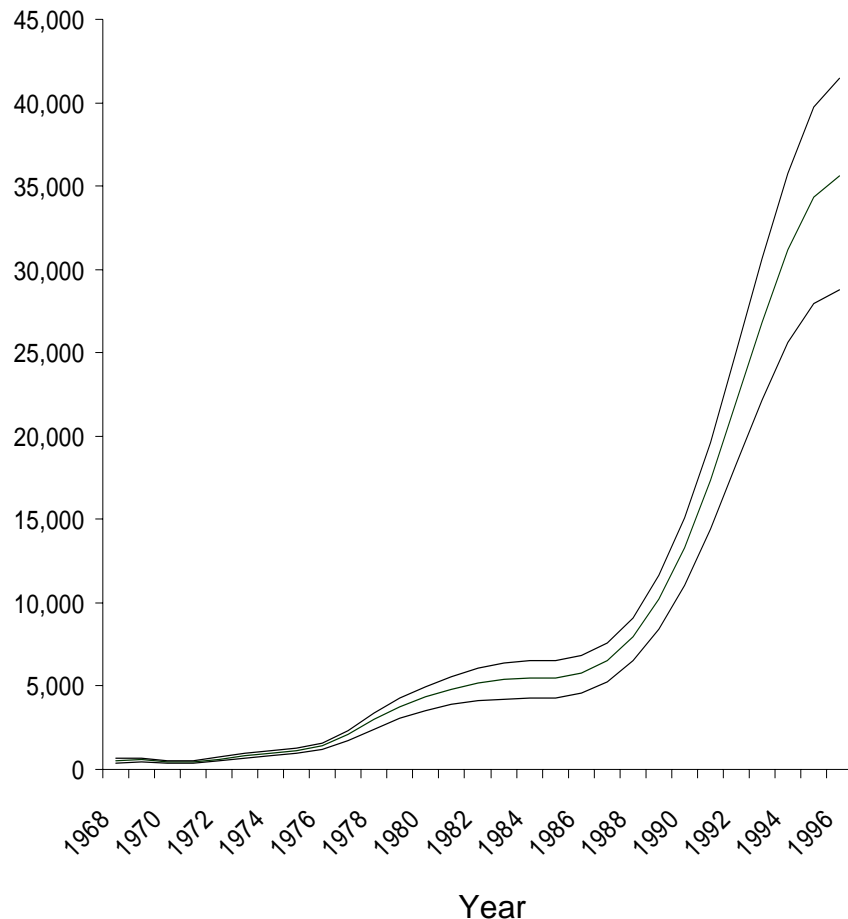


Source: National Household Survey on Drug Abuse (USA)

# Incidence of heroin and crack use in the UK

Supply

**Estimates of number of new opiate users each year in the UK**

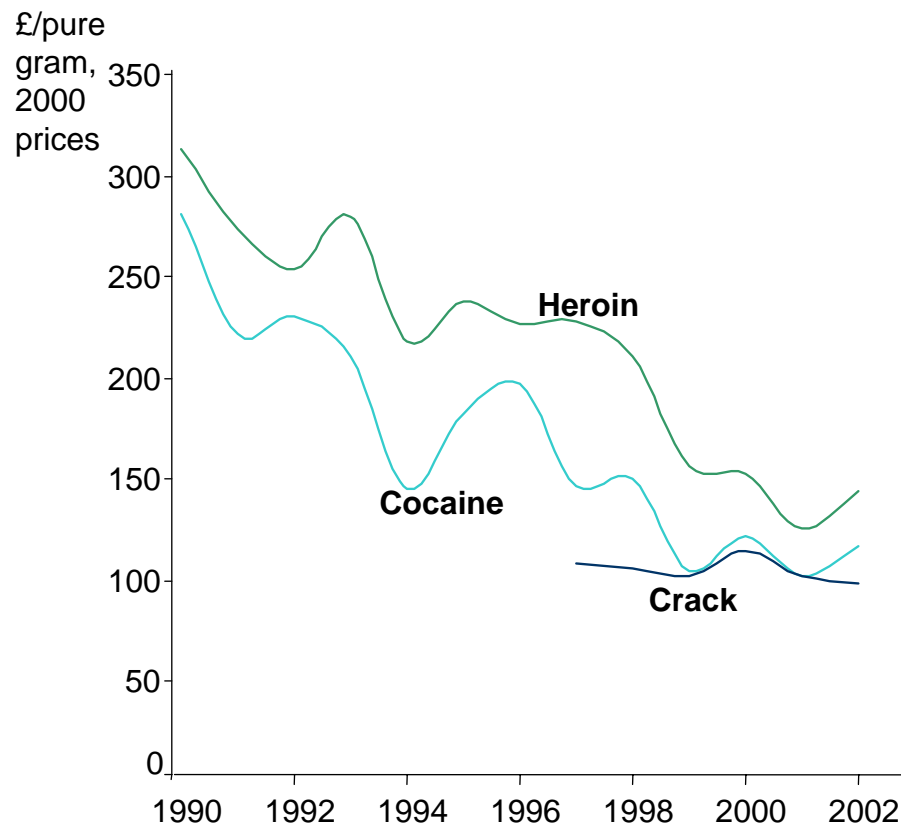


- There is little evidence in the UK on incidence and prevalence of problem drug use
  - more needs to be collected to systematically build up the evidence base, and this should be the responsibility of a new National Drugs Service
- The best available evidence, however, suggests that opiate use in the UK may be levelling out
  - while the number of users has increased dramatically, estimates suggest that incidence rates neared a peak in 1996
  - if sustained, this would feed through to a plateauing of opiate use
- The number of crack users appears to be increasing as use spreads to new areas
  - some crack users will be existing heroin users and so will not add to HHCU numbers
  - others will be non-heroin users and will increase the population of HHCUs

# Supply interventions have had little impact on reducing drugs harms

Supply

## Real purity-adjusted retail prices\*



\* Real purity adjusted prices show a different trend to nominal unadjusted purity prices. Nominal prices have remained largely stable, while purity has risen over time. This leads to falling real purity adjusted prices

Source: NCIS Streetwise, Forensic Science Service Drug Abuse Trends

- Interventions in the UK have not achieved sustained disruption in supply: the decline in real prices indicates that there has been ample supply in the UK. This is supported by evidence that demand can easily be met
- The scale of disruption required to reduce the supply of Class A drugs sustainably is not achievable, even with more resources
  - traffickers adapt and innovate in response to enforcement interventions
  - profit buffers are built in along the supply chain
  - a sustained seizure rate of over 60% is required to put a successful trafficker out of business
  - the UK market only requires a small amount of total global production (4% heroin, 5% cocaine)
- Even if a significant reduction was feasible, consequent price increases are likely to increase harm by fuelling an increase in crime

# Rationale for intervention in the drug supply chain

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Supply

- Our analysis overall shows that the most effective way of reducing drug harms is to focus hard on the HHCUs, identifying and gripping them, and placing them in a continuing treatment regime
- To be effective, any intervention in the drugs supply chain, funded by the drugs budget, should result in reduced drug harms
- The main role of police interventions should be to support the process of driving HHCUs into treatment and keeping them there. If heroin use were made an offence
  - the police should be tasked to identify, test and arrest all HHCUs in their locality
  - they should encourage voluntary registration under the National Drugs Service wherever possible
  - where HHCUs refuse voluntary registration and treatment, the police should charge them so that the courts can impose a DTRO
  - the police should conduct regular sweeps of street dealers with the aim of temporarily disrupting local supply, creating short-term shortages, and driving users to registration and treatment. To reduce local availability, the police would rely on local intelligence and middle markets intelligence if available
  - many dealers are user-dealers, so if heroin use were made an offence, it would be easier to sweep up user-dealers who test positive

# Other reasons to intervene in the drugs supply industry (1)

Supply

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There are other reasons for intervening along the supply chain, even though these interventions will not reduce drug user harms in the UK. These reasons vary from wider foreign policy aims to general development reasons, including aiding failing states

## Aiding failing states

- Large scale drug cultivation occurs in states where there is some combination of weak central government control, anti-government movements and widespread corruption
- the profits of the drug industry can further destabilise such states
- failing states can experience widespread poverty and can harbour or incubate terrorists
- **BUT** the decision to invest UK government funds in helping failing states should be based on foreign policy, defence, development or counter-terrorism and not as an investment in reducing drug harms

## Interventions to disrupt organised crime networks

- Interventions at the border and against wholesalers have little or no impact on reducing drug harms
- **BUT** the estimated hundreds of major importers and low thousands of wholesalers in the UK are organised criminals involved in a business which causes enormous harm
  - strategic intelligence about this group should be improved
  - the case for an intelligence-based national crime agency focusing on these as well as other organised criminal networks, remains strong

## Other reasons to intervene in the drugs supply industry (2)

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Supply

### Dealing with nuisance

- Police should continue to bear down on social nuisance arising from drug supply and use at a local level
  - to disrupt and arrest dealers on the street
  - to close down crack houses
  - to clamp down on local 'gangsterism'
  - to remove sex workers from the streets

### Clarity of objective

- Government should be clear about the objectives of its interventions at every stage in the supply chain, and this clarity should be reflected in targets for Departments and agencies

**There is no reason not to seize drugs whenever the opportunity arises, but the drive of the police and other agencies should be to deal with the criminality of those who supply drugs, recognising that drug seizures in themselves are having little or no impact on reducing harms**

# Handling perception

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Supply

- The focus on drugs harms could lead to a perception that Government no longer cared about intercepting supply. The accusation might be made
  - that drugs would be allowed to run across borders
  - that communities would become flooded with harmful drugs
  - that lower prices would tempt recreational users into problem drug use, creating a surge in HHCUs
- Strategy Unit analysis suggests that these risks are unlikely to materialise
  - there is already ample supply in the UK
  - if prices did fall, harm caused by existing HHCUs would fall
  - given that there is no causal relationship between availability and incidence, there is no evidence that there would be a surge in HHCUs causing an increase in overall harm
  - criminal networks involved in trafficking drugs would still be targeted, and drugs would be seized and proclaimed whenever the opportunity arose
- The handling approach would therefore be to emphasise
  - tackling the criminal networks involved in trafficking drugs, with drugs seized whenever possible
  - combating the role of the illicit drugs business in contributing to state failure, terrorism and transnational crime

# The potential impact of heroin prescription on the UK illicit drugs supply industry

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Supply

- If heroin prescription for registered addicts were to become an important part of the treatment regime for HHCUs, this would have a substantial impact on the illicit heroin market, and some impact on the crack market, together worth an estimated £4bn in the UK
  - the demand for illegal heroin would drop significantly
  - most crack users use heroin, and would be captured and registered if heroin use became an offence: as a result crack use should decline for those registered and in continuing treatment
  - but the smaller market for crack-only users, and for users of other drugs, would continue
- Many of the estimated tens of thousands of street dealers are problem drug users themselves and should be captured in a more coercive regime BUT
  - those street dealers who are not problem drug users may turn to other forms of crime to fund their lifestyle
  - the estimated low thousands of major importers and wholesalers may turn to other forms of organised crime as an alternative to what is currently a lucrative high margin business
- If heroin use became an offence, and heroin prescription became more widely used, local police forces and national policing agencies would have to be alert to the displacement of criminal activity

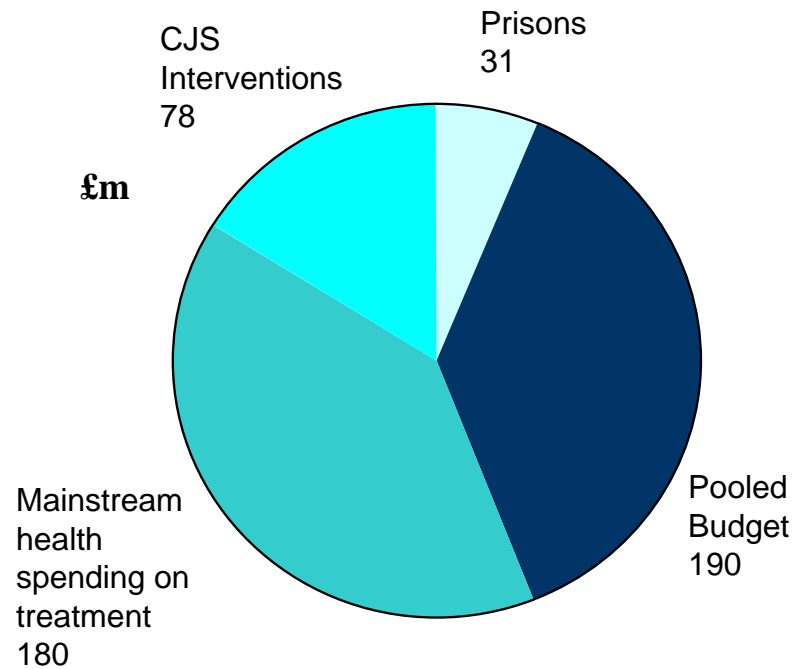
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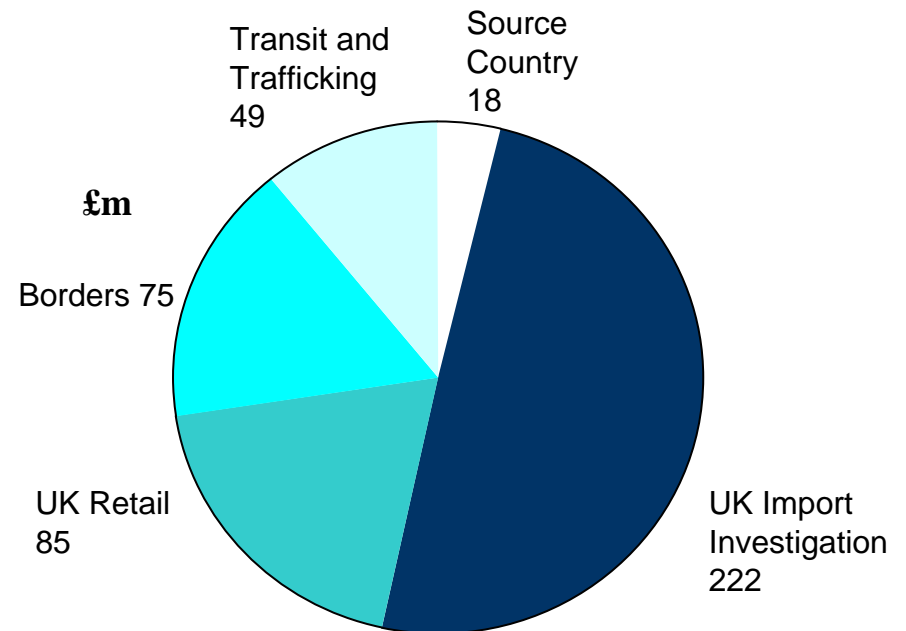
# Currently nearly £1bn is spent on drugs, split almost evenly between demand-side and supply-side interventions

Funding

£480m is spent on treatment and CJS interventions



£450m is spent on reducing availability of Class A drugs



# To estimate costs, the Strategy Unit has built a dynamic model of different options for dealing with HHCUs

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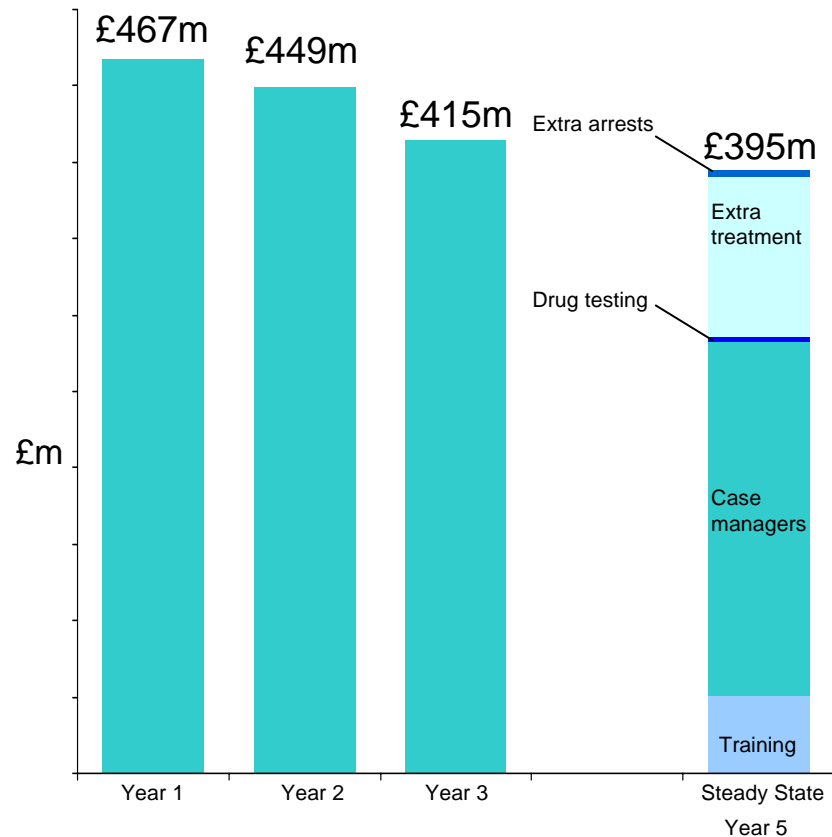
Funding

- A dynamic model has been built using information and data from Phase I to construct a moving picture of HHCUs in the system, and to estimate costs and benefits for the different options
- The SU model is based on a number of assumptions
  - HHCUs were initially distributed between their three main states: HHCUs in treatment; out of treatment; and in prison
  - assumptions were based on the latest evidence and data to determine rates of movement between these states
  - the assumptions are pessimistic: they do not allow for the synergies that a more focused and coercive approach to HHCUs should bring
- The model predicts the speed at which HHCUs are captured through treatment or prison sentences, and then assigned case managers. Actual unit costs are used at every stage of the dynamic process to inform total costs
- It should be noted that, although the options quantify crime harms avoided, some of this benefit may not show up in **recorded** crime statistics, as much drug crime goes unreported
- Projections are made five years into the future - by which point a steady state is reached

# Net additional costs and benefits for the vision

Funding

## Net annual costs



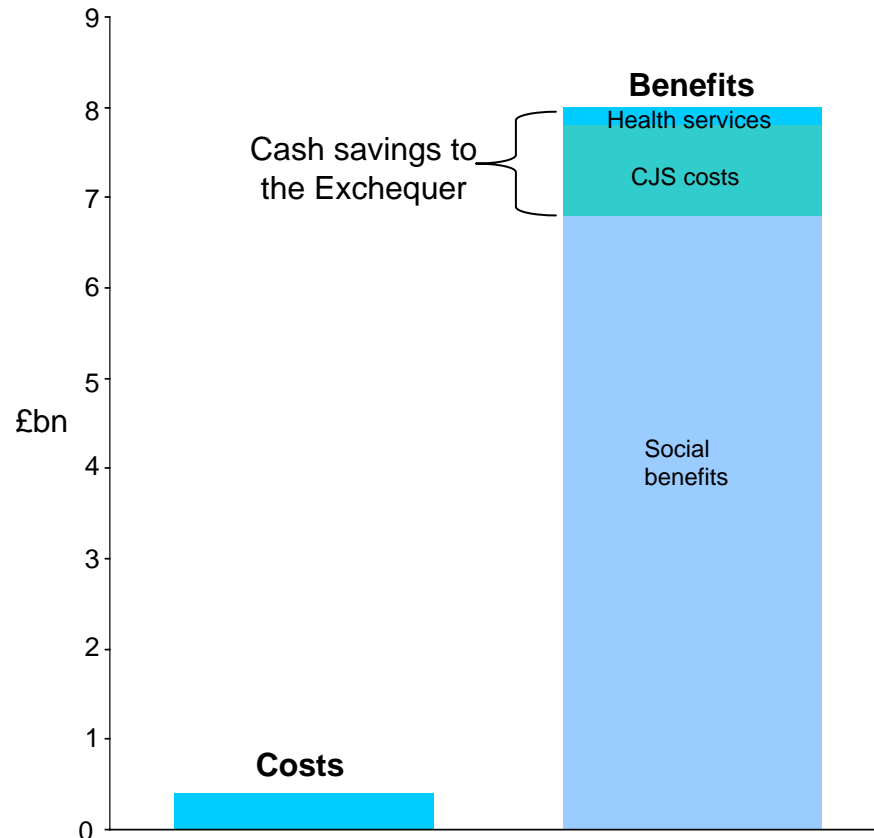
## Steady state benefits

- In terms of avoided crime harms, the vision would generate
  - annual savings of c. **£8bn** by year 5
    - halving the cost of drug-motivated crime
  - **£1.2bn** of the benefits would be cash savings to the Exchequer
- Option 1 would generate savings from full implementation of the vision from 2009/10
- Option 2 would generate savings more quickly, from implementation in 2006/07

Note: estimates include displaced expenditure on current drug testing and Arrest Referral workers and CARAT workers; assumptions use best available evidence, and assume existing performance levels; around 5,000 additional case managers would be required by year 5  
Year 1 includes set up costs for the National Drugs Service and Register

## Scale and breakdown of benefits for the vision

### Steady state costs and benefits



### Steady state benefits

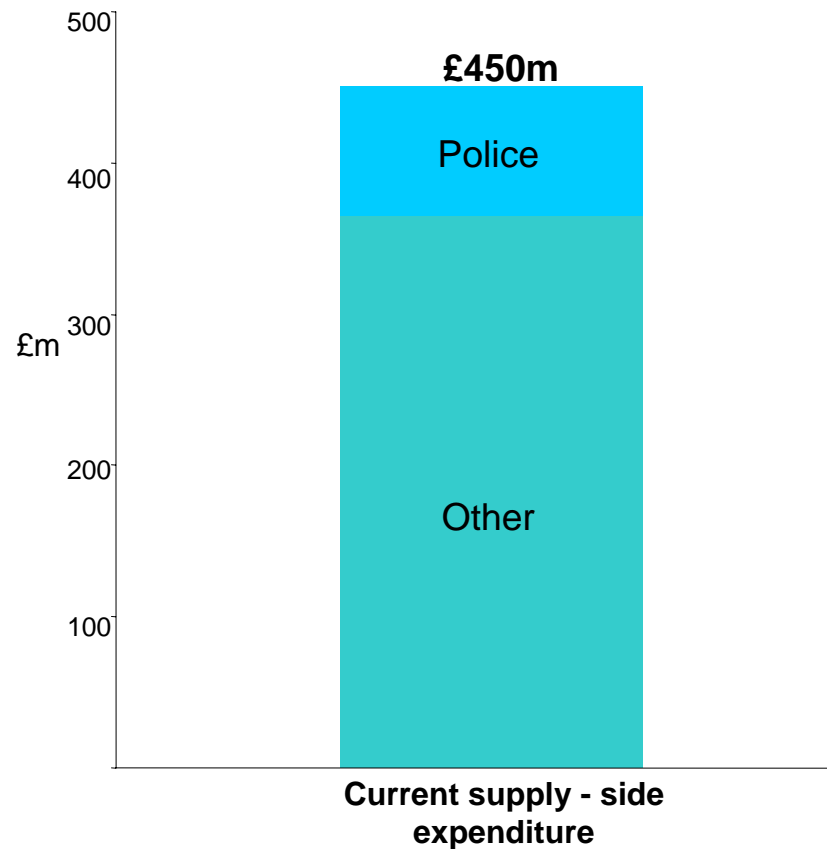
- Cash savings to the exchequer include **£0.2bn in health services and £1bn in avoided criminal justice system costs**
- Because the majority of HHCUs are likely to receive non-custodial sentences and enter treatment through police targeting or voluntary referral, SU modelling suggests that prison places are likely to decrease, by the time steady state is reached

Note: Avoided expenditure in the CJS includes Police activity, prosecution, courts, and other CJS costs; avoided health service expenditure refers to victims of drug related crime; social benefits implies the emotional and physical impact on victims of drug related crime  
Source: Team analysis

# Cost of supply-side interventions

Funding

## Current Spend on interventions against Class A Drugs



## Spend on supply-side intervention

- Of the current total expenditure of £450m on supply-side interventions, £85m is spent on police interventions which, under either option 1 or 2, can be targeted effectively to reduce drug harms
- The balance of drug-related supply-side spend, £365m, does not produce any material payback in reducing drug harms and should be invested in other objectives, such as development, countering organised crime, failed states, drug treatment, or other public goods

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# Summary

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|--|--|
| 1. Diagnosis of current system                             | <ul style="list-style-type: none"> <li>• Around 280,000 high harm causing users (HHCUs) using heroin and/or crack cause c.£21bn of harm pa</li> <li>• The current system has had a limited impact on reducing harms because             <ul style="list-style-type: none"> <li>– it has failed to grip HHCUs: nearly half are arrested each year, but few of these enter treatment as a result</li> <li>– treatment in the UK has failed to grip HHCUs and respond to their needs</li> <li>– there has been no clear organisational focus on HHCUs, or clear accountability for bearing down on harm</li> </ul> </li> </ul>  |
| 2. Options<br>i) the status quo                            | <ul style="list-style-type: none"> <li>• Current and planned changes are bringing improvements but will not have a transformational impact             <ul style="list-style-type: none"> <li>– CJIP is capturing more users in the CJS; treatment services are improving; and a range of measures are being taken to improve delivery</li> <li>– SU estimates that, under the HO best-case scenario, harms may be reduced in the long-term by c.£2bn pa as opposed to c.£8bn pa under a more transformational scenario</li> </ul> </li> </ul>   |
| ii) increasing focus on capture and piloting               | <ul style="list-style-type: none"> <li>• Roll out of pre-arrest initiatives to encourage more users into treatment; implementation of testing on arrest; and responsibility for treatment and case management for drug-using offenders sited within NOMS</li> <li>• Criminalisation of use and registration would be piloted to evaluate the benefits of rollout against key tests:             <ul style="list-style-type: none"> <li>– likely improvements to capture, likely engagement of clinicians, likely impact on prison numbers, robustness of NOMS in taking on the new role, growth in treatment capacity to meet new demand, and extent to which HHCUs self-refer</li> </ul> </li> <li>• SU estimates that, without rollout of criminalisation, this scenario could eventually reduce harms by c.£3bn per annum</li> </ul>  |
| iii) make hard drug use an offence; introduce registration | <ul style="list-style-type: none"> <li>• Heroin use would be made an offence, and a Register would be set up. Coercion would be accompanied by a strong focus on case management for all HHCUs, situated within NOMS. Coercion would maximise the police's role in targeting HHCUs; enable those in the CJS to have their drug use dealt with; and enable those in treatment to be kept there</li> <li>• SU estimate that, in the long-term, this option could reduce crime harms by around £8bn pa</li> </ul>   |
| 3. Supply-side recommendations                             | <ul style="list-style-type: none"> <li>• Supply-side initiatives have a limited role to play in reducing harm:             <ul style="list-style-type: none"> <li>– initiation into problematic use is primarily driven by risk factors rather than availability or price; supply interventions have had little impact in reducing harm, and the scale of disruption required to reduce supply sustainably is not achievable, even with more resources</li> </ul> </li> <li>• The focus of supply-side efforts should be on how best to reduce harm: police have a key role to play in pushing users into treatment and in focusing on local availability; other supply-side activities will have wider benefits, such as in tackling organised crime or addressing state failure, and investment should be reconsidered in that context; drugs will still be seized wherever the opportunity arises, but the drive of agencies should be to deal with the criminality of those supplying drugs</li> </ul> |

## Conclusion

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We can achieve a substantial reduction in the massive crime and other harms currently caused by heroin and crack use, but only through a vision which combines increasing coercion; fundamental organisational reform; and a holistic, fit-for-purpose treatment regime which grips the user. Introducing such a policy would be contentious and disruptive, though the gains, especially in reducing crime, should be substantial. How quickly such a regime is introduced will determine how quickly the gains are made