

Coerced drug treatment in England and Wales

An evaluation of Drug Treatment and Testing Orders

in one locality

PhD Psychology

2012

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Coerced drug treatments were first introduced to the UK in 2000 under the Criminal Justice Act 1998 entitled Drug Treatment and Testing Orders (DTTOs). Since the introduction of DTTOs, drug treatments within the English and Welsh criminal justice system have expanded substantially and DTTOs have since been replaced by Drug Rehabilitation Requirements. As a new initiative DTTOs were under intense scrutiny and subject to much evaluation. One such evaluation forms the basis of the current thesis. Running from 2001 to 2004 the evaluation considered both quantitative and qualitative data relating to all aspects of DTTOs. The findings showed high order revocation rates (57%) though for those who remained engaged with the order there were reductions in drug use and offending. Reductions in drug use whilst on an order were related to length of time on the order, sentencing court and whether the offender was sentenced whilst RIC or in the community. Greater number of previous convictions, positive order outcome and lower overall drug use while in treatment significantly predicted lower reconviction rates. Offenders were positive about the orders liking aspects which worked to increase and maintain motivation. Motivation was a key theme of interviews with both DTTO staff and offenders on the orders. The interviews revealed that the treatment aspect of DTTOs focused on reducing offending rather than drug use, contrary to the expectations of external agencies. Based on the findings from the evaluation and recent changes in drug policy, aspects that coerced drug treatments need to consider include: a shift in focus from reducing offending to treating drug use; use of evidence based psychosocial interventions; the role of motivation and particularly methods of increasing; and a change from focusing on single treatment episodes to instead viewing multiple episodes of treatment in terms of treatment careers.

Acknowledgements

The original evaluation that forms the basis of this thesis was funded by the National Probation Service. The views expressed in this thesis are those of the author and should not be attributed to the National Probation Service.

I am grateful to all of the individuals who agreed to participate in this study. Special thanks go to my supervisors, Dr Marilyn Christie and Prof. Ray Bull, the research and evaluation team and the drug and alcohol service for all their support, advice and encouragement. Special thanks go to Dr. John Bankart for sharing his statistical expertise.

Thanks also go to my family, Andy Powell, Linda Terris and David Terris for enabling me to complete this degree by helping me to find the time needed and for their ongoing support and encouragement.

Contents

Chapter 1

Introduction	1
--------------	---

Chapter 2

Study 1 – DTTO monitoring and outcomes data	41
---	----

Chapter 3

Study 2 - Drug treatment in the criminal justice system: Lessons learned from offenders on DTTOs	80
--	----

Chapter 4

Study 3 - Experiences of DTTO staff and partnership agencies in Delivering and working alongside DTTOs	108
--	-----

Chapter 5

Study 4 – Drug testing in the criminal justice system: Solutions to a costly commodity	143
--	-----

Chapter 6

Study 5 - Drug treatment outcomes in the criminal justice system: What non-self report measures of outcome can tell us	174
--	-----

Chapter 7

Discussion	205
------------	-----

References

271

Appendix A

Letter from Leicestershire Research Ethics Committee	328
--	-----

Appendix B

Patient Information Sheet	330
---------------------------	-----

Appendix C

Offender interview schedule	332
-----------------------------	-----

Appendix D

Offender interview briefing	333
-----------------------------	-----

Appendix E

Staff interview schedule	337
--------------------------	-----

Appendix F

Agency staff interview schedule	343
---------------------------------	-----

Appendix G

Staff interview analysis template	346
-----------------------------------	-----

Appendix H

Agency interview analysis template

349

Chapter 1

Introduction

In 1998 drug treatment policy in England and Wales underwent a dramatic change in focus. Prior to 1998 the focus of drug treatment in England and Wales had been the individual drug user, undergoing treatment on a voluntary basis often within a health setting. However, a rise in the use of heroin and crack cocaine (Newcombe, 2007), in addition to research showing the high prevalence of drugs users in offending populations (Bennett, 1998; Edmunds, May, Hearnden & Hough, 1998) and the benefits of drug treatment (Gossop, Marsden & Stewart, 1998; Gossop, Marsden, Stewart & Rolfe, 2000b) led to a new approach. The 1998 drug strategy moved drug treatment into the realm of the criminal justice system and shifted the focus from benefits to individual drug users to benefits to society through reducing the impact of drug use (i.e. reducing crime). In line with this Drug Treatment and Testing Orders (DTTOs) were introduced in 2000 whereby offending drug users could be sentenced to undergo drug treatment.

The new direction of drug policy in England and Wales in 1998 caused much public discussion. The new drug policy was deemed as being ‘unhealthy’ by Stimson (2000) as it was (a) thought to disregard the health needs of drug users (e.g. blood borne viruses); (b) distorted the helping system by focusing resources on criminally needy rather than those wanting help; (c) focused on class A drugs to the detriment of alcohol; and (d) stigmatised and marginalise drug users by possibly damaging relationships between the police, treatment

services and drug users. Barton (1999b) referred to the criminalisation of health with treatment agencies whereby treatment agencies were being made to focus on criminal justice needs with the possible displacement of voluntary drug treatment clients. Barton (1999b) cited an example of a predecessor to DTTOs - the FastTrack project in Plymouth that resulted in criminal justice clients remaining in treatment after their coerced treatment had ended, resulting in a 'log jam of clients' and increased waiting lists. He also pointed to a shift in the perspective of treatment agencies whereby drug users not involved in offending were more likely to end up on a waiting list.

Despite these initial concerns, drug treatment initiatives in the criminal justice system in England and Wales have continued to grow. This introduction considers the research evidence available at the start of DTTOs. It covers (i) the development of English and Welsh drug policy; (ii) the prevalence of problem drug use; (iii) the relationship between drugs and crime; (iv) the effectiveness of drug treatment; and (v) issues related to coerced drug treatment. More recent literature will be considered in the full discussion of the thesis in Chapter 7.

History of English and Welsh drug policy

Whilst there was concern that DTTOs heralded a movement of drug treatment out of the health service and into the criminal justice system (Stimson, 2000, Barton, 1999b) historically the Home Office had been closely involved in the development of drug policy. Under what has been termed by American researchers (Adams 1937; King, 1972; Lindesmith, 1965) to be the 'British

'System' of drug policy, medical professionals were allowed to make treatment decisions based on treatment needs of the individual with what was seen as little interference from government. In reality, however, the British System is more one of alliance between the medical profession and the government, with both treatment and control of drugs at its heart (Lart, 2006).

Prior to 1916 there was little legal control of drug use. Preparations derived from opium and coca were available from pharmacies and were widely used by the middle classes (Berridge, 2005). Concerns arose during World War II regarding drug use and in an attempt to control cocaine use among service men under the Defence of the Realm Act 40B, the Home Office became the lead government department for drug control (Spear, 1994). Through this, the Home Office founded a loose alliance with medical and pharmaceutical professionals in supporting the expansion of professional control on the availability of drugs.

In 1926 the Ministry of Health Departmental Committee on Morphine and Heroin Addiction, otherwise known as the Rolleston Committee, published a report giving recommendations for dealing with addicts (Departmental Committee on Morphine and Heroin Addiction, 1926). The Committee members were largely medical and their addict clients at that time were largely middle class, often professional - hence their report dealt with such clientele. They made recommendations allowing the medical profession to retain autonomy in the treatment of addicts, but within a framework that was ultimately under the control of the Home Office (South, 2000). Berridge (2005) stated that the Rolleston Report cemented the fundamental alliance between the Home Office,

Ministry of Health and the medical profession, and this determined and underpinned drug policy for almost 50 years. Spear (2002), however, argues that the Rolleston Report merely fine-tuned the existing approach.

By the 1960s the English drug use scene had moved away from middle class professional drug users, with the Home Office noting that new cases of addiction “included increasing numbers initially of beatniks (mainly from the upper socio-economic classes), and latterly...members of the working class, many with a considerable record of juvenile delinquency” (Jeffrey, 1970 p60-74). This led to two reports from the Interdepartmental Committee on Drug Addiction (Ministry of Health and Department for Scotland, 1961; 1965) which heralded a change from the medical disease model of addiction treatable by GPs to the idea that addiction was a socially contagious psychiatric condition (Lart, 1998). Heroin addiction therefore became a ‘menace to society’ (Ministry of Health and Department for Scotland, 1965, para 18) and recommendations were made for restrictions on prescribing, the establishment of specialist treatment centres, the creation of a system of notification of addicts, and a standing committee to review progress. However, these recommendations were not implemented for a further three years during which time the drug scene changed again, with a 250% increase in the number of known heroin addicts (Spear, 1969) and the first illicitly imported heroin arriving on the scene (Spear, 2002).

The Dangerous Drugs Act 1967 enacted the major recommendations of the Interdepartmental Committee (Spear, 1994) and from April 1968 only doctors

licensed by the Home Secretary could prescribe heroin, whereas previously any doctor could prescribe heroin, though licensing policy was set by the Ministry of Health. Guidelines from the Ministry of Health on the development of the specialist treatment centres made explicit the dual role of treatment – care of the individual and control of the social problem of addiction (Connell & Strang, 2005). Treatment of addiction became a specialism, a task for psychiatry largely conducted in hospital settings.

However, the Home Office still retained some control over treatment in these centres. Stimson and Oppenheimer (1982) described the influence the government exercised over the therapeutic work of the treatment centres “it would not be accurate to think of clear-cut policy directive emanating from the government” (p. 113). Close informal links between the Drugs Inspectorate, Department of Health colleagues and clinicians enabled them to exert a subtle influence on clinic policy, though this was not necessarily unwelcome. Clinics struggled with the dual aims of the centres (i.e. ‘control’ and ‘containment’ of the drug problem and treating individual drug users) (Connell and Strang, 2005).

The 1980s saw the emergence of a new ‘heroin epidemic’ (Lart, 2006) and a further change in UK drug policy. Between 1980 and 1985, yearly notifications of addicts to the Home Office Index increased by an average of 30%, with a 50% increase in 1983 alone. By 1985, almost all new notifications of drug addicts entering treatment were heroin users and the total number of people on the Index was 14,688 (Mott, 1994). The Drug Indicators Project (Hartnoll, 1985; Hartnoll, Mitcheson, Lewis & Bryer, 1985) suggested that these figures under-

represented the number of regular opiate users by at least a factor of five, possibly a factor of ten. Of particular concern was the age of the drug addicts. People under 21 years of age accounted for 24% of all notifications in 1985 compared to just 17% of notifications in 1979 (Mott, 1994). This indicated that more young people were starting to use drugs suggesting that drug use was becoming more widespread (Lart, 2006).

With the increase in notified drug users came changes to the perception of the people who used drugs. The 1982 report of the Advisory Council for the Misuse of Drugs (ACMD) 'Treatment and Rehabilitation' (ACMD, 1982) coined the term 'problem drug-taker'. This moved away from the idea of drug addiction as being a short term curable disease towards the ideas of 'chronic handicaps' and 'disorders of behaviour' (para. 5.19). In line with this, the Report recommended movement away from the specialist medical treatment centres and instead the development of generalist teams including different groups of workers (e.g. social workers, community workers, GPs etc.) known as Community Drug Teams (Department of Health and Social Security, 1986; Strang, 1984;).

In 1985 the English government produced a strategy document, 'Tackling Drug Misuse' (HM Government, 1985) which proposed enforcement led measures in its five fronts for action. These fronts for action demonstrated that there was concern in government about the increasing supplies of drugs coming into the country. They included measures to reduce supply coming into the country and also attempted to remove the demand for drug use through prevention and drug treatment. Coupled with the Provisions of the 1986 Drug Trafficking Offences

Act (DTOA) and 1985 Controlled Drugs (Penalties) Act police, customs, courts and prisons were placed at the forefront of policy and practice.

Another influence on drug policy was the discovery of high rates of HIV among drug misusers (Strang, 1989; Strang & Gossop, 1994). The focus of drug treatment changed to that of reducing the harms of drug use to the individual. The birth of harm reduction initiatives, where the aim of treatment was to reduce the risks of passing on HIV, were introduced by ACMD in 1988 and 1989. As a result of pressure to deal with HIV, the criminal justice system started to come into the mainstream drugs policy debate. The ACMD published a series of reports on AIDS and drug use and highlighted the opportunities for interventions in the criminal justice system (ACMD 1988, 1989, 1991, 1993).

The 1991 Criminal Justice Act was the first to introduce drug treatment to the English and Welsh criminal justice system with the introduction of Schedule 1(A)6 orders where offenders could be sentenced to undergo treatment as a condition of a probation order. However, due to a lack of guidance for sentencers, reluctance on the part of probation officers to get involved in legally coerced treatment and lack of support from treatment services, little use was made of this order (Home Office, 1997a).

The 1995 drug strategy *Tackling Drugs Together* heralded a further change in the direction of drug policy, moving away from harm reduction and towards ‘enforcement’, ‘control’ and ‘punishment’ (Duke, 2000). There were four key objectives: to ensure that the law was effectively enforced; to reduce the

incidence of drug related crime; to reduce the public's fear of drug-related crime; and to reduce the level of drug use in prisons (HM Government, 1995:1). While probation and prison services were to develop strategies for tackling drug use and drug related offending, there were no further attempts directly to expand treatment within the criminal justice system.

A key piece of research was published around this time which greatly affected government thinking. The National Treatment Outcome Research Study (NTORS), the first major English study on drug treatment effectiveness, showed that voluntary drug treatment in England reduces drug use and offending. Looking at the effectiveness of drug treatment delivered in 1995 they found substantial reductions in the number of crimes committed and percentage of clients engaging in crime post-drug treatment compared to pre-drug treatment. Follow up after one year showed acquisitive crimes to have reduced to one third of pre-treatment levels. Specifically shoplifting offences were reduced to one third of intake levels and burglary offences had decreased to one quarter of intake levels (Gossop, et al., 2000). Based on these findings, calculations of the savings associated with drug treatment estimated that for every £1 spent on drug misuse treatment there would be a minimum of £3 saving to the economy in terms of reducing victim costs of crime and cost savings within the criminal justice system (Gossop, et al., 1998).

The 1998 drug strategy *Tackling Drugs to Build a Better Britain* (HM Government, 1998b) largely reiterated themes of the 1995 drug strategy with four key aims:

- i) "to help young people resist drug misuse in order to achieve their full potential in society;"
- ii) "to protect our communities from drug related anti-social and criminal behaviour;"
- iii) "to enable people with drug problems to overcome them and live healthy and 'crime free' lives;"
- iv) "to stifle the availability of illegal drugs on our streets."

(HM Government, 1998b).

Of note was a movement away from focusing on individuals (HM Government, 1995) and instead to focus on protecting the community (HM Government, 1998b). This latter strategy proposed that crime-reduction would be achieved by channelling drug offenders from the criminal justice system into treatment.

Prevalence of problem drug use

Whilst examining the development of English and Welsh drug policy it is important to consider the increasing size of the drug misusing population. However, the prevalence of problem drug use is, due to its very nature, hard to determine. Since the development of drug treatment in the criminal justice system more is known about the size of the drug misusing population in the UK (e.g. Boreham, Cronberg, Dollin, & Pudney, 2007; Hay, Gannon, MacDougall, Millar, Williams, Eastwood, & McKeganey, 2008). However, as these relate to prevalence after the introduction of drug treatment in the criminal justice system, the figures will have been affected by the introduction of such treatment. The current review will consider the little that was known about the

size of the problem drug misusing population prior to the introduction of DTTOs. More recent literature on prevalence is considered in the full thesis discussion (Chapter 7).

Prevalence of drug use in the general public

Estimates of the prevalence of drug use in the general public tend to be based on government studies, the biggest of which in Britain is the British Crime Survey. This is a household survey conducted regularly across Britain which includes a self-report drug component. The 2000 British Crime Survey (Ramsay, Barker, Goulden, Sharp, & Sondhi, 2001) found that 34% of the population of adults aged 16-59 years (n= 13,021) had consumed at least one illegal drug at some point in their life, 11% had done so in the previous year, and 6% had done so in the previous month. Looking at particular drugs, 1% of 16-59 year olds reported using heroin at some time in the last year and 1% reported using heroin some time in the last month. Similarly, 1% reported using crack in the last year. Use of both heroin and crack was most common among 16-29 year olds. From the survey responses, Ramsay et al., (2001) estimated that 46,000 16-24 year olds in the general population had used heroin in the last year and 18,000 had used heroin in the last month (50,000 and 11,000 for crack respectively). Such data can only act as a guide however, as the survey data are self-reported and dependent on respondents' truthfulness. Additionally, the survey only covered a sample living in households and did not include the homeless, those in institutions such as prisons and student halls of residence. It was also not necessarily able to reach people who were chaotic and/or rarely at home and so is probably a gross underestimate of drug use in the general

population. As an example of the limitations of these data Hickman et al., (2004) found more drug users presenting for treatment than the number of users of any substances as extrapolated from the BCS in that time period.

Other studies, however, support the findings of low prevalence of heroin and crack use in the general population. For example the 1998-1999 'Youth Lifestyles Survey' found that while the proportion of young people (16-30 years) in the general population using any drug in the last year was 27% (Pudney, 2002), the proportions using heroin or crack in the last year was less than 1% (Goulden & Sondhi, 2001).

Problem drug users

Having determined a rough idea of the size of the drug misusing population, the question then becomes one of what proportion are problem drug users? The notion of the problem drug user (PDU) was first introduced in the ACMD report 'Treatment and Rehabilitation' (1982). Its definition was broad, referring to "any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)" (ACMD, 1982: para 5.13). Edmunds et al., (1998) narrowed this definition down to "that which involves dependency, regular excessive use or use which creates serious health risks" (p. 2). They went on to say that users regarded as problematic "typically consume large amounts of heroin, crack or amphetamine, usually as part of a pattern of polydrug use; they generally show signs of dependency; their drug

use poses risks to themselves and others; and they are often significantly involved in crime to support their drug use." (p. 2).

Size of drug treatment populations

The figure in the Home Office Addicts Index (AI) in 1996 (notifications of all drug users in treatment) was 43,000 (Home Office, 1997b). However, epidemiologists suggest that in order to take account of problem users in touch with agencies but not notified to the AI or those not in contact with agencies this figure needs to be multiplied by a factor of between two and five (Hartnoll & Lewis, 1985). Based on these figures and the British Crime survey, Edmunds et al., (1998) estimated that around 3% of those who use drugs each year may be considered problem drug users.

Regional Drug Misuse Databases (RDMD) replaced the Addicts Index in 1997 and showed that in England in 2001, the number of users reported as being in treatment with drug misuse agencies and/or GPs (for any drug) was around 118,500. Approximately 33,100 of these presented for drug treatment for the first time, or for the first time in six months or more during the six month period ending September 2000 (DoH, 2001). The great majority (87%) of users reported as being in treatment were attending community specialist services – these were thought to include community based drug services, hospital outpatient, and drug dependency unit outpatient services. Again though the data needs to be treated with caution as participation in the RDMD was not mandatory. Therefore, the data may be an underestimate. Also, the system is

based on initial and date of birth identifiers, so it could be subject to incorrect matching or name changes leading to double counting of drug users.

Of note is that not all drug users in contact with treatment agencies would be heavy users or involved in crime. Prior to the introduction of DTTOs offending drug users could choose to attend drug treatment in the community. However, there is no information available on the number of PDUs in voluntary treatment committing offences.

Prevalence in criminal justice settings of substance misuse problems at start of DTTOs

A number of studies were conducted in the late 1990s and 2000 looking at the other side of the issue - problem drug users in the criminal justice system. The New ADAM study (Bennett, 1998) tested arrestees for drugs across five police areas (n=622) and found what at the time were considered to be surprisingly high rates of drug use: three out of four arrestees tested positive for at least one drug (including alcohol); one in five arrestees tested positive for opiates, one in twelve arrestees tested positive for methadone, and one in ten arrestees tested positive for cocaine. Arrestees held for property offences (n=306) were more likely to test positive for cocaine, methadone and opiates than arrestees held for other offences. One in five arrestees said they had received some kind of treatment in the past for drug dependence and 22% said they would like to receive treatment (including 9% who had never received treatment previously). However, the author himself acknowledged that the data were limited and should be treated with some caution. The study sites were chosen for

convenience, non-random sampling was used, and no account was taken of the half life of drugs - hence cannabis which had the longest half life (one month as opposed to two days for opiates) came out as the most common drug (Stimson, Hickman & Tunbull, 1998). Additionally, the New-ADAM study only includes offenders who were arrested giving no idea of drug use in offenders who do not get arrested (Stevens, 2007). However, these data do suggest that PDUs are prevalent in offending populations and acquisitive offenders report higher usage of heroin, crack and cocaine than arrestees held for other offences.

The estimated relatively small group of offending problem drug users impose heavy costs on victims of crime and public services with estimates of criminal justice costs for each problem drug user being in excess of £45,000 per year, with similar social security costs and further health system costs to be taken into account (Edmunds et al., 1998). Godfrey, Eaton, McDougall, and Culyer (2002) using data from NTORS estimated that PDUs account for 99% of the economic and social costs associated with drug use and 88% of total economic costs can be accounted for by drug related crime.

Edmunds, May, Hearnden, and Hough (1998) sampled offenders passing through early Arrest Referral Schemes in Southwark, Derby and Brighton where specified drugs workers were linked to police custody suites to work with PDUs and get them into treatment. The average referral rate per worker per month ranged between 11 and 14. The study sample consisted of 128 PDUs with 90 having been seen by arrest referral workers at or shortly after arrest, with 80% of those referred for treatment going on to make contact with a drug agency.

Edmunds et al., found that 43% of their full sample had had no previous contact with any drugs agency, though most had previously had contact with the criminal justice system. This suggests that while some offending PDUS had previously accessed treatment, a large proportion had not though what proportion of these went on to engage in treatment and what proportion chose to remain out of treatment is unknown. However, the authors acknowledge biases in their sample including a possible over representation of those in custody or treatment, as those were easier to contact.

Drug Treatment and Testing Orders

In attempts to deal with the increasing numbers of drug users based on the findings of NTORS and the NEW-ADAM studies, Drug Treatment and Testing Orders (DTTOs) were introduced under the Crime and Disorder Act 1998 (Home Office, 1998a). These orders aimed to reduce offending by reducing drug use.

Any offender over the age of 16 with a dependency on or a propensity to misuse drugs and for whom treatment may be helpful could be sentenced to a DTTO (Home Office, 1998a). DTTOs were aimed at dependent users of heroin or other opiates, cocaine and amphetamines who were convicted of acquisitive crimes (burglary, robbery, theft including shoplifting) committed to fund their drug use, and were intended to act as an alternative to a custodial sentence for offenders with a significant record of drug related offending. Assessment of offenders was on four main criteria: the type and seriousness of the index

offence; the seriousness of the drug problem and susceptibility to treatment; motivation to change; and volume of drug related offending (Home Office, 2001b). Offenders were required to be motivated to address their offending, have a high risk of repeat offending, and consent to treatment. As well as drug treatment, which offenders had to consent to undergo, DTTOs included drug testing and monthly reviews of the Order, both of which were new initiatives in the English and Welsh criminal justice system.

Offenders could be sentenced to an order of between six and 36 months in length depending on the severity of their drug use and the severity of the offence. Whilst on an order they were expected to undergo treatment (consisting of a mixture of medical treatment, one to one sessions, group work sessions) for a minimum of 15 hours per week for the first three months of the order (Home Office, 2001b).

Offenders were in breach of their DTTOs if they failed to comply with the conditions of the Court Order, set in the form of National Standards for the Probation Service (Home Office 2001b, National Probation Service, 2002). They were taken back to court to be ordered to either continue their DTTO with or without sanctions or be re-sentenced for the original offence.

DTTOs were based on four premises:

- 1) that drugs and crime are linked
- 2) that treatment will reduce offending
- 3) drug using criminals can be coerced into treatment

4) that getting serious drug users into treatment will reduce crime i.e. coerced treatment is as effective as voluntary treatment with serious drug users (Stimson, 2000b).

The evidence for each of these assumptions will now be examined.

The relationship between drugs and crime

Drugs and crime are linked though the relationship between the two remains unclear. There is however, a growing body of literature examining the relationship between the two. Relationships appear to differ dependent on the type of drug used and the type of offence under examination (Bennett, 1998; Bennett, Holloway, Farrington, 2008). Due to length limitations to this thesis, the current review examines mainly theories applying to heroin and cocaine, as DTTOs were aimed at such drug using offenders. For a wider review see Bennett and Holloway (2005).

Three major models have been used to explain the links between drugs and crime:

1. drug use causes crime
2. crime causes drug use
3. drug use and crime have a common aetiology.

Drug use causes crime

The model proposing that drug use leads to crime is perhaps the most cited model, though there is no evidence to date to prove a direct causality. There

are a number of different theories of how drug use causes crime, but in relation to heroin and cocaine use, the main explanations are economic, looking mainly at links between illicit drug use and acquisitive crimes (e.g. theft, shoplifting and burglary). The most common model is the 'economic necessity' model (Goldstein, 1985) whereby drug users become 'enslaved' to a drug (i.e. dependent on it and engage in crime in order to fund further use and avoid withdrawal symptoms). Drug users are seen as having no choice other than to offend in order to fund their drug use. This explanation has traditionally been used to explain people's initiation into offending (Goode, 1997).

Crime causes drug use

The model proposing that crime leads to drug use can again be explained in a number of ways: sub-cultural theory; the situational crime model; and as a form of self-medication. In support of sub-cultural theory, White claims that criminal activity in subcultures provides 'the content, the reference group and the definitions of a situation that are conclusive to subsequent involvement in drugs' (White, 1990, p.223). Thereby, where an individual is in an environment that is supportive of offending and drug use, the desire for sub-cultural status (e.g. that of being a drug user) rather than a need for drugs is what is important. Drug use is then seen to provide status in an otherwise low-status society. Drug use arises and flourishes where sub-cultural values sustain it (e.g. deprived inner city areas), or, where sub-cultural values do not promote drug use but neither do they resist it. The theory suggests that offending is also rife in such environments therefore offending is considered to be normal behaviour but drug use increases an individuals status in that environment. However, White herself

stated that there is no conclusive evidence for this link. Situational crime theory purports that some people are born with, or come to acquire, a “disposition” to behave in a consistently criminal manner” (Clarke, 1980, p136). In this theory, the offender is seen as making a rational choice whether to offend and this is equally true of drug users, whether addicted or recreational users they still make a choice and work out the cost-benefits of offending and also using drugs (Bean, 2004). Supporters of situational crime prevention say crime leads to drug use and by modifying crime ‘hotspots’ and the environment then drug taking can also be reduced. In terms of self-medication, it is thought that some individuals with deviant lifestyles or personalities may also use substances for the purposes of self-medication, in particular ‘dual diagnosis’ clients who suffer from a general mental health condition. In relation to crime, individuals deviant lifestyle (or mental disorder) and/or personality may lead them into a drugs subculture where they feel accepted by the drugs community when previously they have struggled to find acceptance. (This acceptance may be superficial and may result in exploitation by drug users resulting in them committing crimes.) Once part of this community, they may start to self-medicate, to either dampen down the symptoms of their illness or offset any side effects of their psychiatric treatment.

Common aetiology

The third major model proposes that drug use and crime actually have a common aetiology. Again there are sub-models, common origin, reciprocal, spurious or co-morbidity and policy. Firstly, there is the idea that drug use and crime may arise from the same environmental or social context. Indeed,

Seddon (2006) supports Buchanan (2004) in believing that drug related crime cannot be adequately understood without also examining the underpinning issues of poverty and exclusion. He looks back at the history of drug use in the UK and examines the links with socio-economic disadvantage and social exclusion. He argues that it is only through looking at drug related crime in this context that one can develop an effective response to drugs-crime issues.

McMurran (2006) describes a risk factor model whereby risks factors for substance use and crime are highly similar. An accumulation of biological, psychological and social risk factors, combined with an abstinence of protective factors across the lifespan can lead to heavy substance use and associated crime (McMurran, 1996; McMurran & Priestly, 2004). Secondly, the reciprocal model suggests that the relationship between drug use and crime is bi-directional (White, 1990), whereby, at some points in time, drug use precedes crime and at others, crime precedes the drug use. Thirdly, there is a proposition that drugs and crime may not necessarily be linked but may instead be coincidental – the so-called spurious or co-morbidity model. Finally, McBride, Vander Waal, and Terry-McElrath (2002) argue that policy and law have contributed to the relationship between drugs and crime. Each time there is a change in policy the perception of drug use in relation to crime also changes slightly. However at the time of writing there had been little research into this.

As can be seen above, theories for the relationship between drug use and crime abound. The difficulties lie, however, in proving that a direct causal relationship between drug use and crime exists. Evidence for theories comes from studies

that utilise one of three main methodologies – ‘age of onset studies’, ‘changes over time studies’, and ‘qualitative studies’.

Age of onset studies examine whether it is drug use or crime that comes first. Holloway and Bennett (2005), reviewing the literature, found 13 ‘age-of onset’ studies using a drug using population, seven studies using an offending population, and one study from the general population. The benefit of such studies is that they can determine whether drug use preceded crime or crime preceded drug use. They concluded that the majority of the studies showed that criminal behaviour preceded the onset of use of heroin, crack and cocaine. For example Inciardi and Pottieger (1986) surveyed female narcotic users in Miami and found that the average age of first crime was 15.7 years and average age of first heroin use was 17.5 years. Pudney (2002) used data from 3901 youths in the Youth Lifestyles Survey and found that criminal behaviour occurred before the use of illicit drugs. This lends support to the idea that crime might lead to drug use. However, in contrast, recreational drug use (such as cannabis and solvents) preceded crime. Inciardi and Pottieger (1986) found the average age of first inhalent use was 13.9 years compared with the average age of first crime at 15.7 years. Inciardi and Surratt (2001) interviewing cocaine dependent women in Miami found that the average age of first cannabis use was 15 years and first criminal activity was 18 years. While there is evidence that the relationship between drug use and crime may vary for males and females (Johnson, 2004; Makkai & Payne, 2003) the result that criminal behaviour precedes drug use was found across samples of both males and

females. This supports the idea that drug use might well lead to crime (Bennett & Holloway, 2005).

From the Bennett and Holloway review there were eight studies examining 'Changes over time', four using participants from a drug using population, three from an offender population, and one from the general population. These provided some evidence of a connection between drug use and crime, showing that increases in drug use are associated with increases in crime and to a more limited extent, increases in crime are associated with increases in drug use.

For example, Jarvis and Parker (1989) found an increase in prevalence of offending when using heroin, and Hanlon, Nuren, Kinlock & Duszynski, (1990) found the mean number of days per year spent offending more than doubled during periods of addiction to narcotics. However, these studies are based on self report in some instances requiring recall stretching back over 12 months so limiting reliability of these data. In another US study Ball et al., (1981) found the mean number of crime days during periods of addiction was substantially higher than during periods of abstinence (248 days per year versus 41 days per year).

Qualitative research has also been used to examine the links between drug use and crime, and these studies have provided evidence for most of the main theories of drug use and crime. Brain, Howard, and Bottomley (1998), and Rosenbaum (1981) found evidence for economically motivated crime, Wright and Decker (1997) and Brain et al., (1998) found evidence supporting the idea that drug use precedes crime, and Simpson (2003) found evidence to support the reciprocal relationship between drugs and crime. Surprisingly, some

qualitative studies (Bennett, 2000; Liriano and Ramsay, 2003) also provided evidence from offenders that there was no causal connection between drug use and crime. From Holloway and Bennett's extensive review the only conclusion they were able to draw was that the details of the relationship between drug use and crime have not yet been sufficiently researched.

Effectiveness of drug treatment

Community drug treatment is known to be effective in reducing drug use, with smaller effects on reducing crime (for international reviews see - Lurigio, 2000; Prendergast, Podus, Chang & Urada, 2002). Effectiveness research, however, is not without its limitations. Webster (2007) identified four limitations, three of which are relevant when considering literature in support of DTTOs. Firstly, and perhaps the biggest limitation, is that most effectiveness studies do not include a control group of drug users who do not enter treatment. This is important as it means that it is possible that individuals who reduce their drug use and offending after treatment may have done so for natural reasons (e.g. they just grow out of it) or for other reasons and hence the changes in drug use and offending could have occurred regardless of whether they had undergone treatment (Audit Commission, 2002). Secondly, more needs to be known about the mechanisms and contexts through which different treatment approaches operate and succeed or fail (Pawson & Tilley, 1998). Thirdly, there is no commonality in level of severity and nature of individuals' drug problem, indeed peoples drug use changes over time. Some users are also more resilient to treatment than others (Audit Commission, 2002; Health Advisory Service, 2001). Webster goes on to conclude, however, that despite these limitations

the evidence in support of drug treatment effectiveness is overwhelming (Webster, 2007).

The preliminary findings from NTORS (Gossop, et al., 1998), played an important role in shaping Tackling Drugs to Build a Better Britain (HM Government, 1998b) and as DTTOs started was the best available evidence on the effectiveness of English and Welsh drug treatment. The evidence that treating drug use reduced crime was also taken as evidence that drug use causes crime and therefore treating drug use will remove the reason for offending. However, NTORS pre-dated the roll out of the criminal justice system drug treatment and participants in NTORS were community based methadone treatment clients and residential rehabilitation clients, (i.e. a clinical sample of drug users seeking treatment voluntarily). As Gossop, Trakada, Stewart and Witton pointed out in 2006, it is not known whether such findings would have been obtained with other samples such as drug misusers in the criminal justice system (Gossop et al., 2006).

Additionally, Ashton (1999) criticised the NTORS findings on a number of other grounds. Firstly, he reports that it was hard to determine what treatments were actually received by the drug users as part of NTORS. Drug treatment was broken down into different modalities but what the modalities consisted of across the different sites was undetermined. Secondly, Ashton identified the lack of a control treatment group. Without a control group it was not possible to compare the outcome of the treatment group to what could have happened without treatment. Thirdly, in the follow up studies, a number of clients were

lost to follow up; he considers that if NTORS had been able to re-contact all clients the follow up results may have been less impressive. Fourthly, the cost savings calculations come under criticism for a number of reasons, including again the loss of clients to follow up and possible overestimations of pre-treatment crime levels. It should also be noted that the treatment received as part of NTORS was not in isolation - participants may well have had previous unsuccessful treatment episodes and prior to follow up received additional different treatments all of which may have effected the treatment effectiveness findings.¹

Despite all of the criticisms of the existing research, the available evidence in support of drug treatment having a positive effect on drug use, crime, and social domains is overwhelming. Indeed, on the basis of the NTORS study, in spite of his criticisms, Ashton (1999) concluded that drug treatment is effective and worth investing in. But, does this treatment effectiveness carry over to coerced drug treatment?

Coerced treatment

When examining the literature on the effectiveness of coerced treatment, a number of issues can be identified including: the definition of coerced treatment; whether coercing people into treatment affects motivation; and the ethics of coercing people into treatment. The research literature on each of these issues needs to be considered in assessing the effectiveness of coerced treatment.

¹ Some of the issues identified with NTORS have been addressed in the Drug Treatment

Defining coerced treatment

The Concise Oxford Dictionary (1990, 8th edition) defines “coerce” as to “persuade or restrain (*an unwilling person*) by force”. This is different from “compulsory”, which is defined as ‘*required by law or a rule*’ (*ibid*). In compulsory treatment, people have no choice but to enter treatment, they are instructed to do so usually by the courts². In coerced treatment, however, although the client is encouraged to enter treatment (through having restricted choice) they do still retain the ultimate choice. This was the case with DTTOs in the England and Wales where clients were required to consent to an order or face the alternative sentence, in most cases, custody.

Coercion is not a dichotomous variable but is better thought of as being on a continuum rather than either being present or absent (Anglin, Brecht & Maddahian, 1989; Anglin & Hser, 1990; Farabee, Prendergast and Anglin, 1998; Hiller, Knight, Broome, & Simpson, 1998). Also, coercion to enter treatment does not only come from the criminal justice system but can come from a variety of sources including family, friends and/or employers (Wild, Roberts, & Cooper, 2002). Polcin and Weisner (1999) found that 37% of individuals in their study who reported that they received an ultimatum from the criminal justice system also reported an ultimatum from at least one other source including family and friends. Marlowe, Merikie, Kirby, Fresting & McLellan, (2001) identified five sub-types of clients which were characterised by different perceived pressures to enter treatment: (i) negative financial

Outcome Research Study (Jones et al., 2009) which was conducted after the expansion of drug treatment into the Criminal Justice System and is considered in Study 5 and Chapter 7.

² Such treatment does not exist in substance use services in the UK currently, but does in other mental health fields

pressures; (ii) coercive legal pressures; (iii) internally mediated medical and psychological pressures; (iv) coercive social and financial pressures or (v) familial pressures and they demonstrated that “legal pressures may exert substantially less influence over drug treatment entry than do informal, extra-legal influences” (Marlowe et al., 1996, p. 81).

Wild and colleagues suggested that coercion is an inherently subjective concept, as it is the perception of persuasion by threat that influences behaviour and not necessarily the level of threat that actually exists (Longshore et al., 2004; Polcin, 2001; Seddon, 2007; Wild, Newton-Taylor, & Alutto, 1998; Young, 2002;). Hence not all clients legally required to participate in treatment necessarily consider themselves as having been coerced into treatment, and thus they are not necessarily unwilling participants (Farabee, Shen & Sanchez, 2002; Longshore et al., 2004; Wild et al., 1998). Longshore et al., (2004) stated that persons referred to treatment through the criminal justice system should not be assumed to be under greater coercion than others entering treatment voluntarily.

Effects of coercion on motivation

Motivation is widely viewed as a critical factor in treatment participation, retention and success (Hiller, Knight, Leukfield & Simpson, 2002). Motivation, like coercion is not a simple concept. Miller (1985) defined motivation as the “probability of engaging in behaviours that are intended to lead to positive outcomes” (p. 99). Motivation is not static but is a dynamic process that occurs within an interpersonal context (Miller & Rollnick, 1991). The concept of

motivation has been described in many ways (for example see DeLeon, Melnick & Kressel, 1997; DeLeon, Melnick, Kressel & Jainchul, 1994; Miller & Rollnick, 2002; Prochaska and Norcross, 1994).

Level of motivation to enter drug treatment has been shown to influence entry to treatment and length of stay in substance abuse treatment (Simpson, 2001) both of which are known to predict outcome at follow-up (Joe, Simpson, & Broome, 1998). Motivation to address drug use at intake is related to favourable follow-up outcomes in drug use (Shen, McLellan & Merrill, 2000; Simpson, Joe, & Rowan-Szal, 1997;) and also treatment retention and engagement (DeLeon, Inciardi & Marinis, 1995; Joe et al., 1998; Ryan, Plant & O'Malley, 1995; Simpson, Joe, Rowan-Szal & Greener, 1995). However, the relationship between motivation and coercion is unclear. It does not appear to be, as predicted by many, that coercing clients into treatment simply reduces their motivation to address drug use. Hiller et al., (2002) found that some offenders coerced into residential treatment were indeed motivated to address their drug use. Stevens et al. (2005), in a review of the German literature on quasi-compulsory treatment, found that a motivated and coerced client may do better than an unmotivated volunteer. This is perhaps because, as mentioned above, not all coerced clients consider themselves to have been coerced into treatment (Farabee et al., 2002; Longshore et al., 2004; Wild et al., 1998).

There are a number of theories as to the effect of coercion on motivation. Motivation can be differentiated into internal or external motivation: internal motivation is considered to be personal reasons to change (e.g. preference or

belief) and external motivational factors are pressure or coercion from outside the person (Longshore, Bellino & Neavins, 2004). DiClemente et al. (1999) suggested that internal motivation promotes long-term success in changing substance use habits, while external motivation (coercion) promotes short-term abstinence from substance use.

Longshore et al. (2004) proposed that motivation and coercion can interact in two ways: (i) motivation may have less bearing on treatment outcomes when coercive pressure (external motivation) is strong enough to hold a person in treatment (Simpson & Joe, 1993); or (ii) the combination of internal and external motivation may lead to better outcomes than those produced by either motivation on their own should the person transform the external pressure into an internal motive. Longshore and Teruya (2006) broke motivation down into positive aspects (readiness) and negative aspects (resistance) and questioned whether coercion interacts with the positive or negative aspects of motivation. They found that while positive aspects of motivation predicted retention in treatment, drug use was predicted by the negative aspects of motivation suggesting that under coercion those opposed to treatment (i.e. resistant, negative motivation) may merely go through the motions of treatment in order to avoid negative consequences such as custody or job loss.

Wild et al. (2006) using Self-Determination Theory (SDT, Deci & Ryan, 1985) identified three forms of motivation: external motivation – clients' belief that treatment is sought due to coercion or pressure; introjected motivation – internal conflicts (such as guilt or anxiety) associated with the decision to enter

treatment; and identified motivation – where clients identify with the goals of treatment, commit to those goals and choose to seek help. Where introjected and identified motivation are high, Ryan, Plant, and O’Malley (1995) interpreted this as internalising the decision to enter treatment regardless of external motivation levels. Wild et al. (2006) found that external motivation (i.e. coercion) was generally unrelated to measures of client engagement at the start of treatment and concluded instead that client engagement is predicted by the clients’ perception that they sought help because they identified with the goals of treatment and made a personal choice to attend.

However, even in so-called voluntary treatment not all clients are fully motivated to change their drug use (Hough, 2002). Voluntary clients also experience ambivalence about treatment (Klag, et al., 2005). Additionally, an individuals’ motivation can be focused on just one aspect of their behaviour, a person can be motivated to address just one aspect of their behaviour but not another, e.g. an individual could be motivated to address their drug using behaviour but not their offending behaviour. Or they may be motivated to address their drug use but not to enter treatment. This will also cloud an assessment of an individuals motivation. What may be more important than motivation to enter treatment or address substance use/offending at treatment entry is the ability to increase and maintain motivation once treatment has commenced. Longshore and Teruya (2006), Stevens et al., (2006) and Wild (2006) all argue that for research on coerced treatment to be conceptually robust, the complex interactions between legal pressure, other external pressures, perceptions of coercion, and internal motivation need to be examined further.

Effectiveness of coerced treatment

Literature on the effectiveness of coerced treatment is flawed, as until recently the referral source has been used as the measure of coercion (i.e. coerced treatment has been equated with referrals from the criminal justice system (Klag, 2005) which is not necessarily a good measure of coercion as discussed above). However, in the case of DTTOs, it is important to consider the effectiveness of coerced treatment in the criminal justice system.

The Home Office Drugs Prevention Initiative published a review of the English language literature on drugs and crime and interventions in the CJS in 1996. This review produced some support for the effectiveness of coerced drug treatment (Hough, 1996). However, the majority of evidence on the effectiveness of coerced treatment comes from the United States where drug courts have been established for a number of years. It is thought by Bean (2004) that DTTOs were based on these Drug Courts, which came into existence in the USA to combat increasing prison populations and numbers of drug misusing offenders repeatedly appearing at court. To date, there are in excess of 16,000 operational drug court programmes in the USA (Huddleston, Freeman-Wilson, Marlowe, & Roussell, 2005).

USA drug courts show promising outcomes with participation in and completion of the programme being linked to reduced drug use, rates of re-arrest and recidivism (Cosden, Basch, Campos, Greenwell, Barazani & Walker, 2006; Fielding, Tye, Ogawa, Imam, & Long, 2002; Guydish, Wolfe, Tajima, & Woods,

2001; Rodriguez & Webb, 2004; Spohn, Piper, Martin, & Frenzel, 2001). In comparison to groups of offenders not exposed to drug courts, drug court participants show better offending and drug outcomes (Galloway & Drapela, 2006; Gottfredson, Kearley, Najaka & Rocha, 2005; Gottfredson & Exun, 2002; Brewster, 2001). Marlowe, DeMatteo and Festinger (2003) concluded that “drug courts outperform virtually all other strategies that have been attempted for drug involved offenders” (p. 153).

While the research evidence sounds promising, there are limitations to this evidence and its relevance to DTTOs. Firstly, the US drug court model targets low level or first time offenders and the vast majority of schemes aim for abstinence (Bean, 2004) while DTTOs were targeted at repeat offenders using high levels of drugs. Historically, drug courts have made little use of methadone maintenance (Peyton & Gossweiler, 2001), a key part of criminal justice drug treatment in England and Wales. There is also large variation between jurisdictions in the model of drug court offered, criteria of offenders accepted by courts, and treatment available to offenders through the drug court. Not surprisingly, therefore, completion rates from drug courts range from 27% to 66% (US Government Accountability Office, 2005).

Evaluations of USA drug courts are also flawed with methodological criticisms such as small sample sizes, limited tracking of programme failures and drop outs, and lack of comparison groups (Fisher, 2003; McSweeney, Turnbull and Hough, 2008). Additionally, selection effects, sampling and response bias all complicate the evidence (Rodriguez & Webb, 2004; US Government

Accountability Office, 2005). Only a couple of Randomised Control Trials have been conducted on US drug courts and their results remain inconclusive (Hoffman, 2000). However, the US General Accountability Office (2005), in a review using only methodologically rigorous studies, did find that there were positive results on recidivism during and after participation in drug court programmes.

The perceived success of American drug courts has led to their development in a number of other countries including Canada, Australia, Ireland, Puerto Rico and Scotland (Bean, 2004; McIvor, Barnsdale, Eley, Malloch, Yates & Brown, 2006). Australian drug courts, unlike the majority of US drug courts, deal with prolific offenders. The first Australian drug court was established in New South Wales (NSW) in late 1999, slightly before DTTOs in England and Wales. Unlike US drug courts, they aimed to support and treat “serious, usually repeat offenders whose criminal behaviour is the direct result of drug dependency, particularly involving heroin.” (Wundersitz, 2007, p. 20). Again, courts varied across jurisdictions within Australia though all retained key principles of drug courts. Freeman (2002), in an evaluation of the NSW drug court, found significant reductions in drug use (through both self reported spend on drug use and urinalysis). Lind et al. (2002), using a randomised experimental design with NSW drug court participants, found that in terms of time to first subsequent offence and offence frequency participants who remained on the treatment programmes fared better than those whose order was terminated or those in the control group. Again, the NSW treatment programme operated on an

abstinence basis requiring offenders to be drug free at completion of the programme.

Although DTTOs have been based on American drug courts, they have a number of significant differences from the American drug court model in addition to the difference in offender profile and drug treatment approaches. DTTOs use only three of the ten key components of drug courts identified by the US National Association of Drug Court Professionals (NADCP, 1997): review hearings, mandatory completion of treatment; and random and frequent drug testing. While it is encouraged that court reviews under DTTOs are held by the same sentencer throughout the order, in practice this did not happen (Turnbull et al., 2000). In US drug courts treatment participants do not always see the same sentencer but it has been shown that continuity of sentencer is linked to outcomes (Goldkamp, White & Robinson, 2001 cited in Plotnikoff & Woolfson, 2005). Sentencers are also more involved under the US drug court model than they are in DTTOs, in that the court reviews are more frequent, sentencers are involved in treatment planning and have greater discretion of rewarding good behaviour or sanctioning non-compliance (one of the key components of the US drug court model). Bean (2004) described the differences between DTTOs and US drug courts as immense and went so far as to say, “in practice the DTTO turns out to be a weak carbon copy of drug courts lacking certain essential features necessary to make the system work” (p. 14).

Ethics of coercing individuals into treatment

Regardless of the conceptual issues regarding coerced treatment and motivation, a number of ethical issues need to be considered, for example, is it ethical to coerce people into treatment?

Seddon (2007) asked how coerced treatment can be morally justified and gives two possible answers – firstly because ‘its good for them’ and secondly ‘its good for us’ on the basis that treatment related crime prevention benefits communities. He surmised that both of these positions were ethically problematic. Gostin (1991) in considering coerced drug treatment in America, put forward seven conditions that should be met in order for coerced treatment to be ethical: it requires the recipients’ consent; the recipient has a right to undergo due legal process; their drug problem is likely to benefit from the treatment; they pose a serious public health threat (e.g. HIV); the treatment should not be any more restricting than the alternative sentence would have been; the treatment is as least restrictive as possible, (e.g. community rather than inpatient based where possible); and the treatment is intensive and of high quality.

So, how do these conditions relate to DTTOs? Firstly considering consent, Bull (2005) stated that informed consent is a key element of good practice internationally in diverting people from imprisonment. Stevens, McSweeney, VanOoyen & Uchtenhagen (2005) pointed out that coerced treatment may involve a constrained choice but it is still an informed choice. Imprisonment has been justified by the offence and the option of no punishment or no loss of

freedom is not available. Instead Stevens et al., say coerced treatment can be seen as an opportunity to substitute one form of restriction of liberty for another less palatable one. Offenders can still turn down the offer of treatment and serve the custodial sentence if they choose. Again though, Stevens et al., (2005) suggested that in their experience ‘coerced’ drug users viewed it as a genuine choice with which they were presented. However, Seddon (2007) questioned whether drug users are ever in a fit position to be able to make an informed choice.

In the case of DTTOs the assessment procedure not only ensured that an offender was able to give informed consent, but also dealt with some of Gostin’s (1991) other requirements for ethical coercion into treatment. Offenders were not sentenced to a DTTO at their original hearing, instead the case was adjourned to allow time for an assessment by both the probation service and the treatment provider to assess an offender’s suitability for an order. This ensured that offenders underwent due legal process and that DTTOs were targeted at the most prolific offenders who may be susceptible to such treatment. This assessment also gave the offenders a chance to discuss the treatment and give informed consent, with time to consider their decision following assessment prior to returning to court for sentencing.

Tonry (2003) picked up on another of Gostin’s (1991) conditions and stated that in his view the main ethical concern was that the intrusiveness of a court mandated treatment should not exceed that of a conventional punishment. He considered that this also included the consequences of failing the treatment

which should be no more severe than the consequences for the original offence.

DTTOs were intended to be an alternative to a custodial sentence and the majority of DTTOs enabled the offender to stay in the community and receive treatment thereby offering less restriction than if they were in custody.

However, the sentence an offender received on a DTTO may have been longer than the alternative custodial sentence but the sentence length was still suitable for the offence committed.

The question of effectiveness of treatment in general has already been considered above. It is clear that drug treatment can reduce drug use and there is some evidence to suggest that treatment can reduce offending. Whether treatment in the criminal justice system, however, can achieve these aims is as yet unclear.

The merging of drug treatment agencies and the criminal justice system in England and Wales is likely to bring with it a clash of ideologies as each agency has its own set of working procedures, practices and ideologies. Wild (1999) summarises this succinctly. From the treatment providers' perspective, alcohol or other drug-using offenders are viewed as substance using clients whose confidentiality is to be respected. It is expected that clients will relapse and a therapeutic approach (rather than a punishment approach) is optimal (Hall, 1995). The criminal justice perspective on the other hand is that alcohol or drug using offenders are essentially criminals whose behaviour is to be scrutinised and monitored. Treatment is directed by the court and therefore any relapse can be interpreted as a breach of court orders and a punitive approach (rather

than therapeutic) is optimal (Hall, 1995). Prior to the start of DTTOs, commentators were concerned about how these two agencies would work together, specifically around the issue of information sharing (Barton, 1999a; 1999b; Barton & Quinn, 2002). Traditionally, treatment of drug users in the medical setting has brought with it a strict code of patient confidentiality, whereby what takes place between the therapist and client is confidential. But when treatment is provided as part of a court order with the court required to review the offenders' progress, this confidentiality may be breached. In examining the experiences of a predecessor to DTTOs, the FastTrack project operating in Plymouth (Barton, 1999a), where drug treatment was provided by the health service, the treatment provider was reluctant to share information about treatment progress, specifically drug test results. The treatment provider had three concerns: the criminal justice agencies' ability to interpret clinical data; the willingness or otherwise of criminal justice agencies to operate with flexibility; and the ethical duty of health workers to protect client confidentiality (Barton, 1999b). The Crime and Disorder Act (Home Office, 1998a) pre-empted this problem, stating that as part of DTTOs, the courts are privy to health based information thus breaking the traditional bond of confidentiality. In considering the possible clash of cultures Kothari et al., (2002) suggested that all staff in the criminal justice system need to be educated on the methods of rehabilitation of drug using offenders even though they may not be in line with the strict and punitive methods normally used within the probation service.

Another concern raised by commentators on the introduction of coerced treatment was the effect that coercing clients into treatment may have on the

services available to clients who wish to enter treatment voluntarily and do not need to be coerced into treatment. A DTTO predecessor, the FastTrack project in Plymouth, found that waiting lists increased for services available to non-criminal justice referred clients (Barton 1999a, 1999b). Clearly any system of coerced treatment needs to ensure that it does not displace needy people from the treatment queue by virtue of their lack of involvement in crime (Tonry, 2003).

DTTOs in practice

At the time of DTTOs being established evidence existed to suggest that drugs and crime were linked though how was still unclear (Hough, 1996). There was also strong evidence that voluntary drug treatment can reduce offending, though the evidence for the effectiveness of coerced drug treatment was still minimal. Based on this evidence DTTO pilots were established in three probation areas, Croydon, Gloucestershire and Liverpool and were evaluated by Turnbull, McSweeney, Webster, Edmunds, and Hough (2000). The preliminary findings suggested that spending on drugs was reducing as were levels of drug use (Turnbull, 1999). Based on these findings DTTOs were rolled out nationally though the full evaluation report was not published for another three months. Nevertheless, as a new initiative in the drug treatment and criminal justice fields a large number of evaluations were conducted to examine DTTOs.

The current thesis

This thesis is based on one such evaluation of one DTTO team based in one probation area. The evaluation included a number of different approaches and datasets and each of these has been written up as an individual study for the purposes of this thesis. Study 1 details the monitoring information collected during the evaluation period including number of orders commenced, offender demographics, and order outcomes. These data are considered in relation to the pilot studies and other evaluations. Study 2 is based on interviews conducted with offenders at various stages on the order attempting to get their views of the orders. Study 3 is based on interviews conducted with staff working on the DTTOs and staff from other agencies expected to work closely with or be affected by the work of the DTTO team. Study 4 considers the drug test results of offenders on the order examining the outcomes of the order in terms of changes in drug use. Study 5 combines the drug testing results with reconviction rates for a sample of offenders on the order to assess how well DTTOs achieved their aims of reducing offending and drug use. In the final discussion chapter the results from all of these studies are brought together with more of the recent literature on issues surrounding drug treatment in the criminal justice system in England and Wales.

Chapter 2

Study 1 - DTTO Monitoring and Outcomes Data

Introduction

DTTOs were piloted in three areas prior to national roll out (Croydon, Gloucestershire and Liverpool), and were evaluated by Turnbull, McSweeney, Webster, Edmunds and Hough, (2000). The evaluation used a range of methods: analysing monitoring data collected by the DTTO teams; conducting interviews and focus groups with staff delivering the DTTOs; interviews with key professional groups; and interviews with offenders on a DTTO. The pilots suffered from low take up rates which, given the short timescale of the evaluation, meant that the number of offenders included in the evaluation was small.

The three pilot areas were of different sizes and their DTTOs functioned very differently. For example, two sites chose to make all DTTOs alongside a probation order while the other tried to get a stand alone DTTO and all outstanding probation requirements revoked. One site had a strong focus on abstinence with 49% of offenders on an order in this area going into residential rehabilitation, while in another site only 11% of clients went into residential rehab or received a reducing methadone prescription, with the focus instead being on harm reduction.

There was no control group in the pilots but instead offenders on DTTOs were compared to drug using offenders on similar schemes that had been

established in their individual localities such as the Plymouth and Torbay Fast Track Scheme; Partnership Action on Substance Misuse, Crime and Offending (PASCO) in Chester and Warrington; the West Yorkshire drug court and STEP programme, and the Hasting Multi-Agency Drug Treatment and Testing Programme. These schemes varied and were only running in specific localities so do not allow a comparison to ‘treatment as usual’ for the wider drug using offending population.

Across the pilot sites, 210 drug using offenders were sentenced to a DTTO during the evaluation. Seventy-four percent were male, they had a mean age of 28 years, and the majority were of white ethnic origin. Treatment varied between the sites as did drug testing frequency which ranged from three tests per week throughout the order to three to four tests in the first month of an order reducing to two to three a month following that. In total 46% of orders (96 offenders) were revoked across the three sites though this ranged across the sites from 28% to 60%. The mean length of time served on the order was four months (with a range from 0-11 months), again with variation across the three sites.

Based on self-reports from offenders on the orders, their weekly spend on drugs fell from £400 per week in the month before starting the order to just £25 within six weeks of starting an order. Significantly, there was a move away from poly-drug use amongst those offenders. The authors of the pilot evaluation concluded that the DTTO approach was “viable” and that “drug dependent

offenders can be successfully coerced into treatment" (Turnbull et al., 2000, p. 87).

Scotland also piloted DTTOs in 1999-2000. The evaluation by Eley, Gallop, McIvor, Morgan, and Yates (2002) found that DTTOs had become well established in the pilot areas and DTTOs were having a positive impact on drug use and offending. National roll out of DTTOs in Scotland began in September 2001.

Guidance on the establishment of DTTOs was limited and hence, as in the pilots, DTTO teams took a number of forms (National Audit Office, 2004). Some areas chose to contract out all drug treatment aspects of orders to drug treatment services while others preferred to keep all drug treatment and criminal justice aspects of the orders together within probation. Her Majesty's Inspectorate of Probation (HMiP) report – '*A long way in a short time*' (2003) describes the national implementation problems.

As DTTOs rolled out nationally local evaluations were conducted examining different aspects of DTTOs. Some evaluations took a purely quantitative approach to evaluation (e.g. Wiggans, & Libby, 2002), others took a purely qualitative approach (e.g. Ricketts, Bliss, Murphy, & Booker, 2002 and Barker, Horrocks, Kelly, & Robinson, 2002). While still others used a combination of approaches. For example Best, Mann, Morrison-Rees, Witton, and Strang (2002) conducted an evaluation across 12 DTTO teams in London observing DTTO practice, interviewing DTTO staff, gathering data on DTTO outcomes,

using the Maudsley Addiction Profile (MAP), and conducting interviews with court staff. Best et al. found that DTTOs were having a positive effect on reducing drug use and offending behaviour; longer periods of retention were associated with more substantial and enduring treatment effects in relation to drug use, crime, health and injecting behaviours; and teams with stricter prescribing policies had clients who made the greatest reductions in drug use and crime. The Department of Health and Human Sciences at the University of Essex (2002) also conducted a mixed quantitative and qualitative study and concluded that their findings showed DTTOs “beginning to make a real difference to a small but significant number of offenders lives” (p. 58), though the evaluation was based on a limited dataset with only 22 case files surveyed and 46 interviews with offenders.

One of the recommendations made by Turnbull et al. (2000) was that as DTTOs were rolled out nationally, all areas should consider some form of evaluation and monitoring. One such evaluation forms the basis of the current thesis. Following along the lines of Turnbull et al. (2000), the evaluation firstly considered basic monitoring information of the DTTO process. The initial aims were to:

- Examine assessment, referral and take up rates for DTTOs between April 2001 and April 2004.
- Ascertain to what extent DTTOs cater for a new group of drug misusers who would not previously have been in contact with treatment services.
- Examine breach, completion and revocation rates of offenders sentenced to a DTTO between April 2001 and March 2004.

The Study Team

The study probation area established a specialist DTTO team in October 2000 comprising a combination of three Probation Officers (POs), three Probation Service Officers (PSOs), two additional case managers (nurses with experience of drug treatment in the NHS) and a GP for two sessions a week. Rather than work jointly with a drug treatment service, the team aimed to provide all drug treatment and interventions within the probation service in collaboration with other agencies such as the Crime & Disorder Partners, and other community provisions (e.g. local education services, Colleges). As the funding for DTTOs increased so did the staff team to include two further PSOs, an additional sessional GP, a psychotherapist for 3 hours a week and a seconded police officer. High staff turnover meant that during the evaluation, the nurse case managers were replaced with POs. Thus the study team at the end of the current evaluation comprised five POs, five PSOs, two sessional GPs and one police officer, and a psychotherapist for three hours a week. Only the psychotherapist was trained in psychosocial interventions and the majority of staff had minimal specialist training in drug treatment.

As DTTOs were a new initiative, the model of treatment changed throughout the evaluation. Initially, all offenders coming onto a DTTO were allocated a case manager who was either a Probation Officer (PO) or a drug treatment nurse. The case manager was supported by one or two Probation Service Officers (PSOs) the latter of whom would do day to day work with offenders such as conducting drug tests, arranging appointments etc.. The case manager planned

and co-ordinated the treatment, interventions and activities and conducted one-to-one sessions. Later the study DTTO team moved towards a multiple team model with teams consisting of a case manager (PO or nurse) and a supporting PSO. Each team used a keyworker approach where a key worker could be a PO, nurse or PSO (in low complexity cases of under PO supervision). This team model ensured the close supervision of PSOs and enabled teams to specialise. For example, one team included a seconded police officer enabling them to focus on more prolific offenders, another team included a nurse with mental health experience who specialised in offenders with comorbid substance abuse and mental health problems.

DTTO Assessments

Assessments were conducted by the DTTO team and covered four key areas – type and seriousness of index offences, seriousness of drug problem, offender's motivation to change and whether offending appeared to be drug related. More specifically, local targeting criteria stated that there should be a high level of drug dependency with at least daily use of either heroin, crack and/or cocaine over the last three years. The current offence needed to be drug related as would be determined at the PSR writing stage and needed to be serious enough for the offender to be at risk of receiving a custodial sentence and the offender needed a drug related offending history of at least three years. Offenders with a history of violent offences or drug dealing offences were excluded. Also, the offender needed to have demonstrated motivation to address their drug use by having approached a substance misuse agency

regarding maintenance prescribing or detoxification in the last two years. There was no exclusion of offenders with a dual diagnosis.

One-to-one sessions with case managers or key workers

One-to-one sessions were monitored and occurred approximately once a week, scheduled to last for around an hour. As in all drug treatment it was essential for case managers/keyworkers to develop a therapeutic alliance with the offenders. Though, in contrast to other drug treatment services, key workers were required to oversee the enforcement aspects of a court order as well as the treatment aspects. Practical aspects of the orders included: discussing attendance (acceptable and non acceptable absences), upcoming court hearings (review or breach court), completing court review reports and PSRs for further offences as necessary.

The training and skills of the case managers varied greatly. While some case managers were probation officers, others were mental health nurses with experience of drug use treatment. With this in mind, one-to-one sessions would have varied depending on the training and experience of the case manager.

The interventions provided in one-to-one sessions would have included developing a care plan with offenders on an order, providing substance misuse related advice and information, harm reduction advice and 'other structured treatments' (as defined by Models of Care update, 2006).

While staff undertook an introductory Motivational Interviewing course and various other short therapy courses, whether they chose to apply and use what

they learnt in these courses in their sessions was not evaluated. Probation staff had no additional psychosocial training above that included in their probation degree in order to enable them to deliver drug treatment.

One-to-one sessions with PSOs

All Probation Service Officers (PSOs) joined the team without any experience or training in drug misuse. While PSOs mainly assisted in delivery of the group work, physical activities and review courts, they also had one-to-one sessions with offenders and, under the team working model could act as key workers. One-to-one sessions with PSOs may again have covered enforcement aspects of the orders e.g. drug test results, attendance and upcoming court appearances. More experienced PSOs also carried out specific pieces of work with offenders over a 4-6 week period looking at problem solving skills or anger management. This was largely based on the Priestley One-To-One programme, a manualised 20 session intervention developed by Philip Priestley in 1993, however, PSO staff reported that they chose not to deliver all 20 sessions and instead delivered those considered relevant to each individual offender.

Counselling

A psychotherapist attached to the team for three hours a week was able to deliver counselling for individuals wishing to address abuse, bereavement, depression or self-harm where the keyworker felt unable to address these issues. However, due to the fact the psychotherapist was only available for three hours a week few offenders were able to make use of this.

Medical treatment

Two GP's with a special interest in substance misuse were available on a part-time basis to address offenders' drug misuse related problems. Prescribing practice included stabilisation on substitute opioids, maintenance prescribing, prescribing for withdrawal from opioids (community detoxification) and prescribing to prevent relapse. Offenders were referred back to their own GP for general health concerns. While initially treatment was largely abstinence oriented with doctors providing a minimal reducing script of methadone with the aim of abstinence, by the second year of the DTTO programme, the approach had changed largely to methadone maintenance prescriptions in line with a goal of harm minimisation.

Alternative therapies

Two alternative therapies were offered by the DTTO team: acupuncture and yoga. Acupuncture was delivered in a group setting by trained DTTO staff. Yoga was delivered by a yoga specialist. There was a focus on the practical application of yoga skills e.g. to aid anxiety management, sleep and relaxation.

Accredited programmes

Offenders who had not already done so were required to attend Enhanced Thinking Skills (ETS – Clarke, 2000) and Think again (the ETS follow up). ETS is a 20 session CBT based programmed designed to address offence related attitudes and thinking, aiming to reduce reconvictions. The programme covered

training in impulse control, flexible thinking, general and oral reasoning, taking the viewpoint of others and interpersonal problem solving.

A drug misuse accredited programme was available in the study probation area – Addressing Substance Related Offending (ASRO), however due to the strict nature of the programme it was considered inappropriate for offenders on a DTTO hence offenders were not required to attend¹. At the end of the evaluation the Offender Substance Abuse Programme (OSAP) was introduced and all offenders on a DTTO were required to attend this although none of the offenders included in the evaluation would have had the opportunity to attend this before the end of their order.

Group work

The group work and physical activities programmes varied over the duration of the current evaluation. Initially group work was slow to get up and running as it had been hoped that an external agency would provide this, but they were unable to due to staff shortages. Following this, the DTTO team decided to do the majority of the group work provision in-house with minimal support from an external agency.

¹ On the ASRO programme offenders were required to attend a total of 20 sessions held over 10 weeks. If an offender missed a session they were required to make it up prior to the next session. Should an offender miss two sessions they were likely to be removed from the programme. Additionally, the local team delivering the ASRO programme would not let offenders enter the session if they were more than ten minutes late for the session. Given the chaotic nature of offenders on a DTTO it was felt that they would have struggled to attend on time and complete all of the required 20 sessions.

The group work programmed aimed to:

- Address the internal and external triggers which caused offenders to use drugs;
- Promote a healthy and crime free lifestyle and a sense of responsibility and citizenship within society; and
- Recognise diversity and individuality.

Rather than taking an evidenced programme and instituting it wholesale, the study team chose to develop their own modules, drawing on available self-help and programme manuals in order to tailor the sessions to the specific needs of drug misusing offenders on a DTTO. The group work included two programmes, one was lifestyle based and the other focused on issues of Psychology and Health as detailed below.

The lifestyle based programme lasted 8 weeks and included 3 modules:

- individual living skills - covered budgeting, house hold maintenance, debt management and using public transport;
- local citizenship - covered local services available to offenders including citizens advice, libraries, leisure facilities and housing advice including practical activities of going and registering with these services;
- international citizenship - aimed to provide offenders with knowledge and understanding about becoming informed citizens including information on their rights and responsibilities as a citizen, the work of parliament, government and the courts, and ethnic identities in the UK.

These modules aimed to increase individuals' ability to function in society and to feel part of a community. The lifestyle programme was 'closed' meaning that new clients were only able to join the group on Week 1 which came around every eight weeks.

The Psychology and Health programme included modules on:

- emotional health management (4 sessions) – looking at emotional states, the effects of substance use on emotional states and coping skills;
- sleep (3 sessions) – covering sleep hygiene, relaxation techniques, self hypnosis and the use of sleeping tablets;
- cravings (4 sessions) – covering what cravings are, Prochaska and DiClemente's stages of changes (DiClemente & Prochaska, 1998), triggers, using visualisation techniques, developing strategies for dealing with cravings;
- assertiveness and refusal skills (2 sessions) – covering assessing drug availability, handling drug dealers, refusal skills, passive, aggressive and assertive responding;
- coping with depression (3 sessions);
- living with Hepatitis (1 session) delivered by a HCV specialist.

Each of the modules on the Psychology and Health programme was closed but offenders could join the programme at the start of any module.

In addition to the two group programmes, an 8 week long women's group also ran to address issues specific to female drug users. The emphasis of all of the group work was on addressing underlying causes of offenders' drug use and

changing peoples' outlook rather than simply talking about offenders' drug use and drug using lifestyle.

Physical activities

A range of physical activities were available to offenders on the orders. Initially all offenders were required to attend all physical activities, but as the range of activities was developed, offenders were given a choice. DTTO staff chose to use leisure facilities available in the local area to make it possible for offenders to keep using these resources following the end of their orders. It was hoped that these activities would encourage the development of new interests.

Activities included attendance at a local gym, swimming, playing football, golf and badminton.

Drug testing

Offenders were required to be tested for drugs a minimum of twice a week. Tests were by urinalysis for the first 26 months of the evaluation, followed by saliva swab testing for the remainder of the evaluation. Due to a lack of qualified staff (nurses) it was not possible to observe urine tests so tests were changed from urine to saliva testing to enable observation of testing. Tests were conducted on site by POs, nurses or PSOs normally following or preceding attendance at another appointment or group session. Appointments for drug tests tended to be planned in advance and were written on an offenders appointment card for the week. Offenders admitting to using illicit drugs in the two days prior to testing could sign a waiver to this effect. There were no consequences to offenders admitting drug use in this way.

Attendance requirements

Following National Standards (Home Office, 2001) at the beginning of the order, participants were to attend five times a week for a minimum of 15 hours. All of the above treatments and activities counted towards this contact time. A minimum of two urine tests per week were also required. Case managers or key workers determined offenders' activities for the week in advance in line with their care plan, and posted out an appointment card at the end of every week for the following week's activities.

Court reviews

Court reviews, a new initiative on DTTOs, occurred monthly following a detailed report by the case manager or key worker on progress, motivation, and compliance with the order. DTTO reviews held in magistrates court went before a bench of specialist magistrates who had received training from the DTTO team on the nature of drug misusing offenders and the aims of DTTOs. DTTO reviews in crown court went before whichever judge was scheduled for that session.

Methodology

Participants

The participants comprised all 331 offenders sentenced to a DTTO between April 2001 and March 2004. Descriptive statistics for the sample are shown in

Table 1 below. Offenders consented to being included in the quantitative elements of the research as part of consenting to a DTTO².

Table 1: Descriptive statistics for whole DTTO sample

Variable	Values	N	Percent of sample
Age at assessment (in years)	mean = 26.7, SD = 5.9		
Gender	Male	280	85%
	Female	51	15%
Ethnic Group	White	303	92%
	Other	28	8%
Trigger Offence	Theft	170	51%
	Other	161	49%
Employment	Unemployed	244	74%
	Other	87	26%
Sentencing Court	Magistrates	214	65%
	Crown	111	34%
	Unknown	7	2%
Residence at time of sentence	In Custody	153	46%
	Community	157	47%
	Unknown	21	6%

Control Group

Part of the original study design was for there to be a comparison group made up of offenders assessed as suitable for a DTTO but refused an order due to limited DTTO funds (only 110 DTTOs were funded 2001/2002). However, low numbers of DTTO commencements in the early months of the orders, followed by increased DTTO funding (to 157 DTTOs in 2002/2003) resulted in all offenders fitting the criteria and consenting to a DTTO being accepted for an order, thus no Control group was available.

² Ethical considerations in relation to this are considered on page 58.

Measures

Data were collected via Pre-sentence reports, DTTO assessment reports, review court reports, and the Probation Service database computer system (CRAMs) on all 331 offenders. Included in the study were data monitoring at each stage of the DTTO:

- At assessment - total numbers of offenders assessed, demographic details, degree of dependence on drugs, seriousness of offence, volume of offending, reasons for unsuitability, Offenders Group Reconviction Scale (OGRS) Score³;
- where proposals and recommendations were made at Pre-Sentence Report (PSR) these were compared to outcomes at court, (i.e. concordance rates);
- at the time of DTTO commencements⁴ - time of first appointment, current offences, attendance requirements, length of DTTO, frequency of drug tests and drug test results;
- where DTTOs were breached - total numbers breached, reasons for breach, concordance rates at breach hearings (proposals to court outcomes), and outcomes of breach hearings;
- where further offences were committed - demographic details, recommendations to courts and outcomes in courts;
- when DTTOs were terminated⁵ - demographic details, reasons for termination of DTTO and disposal following termination of DTTO; and

³ OGRS scores are predictors of reoffending based on static risks – age, gender and criminal history (NOMS, 2008). OGRS scores were calculated at assessment by probation staff.

⁴ Commencement information relating to those offenders who started their DTTO between November 2000 – March 2001 were also recorded.

⁵ Data relating to offenders whose DTTOs expired between April – September 2004 were also recorded.

- when DTTOs expired - demographic details of those whose DTTOs were revoked for good progress, length of time served on a DTTO, and actual reconviction rates.

All data monitoring information were extracted by the researcher (the author of this thesis) from a number of sources:

- Pre-Sentence Reports,
- Police National Computer (PNC) system previous conviction lists,
- Offender Assessment System (OASys - an assessment tool used to assess the risk and needs of offenders),
- DTTO assessment reports,
- The Probation Service computer database (CRAMS),
- Review Court reports.

Data monitoring information and results of the offender interviews were reported to the DTTO Team and the National Probation Service (Leicestershire and Rutland) on a quarterly and/or annual basis.

Analysis

All data retrieved for evaluation purposes were anonymised by the researcher using codes to relate to individual offenders and entered into Excel by the researcher. Data were analysed using a combination of Excel and SPSS.

In reality, not all data was available on all offenders which limited the analysis. For example, previous offending history (based on PNC data) were available for

only a small proportion of offenders and hence have not been reported on here. However, study 5 uses data from the Offenders Index for a limited number of offenders on a DTTO and previous convictions are considered there.

Ethics

At the time of the study, probation staff were of the opinion that offenders did not have the right to refuse to participate in the quantitative elements of the research as a large proportion of the data collected made up the monthly returns the team were required to make to the Home Office. Prior to commencing the research, advice was sought on the project from the NHS Research Ethics Committee as the researcher undertaking the evaluation was employed by the NHS. The NHS research ethics committee felt that the project was beyond their remit as it did not involve NHS staff or patients as participants (see Appendix A for letter from Leicestershire Ethics Committee). At this time there was no procedure for seeking ethical approval from the Home Office so given the managers within probation had given Probation Service approval the study went ahead gaining without individuals consent. Therefore, by verbally consenting to be sentenced to a DTTO individuals were considered to have consented to take part in the quantitative elements of the evaluation. (For all qualitative elements of the study individuals participants consent was obtained).

Results

DTTO Referrals

Between April 2001 and March 2004 a total of 555 referrals were recorded as having been received for 496 offenders (Table 2). Fifty nine offenders were referred more than once in the three year period.

Table 2: Referrals to the DTTO Team April 2001-March 2004

	2001-2002	2002-2003	2003-2004	TOTAL
No. of referrals	172	168	215	555
No. of new offenders	166	148	177	491

DTTO assessments

Ninety three percent of referrals went on to be assessed by a DTTO case manager. The remaining 7% did not attend their assessment appointment. Over the three year collection period 517 assessments for a DTTO were conducted for the 555 referrals. Of those 517 assessments, 127 (25%) did not fit the criteria or were not considered suitable for a DTTO. The main reason for offenders being assessed as unsuitable for a DTTO was being identified as lacking in motivation to change (Table 3). Other main reasons included the level of an offender's drug problem and their susceptibility to treatment, and the volume of their offending and its relationship to their drug use.

Table 3: Number of assessments not meeting criteria

Reasons for unsuitability	TOTAL
Type and seriousness of index offence (e.g. nature of offence; offence not related to drug use)	9
Seriousness of drug problem and susceptibility to treatment (e.g. not long drug using career; drug free/low level of drug use; already receiving drug treatment; not suitable for group work)	29
Motivation to change (e.g. previous lack of compliance with community orders; lack of commitment and motivation or doubts about ability to comply; did not consent to a DTTO)	33
Volume of drug related offending (e.g. short offending history; not acquisitive offending)	26
Other	
Homeless	8
Lack of previous contact with treatment agencies	4
Currently in treatment	4
Other	6
Not recorded	8
TOTALS	127

There were no significant differences in terms of age (independent t-test, $t(488)=0.767$, $p=0.444$ (2-tailed)), gender (χ^2 (1, $n=455$)= 2.797 , $p=0.094$, phi= -0.87) and ethnicity (χ^2 (1, $n=490$)= 0.032 , $p=.857$, phi= 0.015) for those assessed as suitable compared to those assessed as non-suitable for a DTTO (Table 4).

Table 4: Gender, age and ethnicity of offenders assessed as suitable and not suitable for a DTTO

	Assessed suitable	Assessed not suitable
No. assessed as suitable	388	127
Average age	27.1	26.6
Age range	17-49	17-53
Ethnicity		
White	315	100
Asian	5	2
Black	11	11
Mixed	8	2
Other	1	0
Gender		
Male	311	108
Female	54	17

There was a significant difference in OGRS scores between the two groups with those assessed as not suitable having a higher OGRS score (mean = 73.67, SE=1.10) than those who were assessed as suitable for a DTTO (mean =68.58, SE=2.10, t (410)= 2.253 , $P<0.05$). The magnitude of differences in the means was very small (mean difference = 5.08, 95% CI: 0.65-9.52, eta squared = 0.01).

In all 73% of assessments ($n=377$) conducted resulted in a proposal to the court for a DTTO. The courts largely followed recommendations made by the DTTO

team with 83% of those recommended for a DTTO (n=312) being sentenced to one.

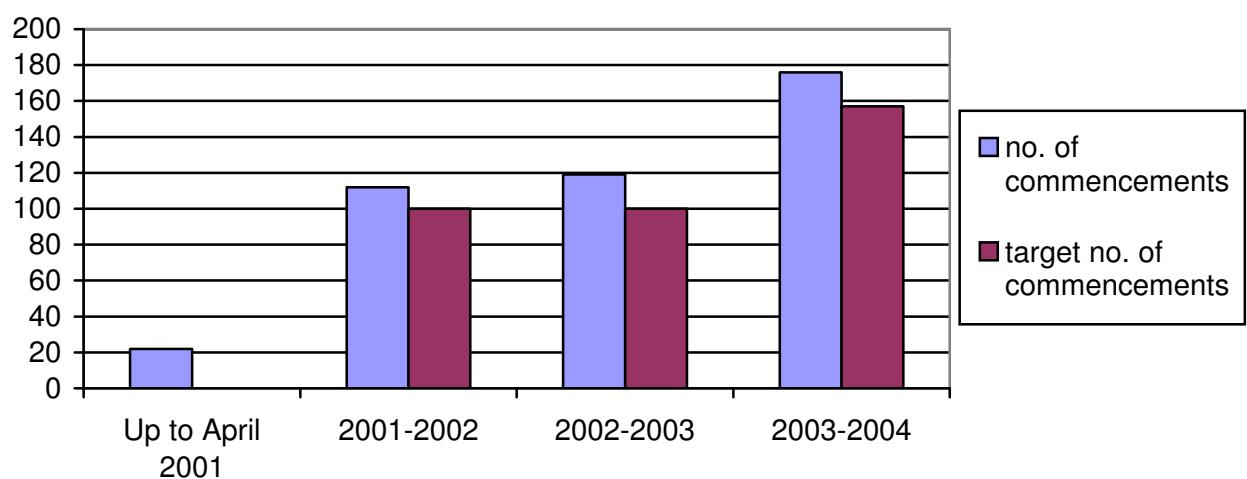
The majority of those who were recommended for a DTTO but not sentenced to one instead received a custodial sentence. It was not possible to determine why the courts chose not follow the recommendation contained in the PSR so it was unclear whether these would make a suitable control group.

DTTO Commencements

A total of 429 DTTOs were commenced from November 2000 to March 2004 relating to 331 offenders⁶. The commencement rate was consistently above the targeted commencement rate of 100 in 2001 to 2003 and 157 in 2003 to 2004, as set by the Home Office (Figure 1). The average length of DTTO commenced was 14.6 months, although this did reduce over the evaluation period from a mean of 21.0 months prior to April 2001 to 13.7 months by 2003-2004.

⁶ Offenders could be sentenced to more than one DTTO.

Figure 1 - DTTO commencements



Eighty-five percent of offenders sentenced to a DTTO were male and 92% were of white ethnic origin. The average age was 26.6 years for men, 26.8 for women.

Table 5: Gender, age and ethnicity of offenders commencing a DTTO

	Males	Females
No. commencing	280	51
Average age (years)	26.6	26.8
Age range	17 – 53	17 – 49
Ethnicity		
White	255	48
Asian	4	0
Black	10	2
Mixed	5	0
Other	2	0
Unknown	4	1

While the majority of offenders (65%) were sentenced to a DTTO by a magistrates court rather than crown court (34%) a large proportion of offenders started their order from custody (46%).

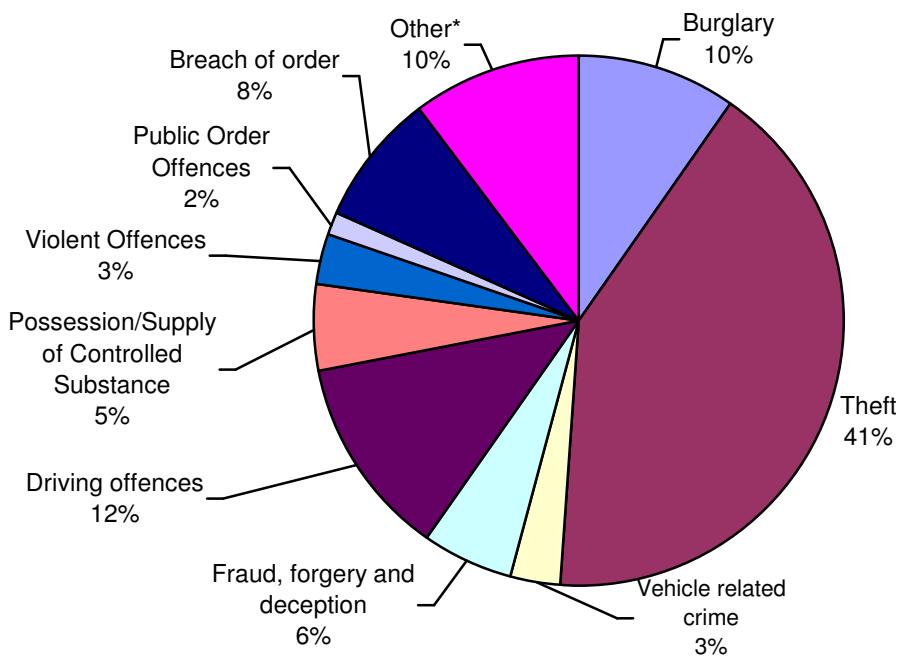
Table 6: Sentencing court and residence at time of sentence

Variable	N	Percent of sample
Sentencing Court		
Magistrates	214	65%
Crown	111	34%
Unknown	7	2%
Residence at time of sentence		
In Custody	153	46%
Community	157	47%
Unknown	21	6%

Offences

The 331 offenders who received a DTTO were convicted of a total of 1244 offences between them at the court hearings that resulted in them receiving a DTTO (including hearings where offenders received a concurrent or consecutive DTTO). There was an average of 3.0 offences per order with a range from 1 to 14 offences per order. A breakdown of the types of offences committed is given in figure 2. The main offences committed were thefts at 41%. In total 60% of the offences were acquisitive in nature e.g. burglary, theft, vehicle theft and Taking Without Owner's Consent (TWOC), fraud, forgery and deception and robbery⁷.

Figure 2: All offences heard at hearings resulting in a DTTO (N=1244)



⁷ Robbery was included in 'other offences'

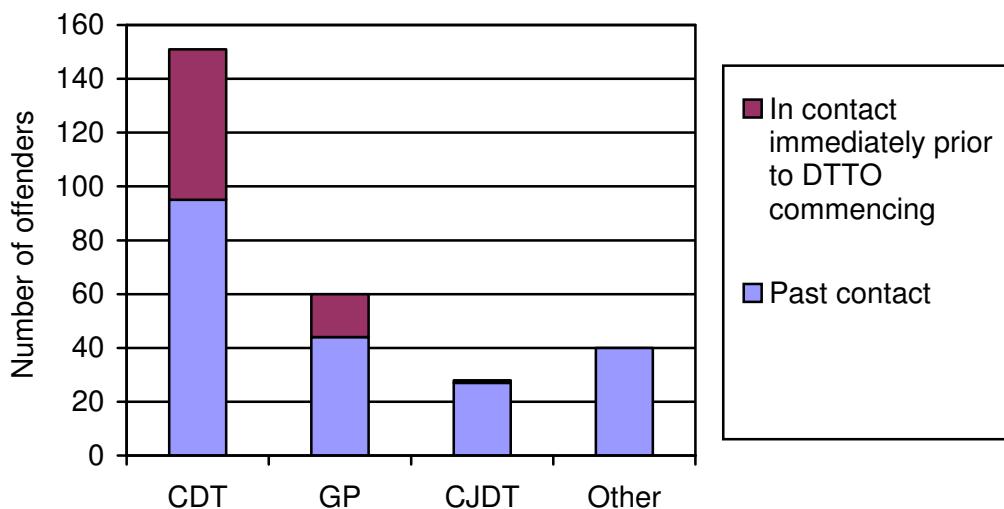
Previous contact with drug treatment agencies

When DTTOs were established it was thought that bringing drug treatment into the Criminal Justice Service (hence making treatment compulsory to some problematic drug users) would bring drug users who had previously chosen not to access drug treatment into contact with treatment services (Hayes, 2002). It was expected, therefore, that DTTOs would be accessing an entirely new group of drug users who had previously not received treatment for their drug use. When offenders' suitability for a DTTO was assessed by the study team, offenders were asked if they had received any previous drug treatment. This information was available for 283 offenders who commenced a DTTO between November 2000 and March 2004. However, only 44 of those offenders (16%) stated that they had not had any contact with drug treatment services prior to their DTTO in contrast to expectations (Hayes, 2002).

Offenders reported contact with a number of different agencies prior to commencing their DTTO, with many offenders reporting contact with more than one agency in the past. These agencies are shown in Figure 3. In total, 151 offenders (43% of all DTTOs commenced in this time period) reported that they had previously had contact with the local NHS Community Drug Team (CDT), 36 of whom (13%) were receiving treatment from that team immediately prior to receiving their DTTO, with an additional 20 offenders (7%) on the CDT waiting list immediately prior to commencing their DTTO. Additionally, 60 offenders reported having received treatment from their GP for their drug-use, 16 of whom were receiving treatment immediately prior to their DTTO commencing. Twenty-eight offenders had received treatment from the local Criminal Justice

Drug Team whilst on a Community Rehabilitation Order (CRO) or following release from custody. Forty offenders reported having received treatment from other agencies including: Addaction; the local Drug Advice Centre (DAC), the Burglary Reduction Initiative (BRIL), the CARATs team whilst in custody; residential rehabilitation; private detoxification treatment; inpatient detoxification or CDTs in other parts of the country.

Figure 3: Offenders' previous contact with services for drug treatment (n=283)



In total only 16% of offenders for whom data were available had not previously been in contact with drug treatment services, 18% of offenders were in contact with the local CDT or their GP, and a further 7% were on the local CDT waiting list immediately prior to being sentenced to a DTTO.

Breach of a DTTO

If an offender breached the requirements of a DTTO, they would be returned to the sentencing court. Between April 2001 and March 2004, 244 offenders between them breached their orders 389 times. This is 74% of offenders on a

DTTO during this time period. Thus, only 26% of offenders did not breach their DTTO⁸.

Table 7 presents the demographics of offenders who breached their DTTO at least once during the duration of the order. Offenders who breached their DTTO were significantly younger at the start of their DTTO ($M=25.99$, $SD=5.38$) than offenders who did not breach, $M=28.47$, $SD=7.04$, $t(124)=2.99$, $p=0.03$, (two tailed). There were no significant differences in ethnicity or gender between those who did and did not breach their DTTO. Multiple regression (including the variables of gender, ethnicity, first months drug test results, sentencing court, community or custody, trigger offence, no of offences committed for sentence and city or county residence) showed no significant predictors of number of days to first breach.

Table 7: Offenders breaching their DTTO

	Breached DTTO (n=244)	Did not breach DTTO (n=87)	Full sample (N=331)
Average age at DTTO commencement (in years)	25.99	28.47	26.63
Gender			
Male	206 (84%)	74 (85%)	280 (84%)
Female	38 (16%)	13 (15%)	51 (15%)
Ethnicity			
White	225 (92%)	78 (90%)	303 (92%)
Non-white	17 (7%)	6 (7%)	23 (7%)
Unknown	2 (1%)	3 (3%)	5 (2%)

⁸ A DTTO could be revoked without the offenders having committed a breach, so the remaining 26% of offenders did not necessarily go on to complete their DTTO successfully.

The main reasons for breaching a DTTO (Table 8) was for failing to attend two or more appointments without acceptable explanation, which accounted for 99% of all breaches, although 6% of those were also breached for ‘other’ reasons such as unacceptable behaviour, refusal to see a GP, giving the office an incorrect contact address, being verbally abusive to staff or failing to inform the office of a significant change in circumstances.

Table 8: Reason for breach

	No. of breaches
Failed to attend appointment/court review	361 (93%)
Failed to notify office of change of address	2 (<1%)
Withdrawn consent	1 (<1%)
Long term sick note	3 (<1%)
Failed to attend appointment and fail to notify office of change in address	15 (4%)
Failed to attend appointment and other reason	7 (2%)
TOTAL	389

The outcomes of breaches varied (Table 9). Only 18% of breaches resulted in the DTTO being revoked outright, with a further 28% of breaches going on to be heard with further offences committed since starting a DTTO. For 42% of breaches the offender was allowed to continue their DTTO with or without penalties, and a further 4% of breaches resulted in the offender being sentenced to a consecutive or concurrent DTTO.

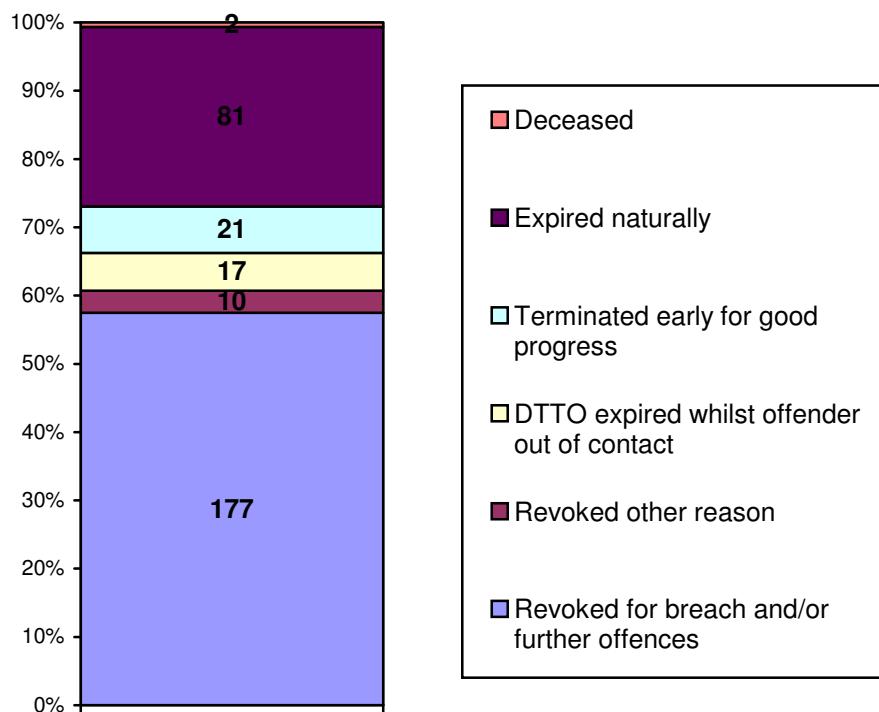
Table 9: Outcome of breach in court

	TOTAL	%
Outstanding	4	1%
Adjourned to test commitment	21	5%
Order to continue without penalties	128	33%
Order to continue with penalties	34	9%
New DTTO	14	4%
DTTO Revoked and offender resentenced	69	18%
Heard with other offences	110	28%
Other	7	2%
Not recorded	2	1%
TOTAL	389	

Order Outcomes

Of the 429 DTTOs commenced, 308 should have expired naturally by the 30th September 2004. Figure 4 shows the outcomes for these orders: 33% of the orders expired naturally or the order was terminated early for good progress; 57% of the orders were revoked for further offences and or breach; 6% of the orders expired whilst the offender was out of contact with the team; 3% were revoked for other reasons; and for less than 1% the offender was deceased.

Figure 4: Outcome of DTTOs due to expire on or before the 30th September 2004 (n=308)



These 308 orders related to 248 offenders (some offenders had more than one order due to expire in that time period). Table 10 shows the disposal of the 248 offenders following the end of their DTTO. Noticeably, for 33% of offenders their DTTO either expired naturally or the DTTO was terminated early for good progress. For 8% of offenders their DTTO was revoked and they received a lesser sentence. Forty-six percent of the offenders had their DTTO revoked and received a custodial sentence.

Table 10: Outcomes for individual offenders for DTTOs due to complete on or before 30th September 2004

	No. offenders *	% of offenders
Order expired	63	25%
Order expired whilst offender out of contact	16	6%
Order terminated early for good progress	18	7%
Order terminated on medical grounds	3	1%
Order revoked with alternative disposal:		
offender received a curfew order	3	1%
offender received conditional discharge	4	2%
offender received a fine	2	1%
offender received a CRO	11	4%
offender received a further DTTO	5	2%
offender received a period of custody	114	46%
DTTO extended	1	<1%
Offender deceased	2	1%
Transferred to another Probation Area	3	1%
Other	3	1%
TOTAL	248	

*Where offenders have had more than one DTTO, only the DTTO with the most recent end date is included in these figures.

There were significant differences in age for those whose DTTO expired or was terminated early for good progress ($M=27.99$, $SD=6.40$) and those whose DTTO was revoked ($M=25.17$, $SD=5.14$, $t(238)=3.565$, $p=<0.001$ (two tailed)).

Offenders whose DTTOs expired or was terminated early for good progress tended to be older than those whose DTTO was revoked. No other statistically significant differences were found. (Gender, χ^2 (1, n=237)=1.794, p=0.180; Ethnicity, χ^2 with Yates continuity correction (1, n=235)= 0.211, p=0.646).

Table 11: Offender demographics for main DTTO outcomes

	DTTO expired or terminated early for good progress (n=69)	DTTO revoked (n=169)	
Average age at start of DTTO	28.0	25.2	
Gender			
Male	54 (78%)	145 (86%)	
Female	15 (22%)	24 (14%)	
Ethnicity			
White	64 (93%)	157 (93%)	
Not White	3 (4%)	12 (7%)	
Unknown	2 (3%)	0 (0%)	

Revocations

Two hundred and one (47%) of the DTTOs commenced between November 2000 and April 2004 were revoked between April 2001 and September 2004. These 201 DTTOs related to 169 offenders as a number of offenders had concurrent or consecutive DTTOs also revoked⁹. The main reason for a DTTO being revoked was due to the offender having breached their DTTO and/or having committed further offences (99%). The 'other' category included

⁹ This figure is higher than the numbers revoked as shown in Table 10 as this section relates to all offenders who had an orders revoked between April 2001 and September 2004 whilst Table 10 relates only to offenders whose orders were due to complete on or before 30th September 2004.

DTTOs that were revoked in the interests of justice due to the offender having a long-term sick note and the DTTO being considered unworkable (1%).

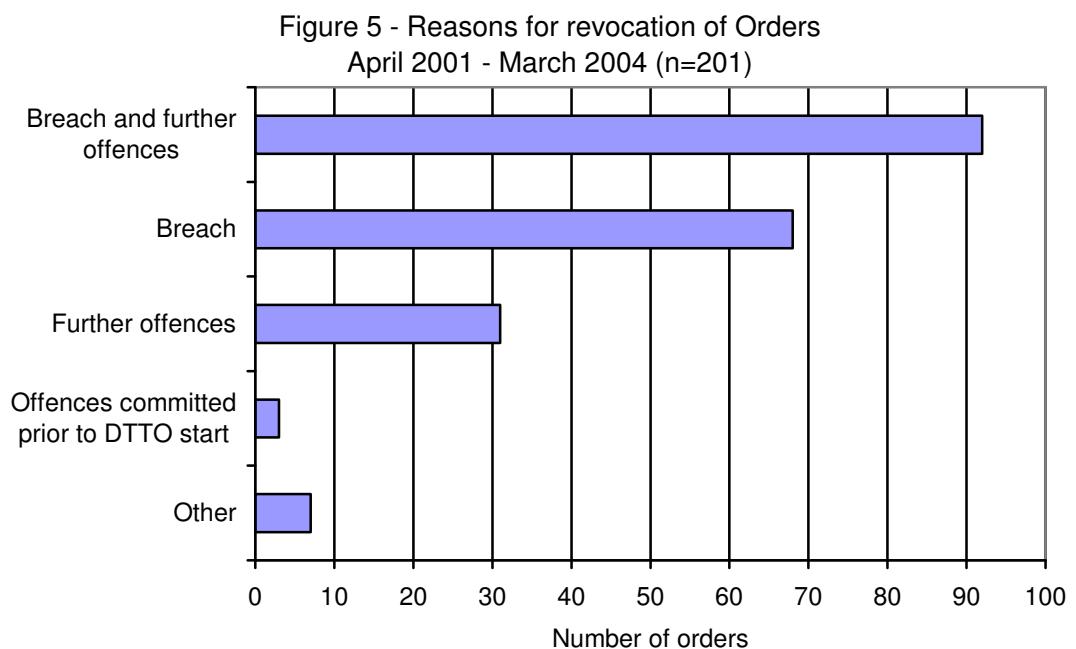


Table 12 below shows the disposal following revocation of a DTTO by reason for revocation. Noticeably the main disposal was custody with 30% of offenders getting a custodial sentence of less than six months and 36% getting a longer custodial sentence. Eighteen percent of offenders were sentenced to another DTTO and ten percent of offenders were resentenced to a sentence lesser than a DTTO (e.g. CRO, curfew order, fine). A further five percent of offenders received a conditional discharge, suspended sentence or no further action was taken while the remaining one percent of offenders received a hospital order, deferred sentence or were recalled to custody.

Table 12: Disposal of DTTOs April 2001 – March 2004*

	Breach	Further offences	Breach and further offences	Other	TOTAL
Custody 0-6 months	26 (38%)	7 (23%)	28 (29%)	0	61 (30%)
Custody longer than 6 months	18 (26%)	12 (39%)	42 (44%)	1 (14%)	73 (36%)
New DTTO	6 (9%)	10 (32%)	20 (21%)	0	36 (18%)
CRO	7 (10%)	2 (6%)	4 (4%)	1 (14%)	14 (7%)
Curfew Order	2 (3%)	0	1 (1%)	0	3 (1%)
Fine	2 (3%)	0	0	0	2 (2%)
Other*	7 (10%)	0	0	5 (71%)	12 (6%)
TOTAL	68	31	95	7	201

* The other category includes conditional discharge, no further action taken, hospital order, recall to custody or suspended/deferred sentence.

Discussion

This evaluation aimed to examine assessment, referral, commencement, breach, completion and revocation rates between April 2001 and April 2004. Further, the study aimed to ascertain to what extent DTTOs catered for a new group of drug misusing offenders. The data show that referral and assessment rates for DTTOs were high with 331 offenders being sentenced to a total of 429 DTTOs in the evaluation period. These 429 sentences related to 1244 offences, 60% of which were acquisitive in nature. A large proportion of offenders (84% of those 283 offenders for whom data were available) had previously been in treatment, with 18% having been in treatment elsewhere immediately prior to sentencing.

Breach rates on DTTOs were high with 74% of offenders on an order during the evaluation breaching their order at least once. Thirty-three percent of orders due to end within the evaluation period expired naturally or the order was terminated early for good progress. Fifty-seven percent of orders were revoked for further offences or breach with 46% of orders resulting in the offender being resentenced to a custodial sentence. Offenders whose order expired naturally or was terminated early for good progress were significantly older at the start of their order than offenders whose order was revoked. There is no evidence in drug treatment effectiveness literature to suggest that older drug users do better in non-criminal justice drug treatment, however, it could be that they are maturing out of their drug use (Winnick, 1962). Perhaps these older offenders have more costs associated with their drug use. With a longer drug using history, older drug users may be suffering more physical consequences of their drug use and therefore be more motivated to address it. It has however been

found that older offenders are more likely to complete offending behaviour programmes such as Addressing Substance Related Offending (ASRO, Palmer, Hatcher, McGuire, Bilby, Ayres & Hollin, 2011). It could be that the treatments and interventions on offer, particularly the group work and physical activities within the criminal justice setting may have been better suited to older drug users.

The breach and revocation rates, while high, were comparable with those in the DTTO pilots (Turnbull, Hough, Clancy, & McSweeney, 2000 & Turnbull, 2003). Indeed, DTTOs in the target evaluation area had a higher rate of positive order outcomes than many other areas (NAO, 2004). Evaluations of DTTOs in other areas assessed their revocation rate alongside ongoing orders. For example, Wiggans and Libby (2002) reported that of the 60 orders included in the evaluation, 35% had been revoked and the remaining 65% were either still on an order or had completed their order. As this includes ongoing orders, their actual completion rate is unclear as ongoing orders could still go on to be completed or revoked. Hence, the approach taken in the present evaluation to look at orders due to end by a certain date rather than simply a measure of all orders started at a certain time.

Of interest was the high rate of offenders who had been for drug treatment elsewhere prior to receiving a DTTO. Part of the original aim of introducing drug treatment into the Criminal Justice System was to access a new group of drug users who had never accessed treatment previously (Hayes, 2002). Only 16% of offenders for whom the information was available had had no previous

contact with other treatment agencies. Of course, it is possible that a proportion of the remaining 48 offenders (14%) for whom data was not available could have previously not accessed any treatment. This suggests that DTTOs may have accessed only a small group of offenders who had not previously accessed treatment. However, DTTOs may also have provided an additional opportunity for drug users who had previously failed in/dropped out of treatment to re-engage in treatment.

The evaluation project served a purpose for the DTTO team of taking responsibility for a large proportion of their monthly monitoring for performance reports for the Home Office on meeting targets. DTTO targets were initially based around the number of offenders getting in to treatment but these changed in 2004 to include the proportion of offenders with successful order outcomes. Meanwhile, targets for all drug treatment services (not just those in the CJS) related to the proportion of offenders retained in treatment for 16 or more weeks (on the basis that longer retention in treatment leads to better treatment outcomes – Gossop, 2005b). These outcomes, however, tell one very little about the changes in offenders whilst on the order e.g. changes in their drug using, their psychosocial functioning or their offending behaviour. As the Home Office aims of DTTOs were to reduce offending by reducing drug use, it is surprising that there were no targets set relating to these. Simply knowing the number of orders that expired naturally is misleading as a small proportion of orders (6%) expired naturally whilst the offender was out of contact with the DTTO team having breached their order. This would however, have been reported back to the Home Office as a successful outcome. Additionally,

without monitoring drug use, offenders could remain on an order for the duration of their sentence without making any changes to their drug use and this would still be reported in the monthly monitoring figures as a successful DTTO completion.

The data reported in the current chapter, provides only minimal information on what happened with DTTOs in the evaluation period. Other aspects of the evaluation add much more understanding to what was a new initiative of drug treatment in the criminal justice system. The offender, staff and agency interviews (studies 2 and 3) give information on the experience of living and working with DTTOs, and the drug testing data (study 4) and reconviction rates (study 5) give further information on the outcomes of the orders.

Chapter 3

Study 2 - Drug Treatment in the Criminal Justice System: Lessons Learned from Offenders on DTTOs¹

Introduction

The evaluation of the pilot DTTO schemes conducted by Turnbull, McSweeney, Webster, Edmunds and Hough (2000) included 230 interviews conducted with offenders on an order. These identified a number of positive aspects of the Orders: access to residential care; group work and counselling sessions; the structure and intensity of the Orders, and support received from DTTO staff. However, the negative aspects of DTTOs included: other offenders continuing to use drugs on the Order; a lack of structure; inadequate support; having to wait for a prescription for substitute opiate medication; and a lack of skills among DTTO workers. Some offenders thought the pilot DTTOs were too strict while others thought they were too lenient. While the pilots aimed to interview all offenders commencing an order within one month of receiving an order, 6 months into the order and close to or immediately following the end of a DTTO, in practice they interviewed 63% of offenders within six weeks of starting an order, 71% of offenders at six months and 49% of offenders at the end of their order (62% who completed their order and 38% whose order was revoked).

¹ A shorter version of this chapter has been published including sections written by co-authors: Powell, C., Bamber, D., Christie, M.M. (2007). Drug treatment in the criminal justice system: Lessons learned from offenders on DTTOs. *Drugs, Education, Prevention and Policy*, 14, 333-345.

The study suffered from non-response bias with many of the offenders not interviewed at the start of their order failing to participate in the scheme within the first four weeks of their order. The research report (Turnbull et al., 2000) contained no information on the format of the interviews or method of analysis.

Following the recommendations of the pilot evaluation scheme, many areas commissioned an evaluation of DTTOs at a local level. Some included interviews with offenders but these were largely used to measure offender success on the Orders (e.g. self reported drug use, offending rates, and changes in health and relationships, e.g. in Turner, 2004).

Two evaluations however, took a qualitative approach to understanding DTTOs from the offenders' perspective. Ricketts, Bliss, Murphy and Brooker (2002), for example, interviewed 15 offenders to discover their experiences on a DTTO. Using Grounded Theory (Strauss & Corbin, 1990) they identified a process of progression where certain elements of the DTTO programme were reported to have differing importance for offenders at different stages of the Order which they called the 'life course of DTTOs'. In the early stages of an order, frequent contact, rapid responses to problems and provision of practical help were considered important by offenders. There was a focus on the physical effects of stopping drug use and appropriate prescribing was considered essential. Relationships with staff were described in global terms, whether positive or negative. By the middle stages of the orders, the physical aspects of stopping drug use were less important and offenders reported to want to be kept busy and they valued interaction with others. Experiencing achievement and having

fun without drugs also became important. Reports from offenders showed that relationships with staff become more developed over the course of an order and offenders had an increasing sense of a personal responsibility for change. By the late stage, there was some evidence of offenders becoming inpatient with the requirements of the order and offenders began to attribute positive changes to their own readiness to change rather than any effect of the order itself. However, direct quotes from offenders in Ricketts et al's. report suggest that the research participants were all well engaged in the DTTO process and there was no representation of offenders who dropped out of a DTTO early on. Unfortunately, there was no information on how participants were recruited into Ricketts et al's. study to see if there was bias in the recruiting methods. Additionally, this development of a life course of DTTOs was developed from a snapshot of one group of participants at different stages of their order. It would be interesting to see if a longitudinal qualitative study talking to the same offenders at different stages of their order would generate similar findings.

Barker, Horrocks, Kelly and Robinson (2002) took a narrative approach to understanding offenders' experiences on DTTOs. They interviewed 11 participants, nine of whom were on a DTTO and 2 were on a Section 1(A)6 order.² Interviewees were between one week and 6 months into their order. The researchers found overall that offenders were positive about DTTOs,

² Section 1(A)6 orders were a predecessor to DTTOs whereby with an offenders consent, a court could sentence a drug using offender to undergo treatment within local drug treatment services.

describing them as an ‘opportunity’ to deal with their drug misuse. Participants reported benefiting from Enhanced Thinking Skills (ETS) and the opportunity to attend training courses. The feedback on the group work revealed problems integrating new offenders into the groups and mixing offenders of different backgrounds. Important features of the orders for the participants included the formation of one to one relationships both with their counsellor and with magistrates for review courts. There were consequences for testing positive for drugs or not attending appointments which participants mostly viewed as fair.

Participants in Barker et al’s research talked about the changes that being on an order had caused, in particular the researchers identified two key areas of ‘loss’ for those choosing to address their drug use and behaviour. Firstly participants talked about their drug misuse and offending behaviour in ways that demonstrated drug using or offending held a positive identity for them. In dealing with their drug use and offending behaviours, participants had to leave behind this ‘expert self’ and form a new identity – that of service user or compliant offender. Secondly, participants talked about detaching themselves from their friends, many had lost contact with non-drug using friends when they started drug use and were now feeling the need to detach themselves from drug using acquaintances, meaning that their social circles were limited.

Taking a narrative approach to looking at DTTOs increased understanding of how offenders view and deal with the orders and the changes that are required of them whilst on a DTTO. However, the data and quotes used suggest that again all the participants were already well engaged in the process of being on

a DTTO. While it was known that participants were recruited between one week and 6 months into the order, it was not described how many of the 11 were recruited in the early stages of the order and how many were recruited some way into the order. The findings seem biased towards those who were actively engaged in addressing their drug use and offending as part of an order and throw little light on offenders who chose not to engage and breached or dropped out of their order.

As part of the current wider evaluation reported in this thesis, qualitative interviews with DTTO offenders were included, aiming simply to sample offenders' opinions and experiences of the Orders. This was in order to feedback to the treatment team on a regular basis to improve service delivery.

Methodology

Participants

It was anticipated that all offenders on a DTTO be interviewed when starting their order, when in breach of an order and at completion or revocation of their order. However, the sheer number of orders commenced and limited resource issues (a half-time researcher and lack of confidential interview rooms) meant that this was not possible. From a total of 331 offenders (422 DTTOs) in the quantitative aspects of the study, 273 interviews were arranged with offenders. A high rate of failure to attend plus one refusal meant that 143 interviews actually occurred with 107 individual offenders. Of those, 72% (77) were interviewed on one occasion only and 28% (30) were interviewed more than

once (i.e. as they commenced each DTTO, as they breached and/or had their Orders revoked). As the only incentive, attendance at the interviews with the researcher counted towards weekly contact time with the DTTO Team.

The demographic profile of the current sample reflected the total population of DTTO offenders in the target area: the majority were male (82%) and of an average age of 26.5 years (SD 5.9). Only 8% were of a non-white ethnic origin. In relation to seriousness of offences and offending history, 67% of the sample received their DTTO from a magistrates court, 32% from crown court; 47% of offenders were remanded in custody at the time of sentence to DTTO and 49% were in the community (this is unknown for 3%).

The interview sample comprised 89 offenders who were approximately six weeks into their Order, 37 in the process of being breached (or having their Orders revoked), and 17 with considerable experience of DTTOs (those whose Orders were due to expire naturally or, who were at least 6 months into their order). The profile of offenders interviewed close to the start of their Order, reflected the total population of DTTO offenders in the target area in terms of gender, age, ethnicity, and seriousness of offence. A slightly higher percentage of this sample, as compared to all DTTO offenders in the target area, went on to complete their Order or have it terminated for good progress (38% compared to 33%), with slightly less (45% compared to 47%) having their Order revoked for breach or further offences (16% of Orders were ongoing at the end of the evaluation period).

A total of 37 interviews were conducted with offenders who were in breach (or having their Orders revoked) as most offenders in breach were no longer in contact with the DTTO Team and difficult to follow up. This sample was therefore biased towards (1) those attending appointments despite being in breach, and (2) those going on to complete their DTTO (50%). This group, however, resembled the larger group of DTTO offenders, except for a greater proportion showing a lower severity of offending at or prior to sentencing to their DTTO.

The group of 17 offenders who had had considerable experience of DTTOs, consisted of 12 whose Orders were naturally expiring and five who were at least six months into their Order. This group differed from the total sample of offenders on a DTTO in the target area as a higher proportion (82%) went on to complete their Order and a lower proportion were sentenced in Crown Court or started their Order from custody.

Materials

Brief structured interviews lasting 10-30 minutes were conducted by the researcher. The interviews were designed to be short and straight forward due to the large sample size expected, to encourage participation and to ease the process of analysis to enable ongoing feedback of results to the service. This design was also chosen to enable interviews to be conducted opportunistically when offenders were waiting for other appointments. Interviews were not conducted in this way however, as the probation service felt this was not

appropriate and preferred that interviews be pre-arranged via offenders weekly appointment cards.

The interviews were tailored according to the stage of the Order at which they occurred (see Appendix D). Commencement interviews covered offenders' reasons for accepting a DTTO, self-reports of their drug use and offending, and previous drug treatment experiences. Interviews conducted with offenders in breach of their order were very short, simply aiming to discover the reasons offenders gave for breaching their order and if they felt there was anything that could be done to prevent further breaches. The breach interviews in particular were designed to be very short and easy to complete to enable them to be conducted opportunistically as it was anticipated that co-operation from those in breach in attending appointments may be limited. Revocation interviews covered why the offender felt their order was revoked, what they felt might have helped them remain on the order and suggestions for improvements. Completion interviews covered offenders' opinions on particular aspects of the orders, which treatments and interventions they found helpful, which treatments and interventions hindered change, how they felt DTTOs had affected their drug use and offending and suggestions for improving DTTOs. The interview schedules are available in Appendix D.

Procedure

The researcher approached case managers to arrange contact with potential interviewees via the offenders' weekly appointment card. The interviews were conducted on Probation Service premises, albeit in a private room. As the

interviews were conducted on Probation Service premises and appeared to offenders to be part of their order, it was important for the researcher to spend some time at the start of the interview explaining the independence of the research and reassuring interviewees of the confidentiality of the interviews. Once this and the purpose of the interviews had been explained to offenders, they were given the option of continuing with the interview or leaving the interview without their key worker being informed. A rough approximation of the introductory briefing is included in Appendix C.

Using a method similar to that developed by Orford, Natera, Copello, Atkinson, Mora, Vellerman et al., 2005, detailed handwritten notes were taken during the interview, including some verbatim quotes. Immediately following the interview (or within 24 hours of the interview) these notes were typed up by the researcher with extra information added from memory to produce a report providing as full an account of the interviews as possible. This approach was taken as there was concern that interviewees would not be comfortable discussing their offending behaviour whilst being tape recorded, particularly as part of a probation order. It was deemed more important to try and maximise co-operation from those interviewed than ensure an exact verbatim record of the interviews. Additionally, for the aims of the interviews, the analysis simply needed to consider the content of these reports rather than how things were said, so did not necessitate a full transcript. It was also planned that findings from the interviews be fed back to the team on an ongoing basis so it was necessary to choose a recording style and analysis methods that made this quick and easy to do.

Interviews were anonymised at transcription stage according to the stage of the order at which they were interviewed, i.e. start (S), breach (B), revocation (R) and completion (C), then by the year in which they were interviewed and then by the order in which they were interviewed. The code therefore is (type of interview, year of interview, interview number) i.e. (CB3) would be the third completion interview conducted in year two.

Analysis

The data were originally analysed by the researcher for each of the three year cohorts and reported to the DTTO Team and their managers in order that issues raised during the interviews could be addressed. Working practices were, on occasions, altered as a result of this for example the introduction of bus passes. (Any changes in working practice that did result from the interviews had minimal impact on the study). It became apparent however that there were very few differences over time in the data and they were, as a consequence, merged and treated as a whole dataset for analysis.

Data were coded and analysed by hand, using content analysis (Krippendorff, 2004). All of the transcripts were combined into one document using the structure of the interview to separate sections of text. Each interview question was taken individually and the transcripts read. Main themes for each question were identified and text relating to these themes was highlighted on the combined transcript and then grouped together by copying them out by hand. Doing this by hand served as a preliminary stage of analysis for the researcher.

Later, once all questions had been analysed, the final stages of analysis involved combining themes that appeared under a number of different questions. The decision to analyse each question separately was taken to ensure that feedback to the DTTO team met their needs.

Results

Reasons for consenting to a DTTO

The majority of interviewees were motivated to address their drug use, as the predominant reason given by interviewees for agreeing to a DTTO were ‘to be drug free’ by the end of their order (54%, 48 interviewees) with a further 18% (16) wanting ‘to be drug free’ and ‘avoid a custodial sentence’. Other positive reasons given included: ‘to try and do something positive’, ‘to get a normal life’ or because they viewed DTTOs as ‘a last resort’. Only 9% (8 interviewees) reported that they accepted a DTTO purely to avoid a custodial sentence.

Overall opinions on DTTOs

Sixty-five percent of interviewees at the start of their Order were satisfied with their DTTO, describing them as “*okay*” or “*allright*”. Only 12 interviewees (13%) were not as satisfied, describing DTTOs as ‘hard and demanding’, with two reports of ‘not getting as much help in reducing their drug use as expected’.

Fifteen of the 17 interviewees with considerable experience of DTTOs were positive about the orders, explaining how DTTOs had provided the help to reduce drug use for those who were motivated to change:

“It’s easy to get off it {the drugs] you have to want to stop. If you want to do it then this is the ideal opportunity. It’s done me well” (CC1).

“If people really want to come off drugs then the course is alright” (CC3)

Interviewees particularly enjoyed being given the opportunity to change their lifestyle, being kept occupied, and welcomed the support that was available to them.

Attendance Requirements

Seventy-six per cent (68) of those interviewed at the start of their Order were ‘satisfied’ with the number of hours they were required to attend as part of their DTTO, describing them as “okay” or “reasonable” because they “keep you occupied” (C10). Indeed, 15 interviewees (10%) requested extra appointments for that very reason. For 24% (21 interviewees) however, the attendance requirements were considered to be too intensive, particularly for those interviewees travelling long distances to attend appointments, relying on public transport, trying to maintain employment alongside the Order or trying to secure accommodation:

“I think the group work is a bit out of order cos I’ve got a job. Not the best thing to have to explain to your gaffer that you need to take two hours off to go to an appointment” (SC5).

However, this was not the case for all interviewees as a number of other interviewees who were employed (n=4) reported that the DTTO team were being flexible around their attendance requirements to enable them to maintain their employment.

The timing of appointments was further raised as an issue by eight interviewees as it was a regular occurrence for there to be two to three hour gaps between morning and afternoon appointments, consequently they were having to “hang around” in-between appointments. Two interviewees explained that the city centre location of the DTTO office made it difficult to resist the temptation to shoplift and also meant that drugs were readily available.

Treatments, Interventions and Activities

The sample of 17 interviewees with considerable experience of DTTOs were asked to identify which aspects of the order helped or hindered them to make changes. Motivation was identified as a theme, with some interviewees saying the fear of returning to jail acted as a motivating factor (n=2), while others felt their own motivation was key (n=2)

“I helped myself really, you’ve got to help yourself otherwise it doesn’t matter” (CB9).

Though there were reports that the order as a whole worked to increase motivation and keep offenders on track (n=4).

“[It] helps you want to do a bit more, just the whole course in general” (CB2).

Praise and encouragement from DTTO staff was also identified as helpful (n=1)

“I to get praised here, never been praised before. Gives you encouragement, lets you know that you can do well” (CC2).

Other aspects identified by individuals included acupuncture, and the support network provided by DTTO staff.

Overall, the majority of interviewees (94%, n=16) with considerable experience of DTTOs reported that they had received the type of help or treatment they wanted:

“I didn’t expect it to help so much, to change my thinking so much”
(CC2).

Interviewees with considerable experience of DTTOs or those interviewed when in breach of their order identified some aspects of the Order that they did not like. Three interviewees found some of the group sessions problematic as they found discussing their drug use actually made them crave drugs, particularly at the beginning of their Orders. Two interviewees also made allegations of offenders selling drugs following certain sessions. As one interviewee explained,

“there is a lot of drug using behaviour going on outside the door which would make it hard to stay clean” (CB8).

Further, two interviewees were aggrieved that there were a number of offenders on DTTOs not motivated to address their drug use who consequently made it more difficult for others to maintain their motivation. They felt this devalued the work conducted by the DTTO Team. Four interviewees reported problems with prescriptions for substitute opiate medications: they wanted access to the doctor on the first day of their Order and a wider range of medications (e.g. minor tranquilisers) rather than just substitute opioids. Additional help was also requested by one interviewee with finding employment, particularly after the first 13 weeks of an Order when contact hours were reduced. Another interviewee also requested help with paying outstanding fines.

Review Hearings

Almost all interviewees with experience of DTTOs (88%) found the court review hearings to be a positive experience. The interviewees valued them greatly as reviews gave them a forum to interact with the judiciary. Interviewees found the input from sentencers motivating (n=4):

"if you get a pat on the back, that motivates you" (CC1),

"[it's] good if you've slipped a bit 'cos they give you a rollicking" (CC2).

And reports of being praised by the judges

"I got praised by the judge; ain't never had a judge praise me before..."
(CC2)

"I've been praised on every single one so I'm going to say they were good" (CC1).

Two interviewees were less positive about reviews hearings. One reported that the quality of a court review hearing depended on the magistrate sitting that day and another felt they attended court hearings simply to be told the date of their next hearing.

Drug Testing

Eighty-three per cent (14) of those with experience on DTTOs were positive about drug testing as a requirement of their orders. Four interviewees reported that they found drug tests to be a motivating factor in reducing their drug use.

As a couple of interviewees explained, *"it keeps me more determined"* (CB8) and it *"deters me from using"* (CC3). There were, however, concerns that drug tests were open to manipulation. Examples were given of urine samples being watered down and swapped with other samples, though mouth swabs were

considered to be harder to cheat. Interviewees also reported that it was possible to continue using drugs on the days they knew they would not be tested and thus return negative drug test results. In order to avoid this, two interviewees suggested that drug testing should occur more frequently, for instance, three or four times a week.

The Breach Process

Fifty-three per cent of offenders with considerable experience of DTTOs (9) were satisfied with the breach process, describing it as “*good*” or “*allright*”. Four of those interviewed reported that the breach process was a deterrent that “*keeps you on track*” (B8). Being allowed to continue to attend appointments with the DTTO Team until the breach was heard in court and the possibility of the breach being adjourned to test commitment were considered to be particularly positive aspects of the breach process. One interviewee also liked how breaches could result in them being given a concurrent or consecutive DTTO by the courts, and not necessarily having the original Order revoked as they explained,

“*you may end up on a DTTO 2 or 3 times before you realise that it is worth it*” (CC1).

Largely, interviewees in breach of their DTTO acknowledged that they had to take responsibility for breaching their Orders with 10 reporting that staff could have done little to prevent the breach. Nine interviewees identified the need for help in finding and maintaining housing and accommodation. Five interviewees felt the DTTO staff should have been more lenient in terms of missed

appointments. Whilst National Standards for attendance stated that offenders were in breach of their DTTO if they failed to attend two or more appointments without a reasonable explanation, those interviewees who had breached their Order felt that on the whole, this was harsh and too punitive. One interviewee reported that,

"they should appreciate that people do sleep in" (BA3),

with others stating that 'allowances should be made', for example if attending college courses, being in employment or trying to arrange accommodation.

Suggestions for improvement

Twelve of the interviewees with considerable experience of DTTOs were able to make suggestions for improvements in three main areas:

1. Groups and activities. There should be a wider variety of groups available; more gender specific activities; more work on offending behaviour; separate groups for those no longer using drugs; and more home visits or appointments out of the office to allow interviewees to get to know their case managers better. The times of appointments should be arranged to avoid long gaps between them.
2. Medical treatment. Prescribing of substitute opiate medication should be available immediately following sentence to a DTTO in order to remove the need to continue offending. The team doctor should be more lenient in their prescribing habits especially with higher doses of methadone at the start of Orders; and prescribe "*sleepers*" (sedatives) when needed and when offenders had shown that they could be trusted.

3. Employment. More assistance with finding work was needed (e.g. through local placements or voluntary work), particularly at the beginning of Orders. One offender explained “*when you finish the Order if you have nothing to do, then you end up going back on the drugs*” (CC1).

Other suggestions for improvements to DTTOs included being more strict with offenders who were not making full use of them (e.g. those with little intention to address their drug use) and generally to provide a similar drug treatment programme for drug users earlier in their drug using career.

Discussion

Structured interviews were conducted with offenders at various points of the order to gain their opinions about their experiences of the orders. The interviews served to provide the probation service with a sample of offenders' opinions and experiences of DTTOs and identify issues for DTTO staff to address. Overall the interviews were positive, with offenders reporting an acceptance of the order so as to address their drug use, and those who went on to complete the order reported getting the help or treatment that they had wanted. Interviewees found drug testing and court reviews to be important motivating aspects of the orders. Interviewees in breach of their order acknowledged that the breaches were down to them and little could have been done to prevent the breach. Suggestions for improvement centred around groups and activities, medical treatment and employment.

In contrast to the Government's ultimate aim of DTTOs to reduce crime through treatment of drug problems, findings from the current study suggested that the main motivation for those offenders on a DTTO was to reduce their drug use rather than their offending behaviour. Most interviewees hoped to be drug free by the end of the Order and saw DTTOs as a preferred alternative to custody. This is also in contrast to the findings of the DTTO pilot evaluation where offenders' main motivation for accepting a DTTO was to avoid custody (Turnbull et al., 2000). The findings of the current study do however support the findings of others that not all clients legally coerced into treatment are unwilling participants (Farabee, Shen, & Sanchez, 2002; Longshore, Prendergast, & Farabee, 2004; Wild, Newton-Taylor, & Alletto, 1998).

The current interviewees saw the breach process as a positive deterrent, particularly the flexibility that allowed the continuation of the DTTO staff support and adjournment periods to test motivation, despite further offences or court appearances. Interviewees recognised that it might take two or three Orders before one was finally committed to change. The fact that the courts allowed adjournments and were prepared to allow DTTOs to continue following a breach suggests that the courts were taking a harm reduction approach rather than a purely punishment role.

Other studies have found limited effects of drug testing on offenders' drug use and have raised issues as to the usefulness of drug testing (Carver, 2004, Home Office, 2004b). However, the current findings from offenders who were 'engaged' in the DTTO process showed that frequent drug testing was

considered a positive requirement of a DTTO, a motivating factor and an incentive to reduce (rather than stop) drug taking. Noticeably, there were no complaints from offenders regarding the inability of the drug tests to detect changes in the frequency or level of drug use. Although a change in year two of the current study from urine testing to oral swab testing resolved some of the problems of manipulation by allowing observation of samples being provided, there were still concerns expressed by some interviewees. For those offenders not motivated to change their drug use, non-random drug tests are open to manipulation (Home Office, 2004b). Only frequent, random drug testing as set by case managers would potentially act as a deterrent for those offenders intent on reducing their drug use.

At the time of writing, substitute prescribing was a key part of drug treatment for opiate addiction in the UK, and an important element of DTTOs. In order for it to be successful, dosage levels of substitute opiates need to be targeted correctly (i.e. at levels high enough to stave off withdrawals but low enough to minimise leakage onto the streets) (Department of Health, (England) and the devolved administrations, 2007). In addition, access to such treatment needs to be rapid for such offending drug users, when their motivation to come off illicit drugs and their hopes for the Orders are high. Much of the criticisms of the current offenders interviewed were that dosage levels were too low and prescriptions were not immediately available as they started their Orders, as was found by Barker et al. (2002), Turnbull et al. (2000) and Ricketts et al. (2002).

While the interviewees seemed to be largely motivated to address their drug use they identified difficulties of mixing drug users with differing levels of motivation to change their drug using behaviour. The current interviewees highlighted the disruption that could be caused by mixing offenders with differing levels of motivation in dealing with their drug use. It cannot be assumed that all those on a coerced treatment order have the same levels of motivation, while some may be motivated, others may be resistant and just 'going through the motions' of drug treatment (Longshore & Teruya, 2006). Such resistant offenders may well cause disruption in groups aimed at offenders who are motivated to change. Perhaps those who are resistant to change could be offered more MI work or a series of MET in order to increase their motivation. More attention therefore needs to be paid to offenders' motivation before including them on all group work.

Interviewees complained that the National Standards for breach due to failing to attend two appointments without an acceptable explanation were overly strict. Given that a common self-declared goal for those on a DTTO was to gain employment/qualification in order to support a drug-free lifestyle, and that the achievement of paid employment is probably one of the most important factors in sustained recovery from drugs (Klee, McLean, Yavorsky, 2002; Platt, 1998; Room, 1998; Westermeyer, 1989), it was important to interviewees that they should be allowed a degree of flexibility to be able to stay employed or attend college whilst still on a DTTO. Indeed, there was a high expectation among the interviewees that DTTOs would help to get them into employment or further training, suggesting that drug treatment programmes in the Criminal Justice

System should be able to work with this particular goal. Appointments with staff and programme activities should not impede such longer-term goals but rather support the aim of meaningful occupation (paid or unpaid work). Almost one third of the offenders interviewed who were in breach of their DTTO, raised issues surrounding accommodation and housing, thus indicating the importance of such practical help to aid clients to achieve a sense of stability whilst on a DTTO and set them up with resources that will remain following the end of the DTTO.

A recurring theme throughout the interviews was that of motivation to address their drug use and complete the order. Offenders reported that they liked aspects of the orders that maintained or improved their motivation. For example, they reported that the breach process acted as a positive deterrent and drug testing acted as a motivating factor and as an incentive to reduce drug taking. Court reviews were also reported as positive and motivating. Issues that offenders did not like seemed to be those that did not act to increase motivation, or practical issues that failed to utilise motivation such as delays in being prescribed substitute drugs, low levels of prescribing, limited opportunities to attend college or work, a low breach threshold for missed appointments, and the failure of DTTOs to help offenders obtain stability e.g. stable accommodation.

A key factor in keeping offenders engaged in drug treatment general is motivation (DeLeon, Inciardi, & Marinis, 1995; Joe, Simpson & Broome, 1998; Ryan, Plant & O'Malley, 1995; Simpson, 2001; Simpson & Joe, 1993) and the

current interviews suggested that coerced treatment is no different: motivation, and aspects of treatment that act to increase or maintain motivation are key to the success of treatment. Therefore a key aspect of treatment on DTTOs needs to be that of increasing and maintaining motivation to address drug use and offending behaviour. Many aspects of the orders worked to increase motivation and it is these aspects of the orders that interviewees appeared to value most. Motivation fluctuates throughout treatment (Ricketts et al., 2002). Offenders can agree to a DTTO and initially be motivated but practical difficulties, e.g. accommodation, attendance requirements and delays in getting a prescription can all act to reduce motivation. Ideally these practical aspects should not be an issue - prescribing should be available immediately, stable accommodation should be able to be found and offenders should be enabled to attend training and employment and not feel that the requirements of National Standards are holding them back. However, in practice these are real issues for offenders on a DTTO which could also emerge once an order is underway and these do affect motivation to engage. Criminal justice drug treatment staff need to ensure that the practical aspects are in place as soon as possible for offenders starting the orders as these are important. Offenders affected by these practical issues may need extra help to stay motivated to address their drug use. Criminal justice drug treatment staff should be working to assess and enhance motivation on an ongoing basis. Where appropriate, MI techniques should be used in key working sessions at any stage of coerced drug treatment, alongside the other aspects of the orders that the current interviewees identified as increasing motivation (e.g. drug testing, court reviews).

The 2003 Criminal Justice Act (Home Office, 2004a) restructured community sentences and DTTOs were replaced by a Generic Community Order with a Drug Rehabilitation Requirement (DRR). This requirement for drug treatment could be made with or without additional requirements such as supervision, unpaid work, activities, accredited programmes, curfews, alcohol treatment, etc.. Some elements of DRRs differ from DTTOs and the findings from the current chapter suggest that these differences may be a move away from the what offenders reported to be positive and motivating aspects of DTTOs.

Firstly, the new Generic Community Orders require the courts to be more onerous in their treatment of offenders who breach the conditions of their Orders than they were previously with offenders on a DTTO. As part of the new Orders, some form of punishment will be attached to the original order for those who are in breach (e.g. extending the Order or adding additional requirements). Offenders in this study reported that they liked being given another chance. The fact that this second or third chance may have extra conditions attached may act to decrease offenders' motivation by making the order harder to complete. However, it could also be that offenders may be more motivated to engage with the order if they know that there are consequences for breaching their order. Secondly, under DTTOs, Court Reviews were compulsory for all Orders regardless of length. Under the new Criminal Justice Act however, Court Reviews are only compulsory for Orders including a DRR of longer than 12 months and are optional for Orders from 6 to 12 months. The current study showed that offenders found court reviews to be positive and motivating, supported by the findings of Turnbull et al. (2000) and Ricketts et al. (2002). By making Court Reviews optional rather than compulsory for those with a DRR of

between 6 and 12 months in length, this may have a detrimental effect on offenders' motivation. However, the cumbersomeness of the review process (in terms of time taken to write review reports and the court time and associated costs) need to be weighed against the potential benefit to offenders. Thirdly, whilst drug testing will continue under DRRs, after the first 16 weeks of an Order, the frequency of drug testing will be reduced to once weekly if offenders are showing progress. Offenders in this study reported the drug tests to be motivating and the effect of reducing the frequency on its usefulness in maintaining motivation should be assessed.

The current 143 structured interviews with 107 offenders provided a valuable insight into DTTOs from the perspective of offenders subject to them. Like DTTOs, however, the evaluation on which this chapter was based, suffered with a high non-attendance rate for arranged interviews. In particular, it proved difficult to recruit individuals who had breached their DTTOs or had had their DTTOs revoked since they were no longer in contact with the DTTO Team. This does suggest that the sample and feedback may be biased as those whose order was breached or revoked may well have different opinions on the order. Additionally, interviews conducted with offenders in breach of their order focused solely on the breach as they were purposely designed to be short to enable them to be carried out opportunistically. More in depth interviews with offenders in breach of their order may have given a more balanced picture of the orders. Other qualitative studies have also failed to recruit a fully non-biased sample (e.g. Ricketts et al., 2002 and Barker et al, 2002) The current study and Ricketts et al., (2002) attempted this to some degree by interviewing

offenders who had had previous orders revoked, but the fact that these offenders accepted a subsequent DTTO suggested their opinions of DTTOs were positive. Turnbull et al., (2002) interviewed a sample of 19 offenders who had had an order revoked, but the average time from revocation to interview was 8 months. As part of the current study, it was planned to interview offenders in custody whose orders had been revoked but due to resource limitations this was not possible. This is, however, a gap in the qualitative literature on DTTOs, what are the experiences of those who choose not to engage with DTTOs? One would expect their opinions of the orders to be vastly different from those who go on to engage with the order. Future research would do well to attempt to access this group.

The current interviews were conducted to serve a purpose for the probation service and the style of interview, questions and method of analysis were chosen to meet these needs. While these interviews have provided insights into the orders, the approaches taken by other researchers such as Ricketts et al. (2002) and Barker et al. (2002) generated a wider understanding of DTTOs for those on the orders. It would have been beneficial to conduct a series of more in-depth interviews with the offenders on orders as part of this evaluation to gain a fuller understanding of their experiences.

The recommendations arising from the current study for the new Generic Community Orders, based on the current offenders' opinions, are that:

- Court reviews, which are optional for Orders from six to 12 months, should be included wherever possible to act as a motivating factor for offenders;
- The punitive elements of the Generic Community Orders with DRRs do not override the drug treatment aspects due to very strict attendance requirements; and
- Drug testing is kept at a frequency of at least twice weekly and is done randomly on occasions set by case managers with offenders held to testing times so as to be less open to manipulation and act as a further incentive to reduce illicit drug use.

Conclusion

A key factor in keeping offenders engaged in drug treatment in general is motivation (DeLeon, et al., 1995; Joe et al., 1998; Ryan et al., 1995; Simpson, 2001; Simpson et al., 1995). The interviews with offenders reported in the current study suggest that coerced treatment is no different - motivation, and aspects of treatment that act to increase or maintain motivation are key to their success. Therefore a key aspect of coerced drug treatment needs to be increasing and maintaining motivation to address both drug use and offending behaviours. Many aspects of these orders worked to increase interviewees motivation and it is these aspects of the orders that they appeared to value most. Some practical issues were identified by interviewees as reducing their motivation. DTTO staff need to continually be assessing and enhancing individuals' motivation levels alongside the other aspects of the orders interviewees identified as increasing motivation.

Despite high attrition rates for DTTOs nationally, the impression from the current sample of offenders suggested that most of those on the DTTOs found them to be positive and helpful. With the focus being on ‘treatment’ rather than ‘punishment’, offenders were given several chances to succeed, which they appreciated and felt to be key to their eventual success. Managers and commissioners could well pay heed to these interviewees, where some flexibility in appointment times, activities offered and locations of such could make the difference between offenders engaging fully with treatment or dropping out of treatment. Offenders should be aided to attain and maintain accommodation and employment without which they believe they are less likely to succeed.

Chapter 4

Study 3 - Experiences of DTTO staff and partnership agencies in delivering and working alongside Drug Treatment and Testing Orders

Introduction

Due to the limited guidance on how DTTOs should be set up a number of different working models were developed in different localities and the professional mix of staff working on DTTOs varied from location to location. Some probation areas employed a Multi-Disciplinary Team model attempting to provide all of the elements of a DTTO within probation services, others set up partnerships with health service agencies whereby a health service agency delivered drug treatment aspects of the orders and the probation service dealt with the enforcement and criminal justice aspects of the orders (NAO, 2004).

As DTTOs were rolled out nationally, evidence of the tensions between agencies involved in establishing DTTOs appeared in journal articles. Stimson (2000b) warned, “there are dangers ahead for drug treatment agencies as they are restructured to cope with criminal justice referrals” (p. 12). He felt that the change in drug treatment policy to focus on the relationship between drugs and crime, rather than focusing on the individual, made it an unhealthy policy. He expressed concern that relationships between police, treatment services and drug users would be damaged as a result of the new policy. Barton (1999b) was wary of what he termed the ‘criminalisation’ of health whereby health

services had to start to work to a criminal justice agenda. By this he meant that drug treatment services were having to change their views on outcomes from simply the welfare of the individual to include a focus on community safety and reducing offending. He cited the Fast-Track project in Plymouth as an example of criminal justice and drug treatment agencies working together in a DTTO predecessor. When referring to treatment outcomes health workers involved in the project mentioned crime reduction as often as achieving stabilisation in drug use and Barton suspected that the health workers had begun to internalise the 'criminalisation' aspect of their work for the project. Barton and Quinn (2002) felt that the criminal justice system was more concerned with the control and management of large groups of offenders than the well being of individuals. Kothari, Marsden and Strang (2002) were concerned that the tendency of the criminal justice system was to administer punishments to drug related offenders and was not primarily concerned with rehabilitating offenders. They felt that criminal justice staff needed to be educated on methods of rehabilitating drug using offenders as the treatment of drug using offenders is different from the punitive methods that they normally employed in the criminal justice system.

The first information in the scientific literature on probation and treatment staff views on DTTOs came from the DTTO pilots. In the pilots treatment agencies provided the drug treatment while probation staff supervised the legal aspects of the order (Turnbull, McSweeney, Webster, Edmunds, & Hough, 2000). Included in the pilot evaluation were process interviews with DTTO staff in order to determine the workings of DTTOs. Turnbull et al., (2000) identified the issue of effective inter-agency working as "perhaps the single most important factor to

address in establishing programmes" (p. 82). The problems identified by the pilot studies were thought to be a consequence of agencies with different working styles, traditions and values trying to work together on a difficult joint enterprise. Turnbull et al., (2000) strongly recommended that work should be done by all involved in the delivery of DTTOs to address this issue.

One of the recommendations from the DTTO pilots was that further evaluations should be conducted and, as DTTOs were rolled out nationally, a number of local evaluations were set up. Included in some of these evaluations were interviews with staff which were used to assess the process of DTTOs and gather staff opinions of DTTOs (e.g. Best, Mann, Morrison-Rees, Witton, & Sharp, 2002; Eley, Gallop, McIvor, Morgan, & Yates, 2002; University of Essex, 2002).

Best et al., (2002) asked staff across 12 DTTO teams in London to complete questionnaires assessing their views and experiences of DTTOs. In addition, six focus groups were conducted to explore issues arising from the questionnaires. The model of treatment provision varied across the 12 sites and Best et al. found a lack of consistency between DTTO teams in all aspects of the orders: staffing, roles and responsibilities, assessments, case management, enforcement, partnerships, communications and tensions. There were also some inconsistencies within teams in relation to client treatment decisions. There were high levels of staff turnover but overall, staff showed positive attitudes to DTTOs with core DTTO team members seeing DTTOs as a

“moderately effective means of addressing drug using behaviour” (p. 29), although they did feel that DTTOs had not been well thought out.

Also included in Best et al.'s (2002) evaluation were questionnaires completed by 15 court staff (judges, magistrates and court clerks) to gather their opinions of DTTOs. Seventy-three percent of court staff thought DTTOs were a good idea in principle. Courts saw DTTOs mainly as a means to reduce drug related offending, though held mixed views on how successful DTTOs were at achieving this.

An evaluation of DTTOs in Essex conducted by the University of Essex (2002), also included interviews with DTTO staff. DTTOs in Essex employed a multi-agency model with six treatment agencies linked to six probation areas across the county. Interviews with DTTO staff found a range of views on abstinence with some expecting abstinence from all drugs and others feeling a reduction in drug use and safer drug use were sufficient expectations. Staff felt that offenders' motivation and self-belief were the most important characteristics needed by those on the orders to achieve success. Questionnaires and focus groups conducted with magistrates, clerks and judges found that they understood the main aim of DTTOs to be stopping drug related offending although only around one third believed DTTOs were achieving that aim.

Included in the current DTTO evaluation were interviews with DTTO staff and agency staff that were used to assess their opinions and experiences of DTTOs: how they were working, what the problems were, opinions on outcomes

etc.. While it was intended that these interviews, particularly the staff interviews, be used to feed back into the development of the DTTO team on an ongoing basis, in practice this did not happen. Instead, the interviews were fed back into the team in a written format on completion of the evaluation project. However, these interviews raised a number of key issues on different aspects of delivering and working alongside the DTTOs hence their consideration in the current thesis.

DTTOs in the study area were initially established almost entirely independent of existing treatment services in the area perhaps in an attempt to minimise interagency relationships problems. Probation staff supported by mental health nurses and a GP delivered the majority of the treatment, interventions and probation aspects of the orders (see Study 1 for a full description of the staff team and treatment aspects of the order).

Aims and objectives

The original aims of the DTTO staff interviews were to:

- 1) sample DTTO staff opinion about the overall impact of the orders
- 2) sample a variety of other agency workers and court staff for their opinions about the overall impact of the orders.

Attention was also paid to other aspects that emerged in the interviews which may have impacted on these opinions.

Methodology

Participants

DTTO Staff

Staff Members of the study team were interviewed at three time periods: when staff joined the team (n=10, 5 PSOs, 5 case managers); when staff had been in post for one year (n=9, 3 PSOs, 6 case managers); and when staff left the team (n=5, 3 PSOs, 2 case managers). This represents all case managers and PSOs in the DTTO team during the evaluation. Case managers and Probation Service Officers were interviewed in order to ensure that different viewpoints were covered in the interviews. All staff approached agreed to participate in the interviews.

Other Agency Workers

Staff at local agencies who were expected to have contact with the study team, or be affected by the work of the DTTO team were approached by the researcher to participate in interviews. DTTO sentencers and commissioners were also invited to participate in interviews. Six staff were approached at the beginning of the DTTO evaluation project (time1 = t1) and 11 staff were approached at the end of the evaluation project (time 2 = t2) to share their views and experiences of DTTOs. All staff from external agencies approached to take part in the study agreed to be interviewed, nobody refused to participate in the study.

The sample included staff from a number of different agencies as seen in Table 1 below. The interviews that were conducted as DTTOs were being established revealed that little was known about DTTOs by agencies outside of the drug treatment field, hence the initial focus on treatment agencies. At time 2, agency staff were chosen to try and give a representative view of the agencies who were actively working with the DTTO team. Table 2 summarises the numbers of agency workers who were interviewed across the two time periods.

Table 1: Agency Staff interviewed

Agency	DTTO start (t1)	Evaluation End (t2)
Local NHS drug treatment services	3	4
Local Arrest Referral scheme	1	
Community Care Assessors		1
Local CARAT	1	
Local probation services	1	
Magistrates		2
Judges		1
DAAT commissioners		2
Local voluntary housing agency		1

The local NHS drug treatment services were the largest drug treatment agency in the local area and included a criminal justice team that specialised in providing drug treatment to clients involved in the criminal justice system but not on a DTTO. Despite the aim of DTTOs being to provide treatment to drug users who had previously not had any drug treatment (Hayes, 2002), local treatment services expected that there would be a large overlap between clients in the NHS drug treatment services and those being sentenced to DTTOs. It was therefore considered important to interview all of the criminal justice staff in the NHS drug treatment team plus the team manager. Hence a larger number of interviews were conducted with the local NHS drug treatment agencies than with any other agencies.

Measures

Semi-structured interviews were used for both staff and agency interviews. The staff interviews varied according to the stage of the project at which they took place and were designed to encourage staff to talk openly about all aspects of DTTOs including their perceptions of the outcomes of DTTOs. The interviews were also designed to identify problems with DTTOs and enable staff to give possible solutions to these with the intention of feeding these suggestions back to the team. The interview schedules for the DTTO staff interviews are in Appendix E. The agency interviews were designed to be slightly shorter and varied depending on the role of the interviewee. All interviews with the agency staff (including court staff) covered overall opinions of DTTOs, perceived benefits of DTTOs over non-coerced drug treatment, opinions on the success of DTTOs at reducing drug use and offending and opinions on value for money.

Workers who were expected to have a closer relationship with, and fuller understanding of DTTOs were asked about their relationships with the DTTO team and the impact of DTTOs on their services. The interview schedule for other agency workers is in Appendix F.

Procedure

Where possible, interviews with DTTO staff were conducted by the researcher away from Probation Service premises. However when this was not possible, interviews were conducted in a private room on Probation Service premises. Interviews with agency staff were conducted by the researcher at their own premises again in a confidential room. Interviews took between one and two hours to complete.

As the researcher was seconded to the Probation Service team for the purposes of this project, it was important to spend some time at the beginning of the interviews explaining the confidential nature of the interviews and that all handling and storage of the transcripts would be done away from probation premises. This was to ensure interviewees felt able to talk openly and honestly with the interviewer.

As with the offender interviews in study 2, contemporaneous hand written notes were taken by the researcher during the interview and added to from memory immediately following the interview or within 24 hours (following a method introduced by Orford et al., 2005). In the agency interviews, at t2 (at the end of the evaluation project), a fellow researcher accompanied the interviewer to the

agency interviews to take the handwritten notes, again adding to the notes from memory within 24 hours of the interview. This approach to recording the interviews was taken in an attempt to expedite the analysis and enable the findings to be fed back to the team in a timely manner. There was also concern that due to the placement of the researcher within the probation service the probation staff may not be comfortable with interviews being tape recorded. Again, as in Study 2 it was deemed more important to try and maximise co-operation from those interviewed than ensure an exact verbatim record of the interviews. The interview transcripts varied in length, with interviews with DTTO staff ranging from 1500 to 2000 words and interviews with staff from other agencies ranging from 750 to 1500 words.

The DTTO staff interview transcripts were anonymised by year of interview, i.e. t1, interviewed on joining the DTTO team, t2, interviewed after being in post for a year and t3 on leaving the DTTO team. Interview transcripts were then organised by job role i.e. case manager (C) and PSOs (P) with numbers allocated according to interview order.

Agency interviews were anonymised by simply allocating a number based on the order in which the interviews were conducted with a prefix for the time period in which they were interviewed, e.g. S for interviews conducted at the start of the evaluation and R for repeat interviews. The only exception to this was where it was felt the agency from where the staff came was significant in the analysis, for example in the section on interagency relationships and the impact

of DTTOs on individual agencies. In these cases, a prefix was used to identify the agency e.g. CDT for the local community drug team.

Analysis

The transcripts consisted of the handwritten notes from the interviews. These were coded and analysed by hand, by the researcher, using a template organising style and analysis (Crabtree & Miller, 1999). Analysis was conducted by hand as no software was available to the researcher at the time of initial analysis. The starting point for the template was the interview schedule, so transcripts were initially organised to fit into this structure. The transcripts were then read repeatedly and emerging themes highlighted on computer printouts by hand. The emerging themes were then used as template headings and the transcripts were reorganised under these headings by rewriting sections of the transcript by hand. The template was amended as new themes were identified.

Staff and agency interviews were analysed separately with initial templates developed from the interview schedule. The template was adapted as the analysis process continued. Final templates can be seen in Appendix G and H for both staff and agency interviews.

The subthemes of both DTTO staff and agency staff were largely similar as the template was initially guided by the interview schedule. Only the themes considered relevant to the main aims of the interviews will be considered in this study. Importantly, both DTTO staff and agency staff first considered how success on DTTOs should be measured – in terms of treatment effectiveness or

compared to other available treatment options. Both groups of interviewees went on to talk about the effect of DTTOs on reducing offending and drug use and their value for money. DTTO staff further discussed why they felt offenders succeeded on orders or breached orders and what could be done to improve outcomes.

In addition to themes regarding the success of DTTO outcomes, the relationship of the DTTO team and agency staff was worth consideration as these were highlighted in the DTTO pilots (Turnbull et al., 2000) as of key importance to the success of DTTOs and may also impact on opinions of the outcomes of DTTOs, particularly for agency staff.

Results

In talking about the impact of DTTOs, the interviewees covered a range of themes as shown in an extract from the template in Table 2 below. There were important differences in opinions between DTTO staff and agency staff and these opinions also changed over time. These are therefore reported separately apart from opinions on interagency relationships.

Table 2: Sub themes for outcomes

DTTO staff interviews	Agency staff interviews
4. The definition of success on a DTTO 5. Outcomes from DTTOs <ul style="list-style-type: none">a. Overallb. Reduction in offendingc. Reduction in drug used. Why offenders succeede. Why offenders breachf. Value for money 6. Inter-agency relationships <ul style="list-style-type: none">a. Problemsb. Solutions	4. The definition of success on a DTTO 5. Outcomes from DTTOs <ul style="list-style-type: none">a. Reduction in offendingb. Reduction in drug usec. Value for money 6. Relationships <ul style="list-style-type: none">a. Positive aspectsb. Negative aspects 7. Impact of DTTOs on other agencies

DTTO staff opinions

The definition of success on a DTTO

DTTO staff considered what constituted ‘success’ on a DTTO. Whilst the aims of DTTOs were to reduce offending by reducing drug use, in practice, staff felt it was more complicated than this. Staff across all three time periods felt that success of DTTOs needed to be assessed on more than just whether offenders completed an order and were drug and offence free, but also improvements in health, self esteem, mental state and movements towards employment. As some staff explained, “*with the sort of people that we are working with anything positive has got to be good*” (t1P4) and “*If I can get a woman to stop selling her body for crack then that’s a success*” (t3P3).

DTTO staff were, however, unclear if a successful outcome on a DTTO should be complete abstinence from drugs or whether this was an unrealistic expectation for the client group and instead they should be aiming for a reduction. Staff explained “[I] think it is a success to cut drug use down” (t2C3) and “we can reduce drug use to a level where it is manageable” (t2C1). This suggests that DTTO staff were taking a harm reduction approach to drug use rather than an abstinence based approach.

Opinions on the overall effect of DTTOs in reducing offending

DTTO staff were asked what they expected the outcomes of DTTOs to be in respect of a reduction in offending. Across all three time periods, staff expected a reduction in offending for those offenders who remained on an Order, “*for those who engage for any length of time the reduction in offending is significant*” (t1C3). Staff went on to explain how this reduction would come about, which was mainly thought to be due to the substitute prescribing removing the need for offenders to have to fund their drug use, “*we are almost giving people the opportunity to handle their drug problem without having to steal*” (t2C4). Staff were realistic, however, and acknowledged that not all offending would reduce, as some offenders were thought to be too entrenched in their offending behaviours and for others, offending and drug use were thought to be unrelated (which may suggest some orders had been targeted inappropriately).

Opinions on the overall effect of DTTOs in reducing drug use

DTTO staff were largely positive in their expectations of reductions in drug use at the beginning of DTTOs and one year into the evaluation (t1 and t2). Some

staff expected DTTOs to have a “*major effect*” on drug use, while again other staff were more cautious, expecting reductions for some but not all offenders, explaining “*if [they] stay on and do activities...not for the majority for the minority it will work*” (t1P1).

Some staff, however, were not so positive, the majority of whom were interviewed on leaving the DTTO team (t3). They explained “*People just carry on using. The vast majority continue to use. If you were to measure a few clients, less than 20% would be drug free, most use all of the time*” (t3C1).

DTTO staff referred to a reduction in drug use rather than complete abstinence for all drugs. They were realistic that relapses were to be expected “*have to take a long term view as it is a long term problem – they will cease and then relapse*” (t1P2). Some staff did not view relapse as entirely negative as they felt that offenders would still have learnt some skills whilst on the order and developed resources that they could use should they choose to attempt to address their drug use at a later time.

Value for money of DTTOs

DTTO staff were asked if they felt DTTOs offered value for money. A number of staff felt that they did not have enough information about the outcomes of DTTOs to be able to make a judgement. Staff who did, however, tended to give an overall judgement and then go on to clarify that judgement by describing their basis for that decision.

DTTO staff on joining the DTTO team and after being in the team for a year varied in their opinions though the majority were positive saying "*I know that it has cost a lot of money but I think it is worth it*" (t2P2). They assessed cost effectiveness in a number of ways – in relation to reductions in offending and drug use and in comparison to other treatment or sentencing options.

DTTO staff felt DTTOs were cost effective in relation to reductions in offending "*Even if what we are doing is very expensive, if we are reducing reoffending then its worth it*" (t2C6). Closely tied into this, staff talked about reductions in drug use "*If you look at it in terms of the amount of offending needed to fund a habit which is not happening now then it has definitely more than paid for itself*" (t1C2).

In comparison to a custodial sentence, DTTOs as the alternative sentence were thought to be cheaper and gave a chance to change offenders' behaviour. In comparison to other drug treatment however DTTO staff acknowledged that DTTOs were more expensive than other locally available treatments and were unable to compare outcomes but felt the nature of the DTTO treatment (its intensity and the effect of coercion) would make it more cost effective than other treatments available.

By the time staff were leaving the DTTO team, however, they were less positive about the cost effectiveness of DTTOs. Some staff felt that DTTOs did provide value for money to some extent, referring to the comparative cost of prison,

benefits to children of drug misusing parents and reductions in offending. Other DTTO staff, however, did not think DTTOs were value for money.

Why offenders succeed

DTTO staff were asked why they felt offenders succeeded on an Order. The main reason given was, “*for whatever reason, they are totally motivated at that time*” (t3C1). Staff went on to discuss sources of motivation to change which included: big lifestyle changes (e.g. new partner or child); wanting a change in lifestyle, “*some people are just fed up with their lifestyles*” (t1P3); or wanting to avoid prison. Some staff felt that offenders viewed DTTOs as their “*best*” or “*last*” chance.

Other factors that DTTO staff felt were important in success on a order included: accurate judgements being made of motivation and suitability at initial assessment; the support that staff provided; the external support network available to those on an order such as: family members; age and maturity of offenders; stable accommodation; intensity of the order, and individual offenders’ response to pressure.

Why offenders breach

When asked why they felt offenders breached the order, DTTO staff revealed a number of key themes. Again, the main themes were related to motivation. Staff felt that offenders breached because they were not ready to address their drug use or participate in the order and had accepted an order without wanting to make changes to their drug use. Similarly, some reported offenders who

were lacking in motivation and thought breaching the order was acceptable, "They think they can get away with it. They can get away with not turning up" (t2P1). For some offenders, breach was considered inevitable due to the chaotic nature of their lifestyles, "Their lives are so chaotic – they are not used to keeping appointments" (t1P3). Tied into this were National Standards which were considered to be "harsh" for such a "chaotic group" of drug users. Group work sessions also appeared as a theme, with thoughts that offenders did not want to mix with other drug users on the groups or were signed up for inappropriate groups so not turning up as one staff member explained – "some will complain that its due to us putting them on the wrong groups e.g. non IV users on the Hep C group or clean offenders on a group knowing that there will be offers to share drugs on the walk back to [the DTTO base]" t2P3.

Other reasons given for offenders breaching included a lack of things that staff felt were necessary for success such as accommodation, support outside the order, having low-self esteem or simply relapsing into drug use. DTTO staff also identified that they did not feel equipped to handle some offenders with serious mental health problems.

Agency staff views

What is success?

There was a split in agency staff as to what they felt constituted success on a DTTO. Some agency staff felt that DTTOs should be aiming to get people drug free, "probation see success as completing their order but we think they should be drug free" (R5), while others felt that interim goals should be considered as

success such as periods of abstinence and reductions in risk drug taking behaviours, “[We] should be looking at reducing and being able to function in society as a whole” (R6). Magistrates and judges in particular were expecting a focus on reducing drug use “*Probation see success as completing the order but DTTOs should concentrate more on reducing drug use more than it does*” (Court1).

Opinions on the overall effect of DTTOs in reducing offending

Agency staff interviewed at the beginning of DTTOs largely expected offending to reduce, but were unsure by how much. Some staff expected big reductions even if only due to Orders keeping people occupied during the day and providing a substitute prescription. By the end of the DTTO evaluation, however, opinions differed. While some staff declined to answer, feeling they did not know enough about the outcomes (including the magistrates and judge), a few other staff felt offending had reduced though acquisitive crime had not necessarily reduced. Some staff felt that DTTOs had done little to reduce offending as one explained, “*For re-offending and substantially permanently changing peoples’ lives they’ve done f*** all*” (R1). Similar to interviews with the DTTO staff, explanations offered for this limited effect included the entrenched nature of offenders; drug use and offending and agency staff queried the assumption that reducing drugs would reduce crime.

Opinions on the overall effect of DTTOs in reducing drug use

Agency staff interviewed at the start of DTTOs (t1) largely expected reductions in drug use, though similar to DTTO staff, were not sure by how much.

However, by the end of the evaluation period (t2) staff from other agencies, including the magistrates and judge, felt that DTTOs had had limited effects on drug use: while some felt drug use had reduced but “*not as much as we had hoped*” (R9), others explained, “*I have seen no evidence of them making a difference to people’s drug use*” (R2). Agency staff, however, went on to identify a number of issues that they felt had limited the ability of DTTOs to reduce drug use including: the focus of the probation service on offending behaviour rather than drug use; the testing arrangements meaning offenders knew when they could use drugs; and low level prescribing practices within the team.

Value for money of DTTOs

Agency staff at both time periods were mixed in their opinions, while some felt DTTOs were value for money, others were unsure “*given the current numbers is doesn’t look like it is providing best value*” (R1). Again they judged value for money in relation to the effectiveness of the orders in reducing drug use and the cost of providing other treatments.

In relation to reducing drug use and offending, DTTOs were deemed not to be cost effective “*They’ve not made a significant impact of people’s drug use. Whether they make a significant impact on offending and reconviction rates I don’t know. They are not value for money by whatever criteria – drug use, offending, reconviction*” (R2). In comparison to the cost of custodial sentences, however, DTTOs were considered to be cost effective. Largely though, it was

the limited effect of DTTOs to reduce people's drug use that clouded agency staff opinions of cost effectiveness.

In comparison to other treatments, agency staff felt that the money invested in DTTOs would have been better spent elsewhere "*good value for money would be to close down DTTOs*" (R1). DAAT commissioners however felt that local DTTOs were very cost effective in comparison to DTTOs in other areas but that value for money depended on what was considered to be success of a DTTO.

Relationships between DTTO team and key local agencies

The pilot evaluations (Turnbull et al., 2000) identified partnership working and strong agency relationships as key to the success of DTTOs. With this in mind, and the possibility that relationships may affect agencies opinions of DTTOs, it was thought important to consider the findings on this area. Both the DTTO staff and the agency staff opinions are reported below.

While DTTO staff after recently joining the DTTO team, were able to give good examples of some relationships with other agencies, others were described as "*frustrating*" and "*problematic*". There was talk of suspicion and "*resentment*" due to the allocation of funding and other agencies struggling to understand the needs of a court order. This was particularly reported in relation to the local NHS drug treatment team. Despite this, however, DTTO staff reported relationships on a personal level to be good. Agency staff at the start of DTTOs were largely positive about inter-agency relationships, describing them as "*good*", again particularly on a one to one basis.

After a year in post, DTTO staff reported that inter-agency relationships were “improved” and “generally very positive” and at the end of the evaluation, agency staff described relationships as positive.

Both DTTO and other agency staff identified positive aspects to the inter-agency relationships. DTTO staff identified good information sharing about clients, and the extra pool of resources that other agencies were able to provide both to offenders on an order and the DTTO staff themselves, - “*they have got skills which we can learn from and use. If you have a good relationships with them you can use their expertise*” (t2C4). Agency staff identified getting people into treatment and good communication as positive aspects.

A key issue affecting the relationships, identified by DTTO staff and agency staff alike, was thought to be the different treatment philosophies between the agencies, “*there’s always going to be institutional differences in collaborations*” (R4). In line with this, agency staff sometimes described the DTTO team as “*distant*” and “*isolated*” though this was thought to be partly due to a sense of needing to keep a distance to ensure a clear distinction for clients between the different drug treatment agencies.

Impact of DTTOs on other agencies

One aspect that may have influenced other agencies’ opinions of DTTOs was the impact that DTTOs have had on their service. In interviews at the start of DTTOs, DTTOs had had very little impact on the other agencies but by the end

of the evaluation, bigger impacts were reported. Other drug agencies in the area reported increased caseloads as a result of DTTOs. The local NHS drug treatment service in particular reported an increase in workload as they received a large number of referrals from the DTTO team as orders came to an end. NHS staff identified particular issues with the clients which they felt related to the different ethos of the NHS drug treatment agency and the DTTO team.

As one agency staff member explained, “*They were given the message by the DTTO team that their illicit drug use doesn't matter if they stay out of trouble...the work we do with people is more difficult because of that*” (CDT1).

Also, despite overall reports of positive relationships between the NHS and DTTO teams, there were some reports of hostility when NHS staff talked about the impact of DTTOs on their services, – “*The team are dismayed, cynical, p****d off and [it] causes hostility because people here work their a***s off and they piss about with 10 people*” CDT4.

DTTOs had little impact on a local housing agency other than providing more access to treatment and increasing liaison between drug workers and GPs. Other local treatment agencies just reported increased workloads as a direct result of DTTOs in this area.

Discussion

Study 3 aimed to sample DTTO staff opinion about the overall impact of DTTOs and sample a variety of workers from other agencies for their opinions about the overall impact of the orders. DTTO staff and staff from other agencies had very

different opinions on the outcomes of DTTOs and even what DTTOs should be aiming for. Opinions also varied over time, with both DTTO and agency staff being optimistic as DTTOs were initially established, but being less so by the end of the evaluation or for DTTO staff, on leaving the DTTO team. Largely though, while DTTO staff felt the main aim of DTTOs should be to reduce offending and considered the project to be successful on this front, staff from other agencies and sentences felt DTTOs should be achieving a reduction in drug use, and felt that DTTOs were not necessarily successful on this front. DTTO staff identified motivation as a key factor in the success of offenders on an order and lack of motivation was one of the main reasons given for offenders failing to succeed on an order.

Other DTTO evaluations which considered staff opinions on DTTOs (Best et al., 2002; University of Essex, 2002) only considered the success of DTTOs in relation to reducing drug use. However, similar to our study, both Best et al., (2002) and the University of Essex (2002) reported that court staff – magistrates, judges and clerks saw DTTOs main aim as being to reduce drug related offending though there were mixed views on whether DTTOs were achieving this aim. Our findings support those of the University of Essex (2002) who also found that staff felt individuals' motivation was an important characteristic in achieving success on an order.

The difference in opinions on outcomes from the orders reflected the different treatment philosophies of the different agencies. The probation service seemed to still be coming from the perspective of reducing offending as the key outcome

while the health agencies still viewed reducing drug use as key. As the health service staff interviewed were not directly involved in delivering drug treatment on a DTTO (unlike DTTOs in other areas), they had retained their focus on the welfare of the individual rather than on reducing the harm of the individual to society, and in this instance because of their limited involvement with the orders, had not been 'criminalised' (Barton, 1999b). However, the fact that DTTO staff focused on reducing offending with little attention to reducing drug use suggests that the treatment and interventions received as part of a DTTO were very different to that received in a traditional drug treatment agency.

While Barton (1999b), Stimson (2000b) and Kothari et al., (2002) were concerned that the health service would have to internalise aspects of criminality, in this instance, it was the probation service who were required to internalise aspects of health treatment. The fact that they retained their focus on reducing offending suggests that they struggled to internalise aspects of health treatment.

Initially, when the DTTO team under examination was first established, there was a mix of probation staff and experienced drug workers with nursing backgrounds in the team. However, as the evaluation progressed, there was a high staff turnover. Those experienced in drug work left to be replaced with probation staff, leading to a decrease in the levels of experience in working with drug users. As the drug treatment industry expanded with the expansion of DTTOs and the introduction of the Drug Interventions Programme (DIP) there was a shortage of skilled workers (NTA, 2002) and there was a fear that this would cause "a shift towards work with more poorly understood efficacy" (Hunt

& Stevens, 2004, p 339). Without the influence of trained drug workers in the DTTO team, it would have been easy for probation staff to return to the focus of the probation service on reducing offending. Part of the role of the DTTO mental health nurses was to share their experience of working with drug users with the probation staff, while the probation staff shared their experience of working with offenders. However, once the nurses left, only the GPs remained with formal training (but no qualifications) in drug treatment and their sole role was prescribing substitute medication. This could explain the current finding that the local DTTO team focused on reducing offending. DTTO teams aiming to provide all drug treatment interventions within the probation service would be advised to keep a mix of staff skills to ensure offenders get balanced treatment.

In spite of attempts by the DTTO team to reduce issues of interagency tension by providing all treatment and interventions in house, the interviews with staff from other agencies highlighted the tensions between the agencies found by others as DTTOs were being rolled out (Barton, 1999a, 1999b; Kothari et al., 2002; Quinn & Barton, 2000; Stimson, 2000b). While partnership working between the criminal justice system and the health care system was relatively new in the drug treatment field, partnerships between health and criminal justice have occurred in other disciplines. An obvious example is the role of mental health services in dealing with mentally disordered offenders within the criminal justice system. Kurtz and Turner (2007) interviewed staff in a forensic mental health setting where staff worked with personality disordered offenders in a regional secure hospital. They found difficulties in staff trying to balance treatment aims with the need to ensure community safety. Generally, the

majority of forensic staff described these duties as being separate referring to a concern to either reduce recidivism or give priority to health care concerns.

Kurtz and Turner found that staff who were able to integrate the two tasks of the unit were those who worked more closely with community agencies and gave descriptions of comparatively positive relationships between the unit and external world. In theory, the DTTO staff also had two tasks to perform: to reduce offending (public protection oriented goal) and to reduce drug use (health care oriented treatment goal) which led to tensions between a caring and punishing role. Development of a therapeutic relationship is key to helping an individual change their behaviour in a therapeutic setting as the quality of the therapeutic alliance is known to predict outcomes (Hovarth & Symonds, 1991). Having spent time building a therapeutic relationship with an individual and then having to instigate breach proceedings (taking on the punishment role) against that individual, for example for failing to attend an appointment, will inevitably affect that relationship. The fact that DTTO staff considered success to be a reduction in offending may reflect their difficulties in integrating these two roles and the two relative aims hence focusing only on the aim relating to the criminal justice setting. As the moving of drug treatment into the criminal justice system was relatively new at the time of the evaluation, it would be worth investigating the conflict of roles and aims further to assess the impact of having to combine roles on therapeutic relationships and treatment outcomes.

Implications

The fact that DTTO staff saw their main aim as reducing offending rather than drug use has clear implications for drug treatment in the CJS. As other agency

staff identified, offenders were successfully completing their DTTO without having addressed their drug use. So, what happened to the intended drug treatment aspects of Drug Treatment and Testing Orders? The interviews in study 2 showed offenders came onto DTTOs motivated to address their drug use with some seeing DTTOs as their “last chance” to do this. If their treatment provider has no expectation for them to change their drug use or indeed, any treatment approaches to deal with it, then there is a mismatch of expectations and goals.

Yahne and Miller (1999) discussed the concept of hope and its role in treatment. They stated that hope is otherwise known as: optimism, the placebo effect, self efficacy and positive effect and considered hope to be a vital element in healing. In their theory, hope is made up of five components: hope as will, hope as way, hope as wish, hope as horizon and hope as action. (This broadens out previous theories of hope which were based only on hope as will and hope as way (e.g. Snyder, 1994)). Hope has been described both as a trait (e.g. being hopeful all of the time) and a state (feeling hopeful at the moment). Inspiring hope has been described as a practitioner’s first duty to the client and a major contribution to treatment (Pipher, 1996). Higher levels of hope, as self efficacy, have been shown to be correlated with longer abstinence from substance abuse (Irving, Seidher, Burling, Pagliarini, & Robbins-Sisco, 1998). Yahne and Miller (1999) described the job of counsellors and therapists, on occasion, as providing the client with hope when the client has none of their own. But, if treatment staff hold no faith in the ability of their treatment to address drug use, then how can they build that hope in others? Additionally, in

the case of DTTOs, it appears that even though some clients came to DTTOs motivated and hopeful to change their drug use (see study 2), the DTTO staff perhaps had no hope that they would be able to address their drug use. For those offenders who were motivated and hopeful and saw DTTOs as a 'last chance' to address their drug use, failing to do this whilst on a DTTO would severely affect their hope that they would ever be able to address their drug use and become drug free.

In motivational interviewing (MI), hope is considered to be a critical aspect of motivation. In MI a person's hope or self efficacy is defined as their confidence in their own ability to change (Miller & Rollnick, 2002). Repeatedly individuals come to treatment wanting to change but with no hope that they can do this (Yahne & Miller, 1999) and this could be particularly true in coerced treatments. Motivational Interviewing provides clinicians with a number of tools to assess and build confidence (e.g. using evocative questions, the confidence ruler, reviewing past successes, a focus on personal strengths, and hypothesising about change – Miller & Rollnick, 2002). But where clinicians have no belief or experience in the treatment they provide, these tools will be ineffective.

As in Study 2, motivation to change was identified by DTTO staff as a key issue affecting success on the orders. This is in line with the literature on motivation in voluntary drug treatments (De Leon, Inciardi, & Marinis, 1995; Hiller, Knight, Leukfiled, & Simpson, 2002; Joe, Simpson, & Broome, 1998; Ryan, Plant, & O'Malley, 1995; Shen, McLellan, & Merrill, 2000; Simpson, 2001; Simpson, Joe, & Rowan-Szal, 1997; Simpson, Joe, Rowan-Szal, & Greener, 1995). DTTO

staff felt success on an order was determined by motivation and the main reason they gave for offenders breaching the order was a lack of motivation. This has implications for DTTOs. Staff identified the accurate assessment of motivation as important when assessing suitability for a DTTO but stated such an assessment was hard to do, particularly for offenders assessed in custody. The initial targeting criteria for the local DTTO team stated that offenders must have displayed motivation by "having approached a substance misuse treatment agency regarding maintenance or detoxification in the last two years" (Flannery, n.p.) though this contradicted the national aim of using DTTOs to access a new group of drug users (Hayes, 2002). The criteria then went on to say, "motivation will be fully assessed by the DTTO team". What this full assessment of motivation consisted of is unclear. It is known that offenders were considered not suitable for a DTTO if they had shown a previous lack of compliance with community orders as this was considered to demonstrate a lack of motivation (see Study 1, Table 3). Assessment for a DTTO was conducted using the standard probation assessment tools: initially the Assessment, Care Recording and Evaluation System, (ACE) – developed by Warwickshire probation service and the University of Oxford, (see Raynor & Kynch, 2000 for further information); later replaced by the Assessment Evaluation and Monitoring System (AEMS – Gibbs, 1999) which was later replaced by the Offender Assessment System (OASys) (OASys Project Team, 1999). These assessment tools focus on motivation to address offending rather than drug use and motivation to address one aspect of behaviour does not necessarily equate to motivation to address other areas of behaviour as well. While the aim of DTTOs was to reduce offending it intended to do this by

reducing drug use so therefore, offenders motivation to address their drug use is key. DTTO staff did attempt to place offenders on Prochaska and DiClemente's transtheoretical stages of change model (DiClemente & Prochaska, 1998; Prochaska & DiClemente, 1992) in relation to their drug use. This model suggests that there are five stages of change: precontemplation, contemplation, preparation, action and maintenance, with people showing different behaviours and attitudes (and motivation) in relation to change at each stage. An offenders' stage was determined simply through conversation around the topics of drug use, change and previous attempts at treatment. Those in the preparation and action stages of change were considered by DTTO staff to be sufficiently motivated to be suitable for a DTTO. However, Prochaska and DiClementes model looks at 'readiness to change' which, according to Miller and Rollnick (2002) is only one of three critical components in motivation, the other two being willing (an individual's perception of the importance of change) and able (an individual's confidence in the possibility of change). By looking only at an individuals' readiness to change their full motivation is not assessed. Additionally, it is not possible to assess motivation to address drug use based on an individual's previous compliance with community orders, orders which were never intended to address drug use. This is a probation assessment of risk rather than an assessment of motivation to address drug use.

Assessments of motivation need to consider what aspects of behaviour an individual is motivated to change.

Given that offenders were being coerced into treatment, i.e. if they did not agree to a DTTO they were likely to serve a custodial sentence, offenders had a good

reason to appear motivated to address their drug using or offending behaviour. This is especially important given the fact that almost half of all offenders sentenced to a DTTO in the study area were in custody at the time of sentence (see Study 1). This was a much higher rate than was found in other areas (e.g. Scotland, Eley et al., 2002). With this in mind, accurate assessment of motivation to change offending or drug use behaviours for this client group would have been hard to achieve. Instruments to measure motivation to address their drug use, and in particular a person's stage of change have been developed e.g. the Readiness to Change Questionnaire (Rollnick, Heather, Gold, & Hall, 1992). Inclusion of these at DTTO assessment would perhaps have aided probation staff in their assessment of offender motivation to address their drug use. Additionally, some other probation areas (e.g. Scotland, Eleu et al. 2002) chose to adjourn sentencing for a period in order to allow assessment of motivation through attendance at arranged appointments and engagement with treatment offered during this intervening period. This may be worth considering for all probation areas to enable a better assessment of motivation to address drug use prior to offenders starting an order for drug treatment.

As treatment in the CJS is coerced, thus making assessment of true motivation difficult, perhaps a larger proportion of treatment time, at least initially should be used to build and maintain motivation to address drug use. One possible way to do this would be with the use of structured techniques such as Motivational Interviewing (Miller & Rollnick, 2002) or Motivational Enhancement Therapy (National Institute on Alcohol Abuse and Alcoholism, 1995) designed to work on ambivalence and increase motivation. Some attempts have been made to use

motivational interviewing techniques in criminal justice populations to engage offenders in treatment programmes (Miller & Rollnick, 2002). These techniques work to engage clients in treatment, i.e. to be ready, willing and able to make changes in their behaviour. With this in mind, it is important for DTTOs to address their issues around what drug treatment should consist of before MI and MET could be used effectively. Increasing motivation to engage in treatment without having established a drug treatment programme, including the use of qualified drug treatment staff, is pointless. The use of therapies to increase motivation will be considered further in the full thesis discussion in chapter 7.

Methodological issues

Potter and Hepburn (2005) highlighted a number of issues with qualitative interviews which need to be considered for truly transferable results. Of particular relevance to the current study is a failure in the analysis to acknowledge the interviews as an interaction in which the interviewer played a role. Transcripts from the interview contained only notes on the responses of the interviewee; there is no record of the interviewers' speech, questions or encouragement. The interviewers' questions, prompts and encouragement may all have affected the way in which the questions were answered by the interviewee. By not including the interviewers' speech in the transcripts, their impact on the interviews is lost. However, this method of recording the interview was chosen specifically to be quick, easy and less intimidating to participants.

Another issue is the relationship between the interviewer and interviewee (referred to by Potter & Hepburn, 2005 as the footing or speaking position).

While the interviewer was employed by the NHS and seconded to the probation service, the interviewer was often seen by DTTO staff as external to the DTTO team and by NHS staff as 'one of their own'. Given the frictions that were reported between the DTTO and NHS teams this needs to be considered. The interviewer attempted to make clear in all interviews their position as an external researcher in order to aid interviewees to feel able to talk openly and honestly. However, DTTO staff could have limited their responses because of the researcher's links with the NHS drug team in terms of supervision and management. Similarly, the NHS drug team could have felt unable to give open and honest responses due to the fact the interviewer was largely based with the DTTO team.

Conclusions

DTTO staff and agency staff had differing opinions on what constituted success of DTTOs. While there are a number of possible explanations for this such as differing treatment philosophies and the inability of probation staff to integrate their public protection and health oriented roles it would be interesting to compare opinions of what constitutes success on DTTOs between treatment agency and probation staff who co-deliver DTTOs. Obviously the opinions of the staff in delivering the treatment affect the outcomes of the order, so it appears that in this locality treatment on DTTOs was simply focusing on reducing offending, perhaps due in part to the loss of drug treatment

experienced staff over the first year and the probation setting in which the programme occurred.

Offenders' motivation to change was identified by DTTO staff as important in ensuring success on the orders. In particular DTTO staff felt that assessment of motivation when assessing an offenders' suitability for an order was key. It appears that being coerced into treatment does not mean that offenders are lacking in motivation but those that are motivated, may have a better chance of success. Assessment of motivation is therefore important. However, accurately assessing motivation in coerced treatment will necessarily be hard. Possible methods for improving assessment of motivation in coerced treatments is to use validated measures or to offer motivation related treatment for a short period of time before sentence purely to assess motivation. However, in order to make full use of increases in motivation, effective interventions and treatment delivered by qualified drug treatment staff needs to be in place for motivated individuals to engage with. Without these treatment and interventions focusing on drug use there is little point in increasing offenders' motivation to change their drug use. This treatment provision could be achieved through the merger of probation and health teams, working co-operatively and making use of each others skills as has been the case in other probation areas or through the probation service hiring qualified drug workers to provide the drug treatment aspects of the orders.

Chapter 5

Study 4 - Drug Testing in the criminal justice system: Solutions to a costly commodity¹

Introduction

Drug testing in the UK criminal justice system (CJS) was first introduced as part of community sentences under the Crime and Disorder Act within Drug Treatment and Testing Orders (Home Office, 1998a, Sections 61-64). While drug testing in the community as part of a court order is a relatively new approach to dealing with drug misusing offenders in England and Wales, in the USA, drug testing is one of four key components of their drug court model (National Associate of Drug court Professionals, NADCP, 1997). To date there are more than 16,000 operational drug court programmes in the USA (Huddleston, Freeman-Wilson, Marlowe, & Rouseell, 2005); they target low level offenders, the vast majority aiming for abstinence from drugs (Bean, 2004). Evaluations of such drug courts link drug court participation to a reduction in drug use and recidivism (Cosden, Bosch, Campos, Greenwell, Barazani, & Walker, 2006; Henggela, 2007; Rodriguez & Webb, 2004). However, as discussed in chapter 1, research on US drug courts has been criticised on methodological grounds and little can be said with any certainty

¹ A shorter version of this was published as: Powell, C., Christie, MM., Bankart, J., Bamber, D., Arrindell, T. (2009) Drug Testing in the criminal justice system: Solutions to a Costly Commodity. *Journal of Substance Use*, 14 (6), 393-407.

about the effectiveness of drug courts over the longer term in tackling substance use (Belenko, 2002).

Carver (2004) discussed the use of drug testing as part of these American drug courts describing it as

“the objective measure of how the participant is doing. It cuts through the denial and dishonesty that is so much a part of addiction” (p. 143).

He goes on to discuss flaws in the implementation of drug testing in the US.

These include infrequent testing, testing on scheduled reporting days, a lack of internal controls enabling offenders to manipulate the results and no action being taken on positive drug test results.

Unlike the USA drug court system, where the aim is to achieve almost immediate abstinence from drugs, DTTOs seemed to operate under a philosophy of harm reduction rather than abstinence (Bean, 2004; Study 2). On the DTTOs drug testing is only used as an indication of compliance, with a requirement for testing on a frequency set by the court at the time of sentence (minimum of twice a week - Home Office, 2001a). It is not tied to sanctions (i.e. test results are not used in isolation to initiate breach proceedings - Home Office, 2000) or rewards to increase participation in treatment.

Drug testing has now become a routine part of the criminal justice system in England and Wales (e.g. ‘on-charge’ testing, ‘pre-sentence’ testing, and Drug Rehabilitation Requirements (DRRs which replaced DTTOs)). It has been used to identify those who would benefit from treatment, encourage access to

treatment, and monitor progress and drug use while on community orders (Home Office, 2001b). A Home Office (2004b) evaluation of drug testing reported that at the point of being charged with an offence, only 7% of offenders thought drug testing would reduce their drug use and 11% thought that it would reduce offending. If it was believed that drug test results would be shown to the courts, 30% anticipated they would reduce their drug use due to fear of harsher sentencing or having to enter a treatment programme. For offenders on community orders 60–70% believed that drug testing *would* or *did* help to reduce their drug use; only 30% reported that it made ‘no difference’. Yet despite such positive beliefs about drug testing, no significant relationships were found between drug test results and subsequent drug taking behaviours. Only 9% of a group of 65% of offenders followed up after failing to attend for testing, reported concern about testing positive for drugs. This reduces criticisms that the data was biased due to offenders not attending testing appointments for fear of testing positive for drugs. The authors concluded that drug testing simply offered opportunities to discuss treatment options with the resultant increased access to services probably affecting outcomes rather than the drug testing per se. Weak evidence emerged that drug testing also led to an increased recognition by some offenders that they had a drug problem and this was thought to have a direct effect on reducing both drug misuse and offending as well as increasing treatment-seeking (Home Office, 2004b).

In a meta-analysis to assess the effectiveness of criminal justice treatment programmes in reducing drug related crime, Holloway, Bennett and Farrington, (2005) found no evidence that routine monitoring drug testing worked to effect

positive outcomes (Holloway et al., 2005). Carver (2004) pointed out that, "when done poorly, drug testing is not only a waste of money but may actually hinder recovery" (p. 164). However, interviews with offenders on DTTOs showed that they considered drug testing to be a positive requirement of the order; the majority were in favour of routine testing, explaining that it was a motivating factor in reducing their drug use even if only immediately prior to days on which they knew they would be tested (McSweeney, Stevens, Hunt, & Turnbull, 2008; Study 2).

Drug testing data were collected routinely for the duration of a drug user's contact with a DTTO team, although currently no attempts have been made to examine such data. Whilst some basic analysis of drug testing data was conducted in the evaluation of the pilot DTTO schemes (Turnbull, McSweeney, Webster, Edmunds, & Hough, 2000), supplementary self-reports from offenders were also used. The only evaluation that attempted to use drug testing data was the Scottish pilots (Eley, Gallop, McIvor, Morgan & Yates, 2002) who reported they found a steady decrease in positive drug tests at different stages of the order. Due to non-attendance for testing appointments this data was calculated on individuals test number (i.e. first, second, third, fourth, fifth test etc.) rather than on actual time spent on an order. Of 21 offenders who had reached 15 tests, 55% of the 15th test for these individuals was positive for opiates. Although the numbers are limited, this is an improvement on the percentage of 1st tests that were positive which was 79%. Other DTTO evaluations were based solely on self reports of drug use (Best, Man, Morrison-

Rees, Witton, & Strang, 2002; Eley et al., 2002; McSweeney, Stevens, Hunt, & Turnbull, 2007; Wiggans & Libby, 2002).

Although self reported drug use has been shown to be relatively reliable (Barnea, Rahav, & Teichman, 1987) lower levels of agreement between them and drug test data have also been found. Neale and Robertson (2003) found high levels of concordance between self-reported drug use for the previous three days and oral fluid testing results: 94% concordance for methadone and 86% concordance for opiates. Darke, Hall, Heather, Wodak, & Ward, (1992) and Zanis, McLellan, & Randall (1994) produced similar findings. However, there have been suggestions that concordance between self-report and test results in chaotic and young drug users will be lower than in stable and older addicts (Kilpatrick, Howlett, Sedgwick, & Ghodse, 2000; Magura, Goldsmith, Casriel, Goldstein, & Lipton, 1987). Given that DTTOs were aimed at the more severe chaotic drug misusing offenders this raises some concerns regarding the reliability of self-reported data in such a group. Similarly, an evaluation of Mandatory Drug Testing (MDT) found that self-reported drug use significantly underestimated actual drug use, though MDT served as a deterrent for a small proportion of prisoners, mainly cannabis users (Singleton, 2005).

Since drug testing data are readily available for offenders on a DTTO it seems important to examine them in order to see if such data can add to the findings of self-report studies into drug use during drug treatment in the criminal justice system. And, whilst DTTOs have now been replaced with Generic Community

Orders with Drug Rehabilitation Requirements (DRRs, Home Office, 2004a) drug testing continues on DRRs.

This chapter examines drug testing data from offenders on a DTTO collected over a four year period as part of a larger evaluation in one UK probation area. The larger evaluation used quantitative and qualitative methods to assess the impact of one DTTO programme on reducing crime and drug use. Included in the evaluation were interviews with DTTO staff which are also worth consideration.

Aims

This chapter has two aims. Firstly, to use drug testing data to examine changes in offenders' drug use whilst on a DTTO. Secondly, to examine the opinions of DTTO staff who administer drug tests and explore their experiences of the new initiative of drug testing in the criminal justice system in England and Wales.

Quantitative Methodology

Participants

All 331 offenders given a DTTO in the study area between November 2000 and September 2004 were required to undergo a drug test at least twice a week. Offenders consented to use of their drug test results in this evaluation at the time of consenting to a DTTO.

Drug test results were available for 317 offenders (96%); the remaining 14 offenders had breached their order or committed further offences within one month of starting their DTTO. They were then out of contact for the duration of their order (hence were not tested for drugs).

Only offenders with a known outcome for their DTTO (i.e. DTTO expired, terminated early due to good progress, and DTTO revoked and resentenced) and at least two months worth of drug testing data were included in the statistical analysis (n=224). Offenders whose DTTO was ongoing were not included in the analysis. Where offenders had multiple DTTOs, only their first order was examined. Such offenders must have breached their original order or committed further offences to receive a further DTTO so, for the purposes of analysis, their order outcome was considered to be negative.

Descriptive statistics and other factors taken from the standardised probation assessment paperwork for offenders with a known DTTO outcome and at least two months worth of drug testing data (n=224) are shown in Table 1. There were no significant differences between this sample and the full sample of 331 offenders in terms of demographic variables such as age and gender.

Table 1: Descriptive Statistics for sample with a known DTTO outcome and at least two months of drug testing data (n=224)

Variable	Values	N	Percent of sample
Age at assessment (binary)	<= 25 > 25	114 110	51% 49%
Age at assessment (continuous)	mean = 26.5, SD = 5.92		
Gender	Male Female	190 34	85% 15%
Ethnic Group	White Other Unknown	208 13 3	93% 6% 1%
Trigger Offence	Theft Other Unknown	114 103 7	51% 46% 3%
Employment	Unemployed Other Unknown	165 36 23	74% 16% 10%
Sentencing Court	Magistrates Crown Unknown	151 70 3	68% 31% 10%
Residence at time of sentence	Remanded in Custody Community Unknown	97 116 11	43% 52% 5%
Sentence length	<12 months 12 months 13-17 months 18 months 19-24 months	9 123 14 44 34	4% 55% 6% 20% 15%
DTTO Outcome* (binary)	Positive Negative	89 1355	40% 60%
DTTO Outcome (all)	Revoked New DTTO Expired Good Progress	105 30 69 20	47% 13% 31% 9%

* Positive category includes: Expired and Good Progress. Negative category includes Revoked and New DTTO

Measures and Procedure

The DTTO in the study area used two methods of drug testing: urinalysis for the first 26 months, followed by saliva swab testing. Offenders admitting to using illicit drugs in the two days prior to testing could sign a waiver to this effect (interpreted as a positive test result for the purposes of analysis). Between April 2003 to March 2004 1.7 tests per week per offender were conducted (a range from one to 15 tests per offender per month²) (if offenders were tested twice a week an average of nine tests per month would be expected). It is unknown whether this lower rate of testing was due to offenders failing to attend appointments or DTTO staff not arranging sufficient testing appointments. All urine tests were unobserved due to a lack of qualified staff. Urine samples were sent for laboratory analysis at a local hospital. The introduction of saliva testing meant all tests could be observed and a combination of on-site and laboratory analysis used.

Only test results relating to the presence or absence of opiates were used: the majority of offenders were primary opiate users and this was the only drug testing data available for the entire study period. Prescribed opiate drugs (i.e. methadone and buprenorphine) were not monitored as they were not tested for regularly. Length of DTTO actually served was calculated based on commencement date and either revocation or order expiry date.

Individual test results were recorded by administrative staff on a computer information system and downloaded by the researcher seconded to the

Probation Service from a drug treatment research team. Data were summarised for individual offenders by month of order based on the date of the first drug test sample being taken.

Statistical Analysis

A General Linear Model was used to determine which of our Independent Variables best predicted our Dependent Variable ‘change in percent drug free test results’ over the duration of an individual’s contact with the DTTO team, (i.e. percent negative tests in the final month minus percent negative tests in the first month of an order). The IVs were the main expected predictors of change in drug use: Sentenced in a Magistrates or Crown Court, Starting the DTTO remanded in custody (RIC) or in the Community, Age, Trigger Offence, Employment status, Order Length, Ethnicity and Gender³. Residence at time of sentence was not included as a variable as it was not expected to influence drug use. Order outcome was excluded as change in drug use preceded order outcome so order outcome could not predict change in drug use.

The residuals from the final General Linear Model were normally distributed with minimal skewness and kurtosis. Visual inspection of the histogram of the residuals was symmetrical and approximately Gaussian (see figure 1). No formal tests were conducted due to the large size of the sample population. Skewness and kurtosis statistics were both less than two times their standard

² DTTOs in other areas also experienced a lower rate of testing than anticipated, (see Best et al., 2002, Turnbull et al., 2000)

³ Criminal history was not included as a predictor of change in drug use as no reliable information was available on this from probation records. Previous conviction frequency is considered however for a sample of offenders in chapter 6 in relation to reconviction rates.

error (Skewness=0.15, standard error of skewness=0.41, Kurtosis=0.24, standard error of kurtosis=0.34) therefore there was no significant skewness or kurtosis. There was homogeneity of variance as can be seen in figure 2. Although, the plot does not display purely random variation there is homogeneity of variance as as the predicted values increase there is no corresponding increase in the variability of the residuals.

Figure 1: Histogram of the residuals

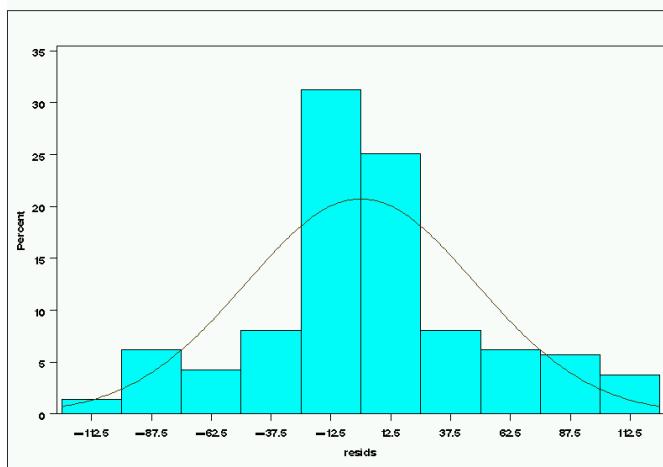
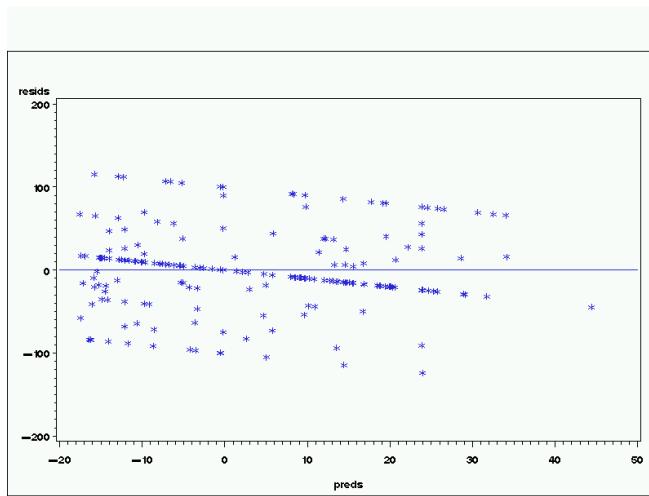


Figure 2: Scatterplot of the association between the residuals and predicted values



Qualitative Methodology

The overall evaluation project included one- to two-hour semi-structured interviews with 17 DTTO staff covering opinions on various aspects of DTTOs. Of relevance to this chapter are their opinions about drug testing (see question 3 in interview schedule in appendix E). They were interviewed at the start of the evaluation or on appointment to the DTTO team (n=8); and when in post for more than one year or at the point of leaving the team (n=9).

All interviews were conducted by the researcher. Contemporaneous notes were taken during the interviews rather than audio-taping in order to maximise staff co-operation (see the methodology in study 3 for more information). Data were transcribed, coded and analysed by hand using template organising style and analysis (Crabtree & Miller, 1999) as reported in study 3.

Results

Quantitative Results

The distribution for number of months for which drug tests were available was positively skewed (Figure 3). Few offenders had drug tests available after 12 months as the majority were sentenced to 12 month orders. Only 7% of offenders had data for 13 or more months. The high number of offenders with only a few months of drug testing data (54% had five or less months of drug test results) was due to offenders not attending testing appointments, being out of contact with the team (in breach of their order) or having their order revoked.

Figure 3: Number of months with Drug Test Results

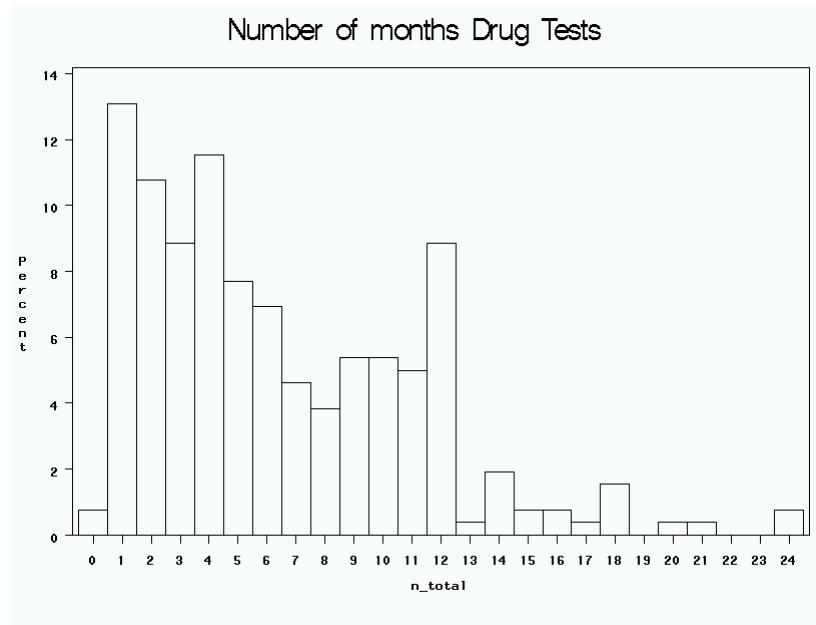


Table 2 shows changes in negative drug tests over the duration of the order regardless of the order outcome (i.e. expired, order revoked and offender resentenced). A negative score means a decrease in negative drug tests.

Table 2: Changes in Percent negative tests by Category: Who Improved?

	Average percent drug free first month of order(n)	Average percent free last month of order (n)	Average change (Last month –First month) (n)
OVERALL	29.99 (224)	35.80 (224)	+5.8 (224)
Age			
Age <= 25	31.9 (114)	34.2 (114)	+2.6 (114)
Age > 25	28.3 (110)	37.4 (110)	+9.1 (110)
Sentencing Court			
Magistrates	22.45 (151)	32.60 (151)	+10.1 (151)
Crown	45.90 (70)	40.43 (70)	-5.5 (70)
Residence at time of sentence			
RIC	44.98 (97)	39.21 (97)	-5.8 (97)
Community	17.22 (116)	31.46 (116)	+14.2 (116)
DTTO outcome			
Positive DTTO outcome	31.97 (89)	51.61(89)	+19.6 (89)
Negative DTTO outcome	28.68 (135)	25.38 (135)	-3.3 (135)
Sentence length			
Order length given up to 12 months	33.2 (110)	37.0 (110)	+ 3.9 (110)
Order length given 12 to 18 months	31.9 (45)	44.60 (45)	+14.1 (45)
Order length given 18 to 24 months	27.7 (69)	30.6 (69)	+ 3.6 (69)
Order length served			
Order length served Up to 12 months	32.1 (140)	32.7 (140)	+ 0.6 (140)
Order length served 12 to 18 months	27.2 (74)	37.9 (74)	+10.7 (74)
Order length served 18 to 24 months	21.4 (10)	63.4 (10)	+42.0 (10)

* Positive DTTO outcome includes: Expired and Good Progress. Negative DTTO outcome includes Revoked and New DTTO

Out of 224 offenders with a known DTTO outcome and at least 2 months of drug tests results, 67 (30%) had a better last month than first month (i.e. lower

drug use in their final month indicated by a higher percent negative drug tests in their last month on the order than the first month). 108 (48%) had the same percent negative drug tests for the first and last month of their order, of whom 19 (18%) had all negative drug tests and 49 (22%) had a worse final month than first month.

Age is associated with change in percent negative tests, with those aged over 26 improving by 9%, and those younger than 26 improving by only 2.5%. However, this was not found to be significant either in a univariable model or after adjusting for the effects of significant predictors (see table 3).

Table 3: Univariable Tests of association with change in drug use

Predictor	beta	95% cl (beta)	P	r-squared
Age Group 25+ v <25	6.5*	(-6.6, 19.6)	0.33	0.004
Gender Female v Male	18.0*	(-0.4, 36.3)	0.06	0.02
Ethnic Group Other v White	0.26*	(-29.0, 29.5)	0.99	0.000001
Employment Employed v Unemployed	-2.05*	(-20.9, 16.8)	0.83	0.0002
Trigger Offence Other v Theft	-2.4*	(-15.8, 11.0)	0.72	0.0006
Residence at time of sentence Community v RIC	19.3*	(5.8, 32.9)	0.005	0.04
Sentencing Court Crown v Magistrates	-16.6*	(-31.3, -1.9)	0.03	0.02
Sentence length	0.35 +	(-7.2, 7.9)	0.93	0.0
Order length served	0.04 +	(-0.006, 0.09)	0.09	0.01

* beta coefficient refers to the difference in mean values for these categorical variables. A positive difference means the first category has done better (so Community does better than those RIC).

+ beta coefficient represents the increase in the dependent variable for a 1 unit increase in the predictor

Table 4 shows variables which were found by a GLM to be significant predictors of change in drug use (i.e. change in percent negative drug tests comparing first and last month). Non-significant variables included: employment status, gender, trigger offence, and length of DTTO sentence.

Table 4: Change in percent negative drug tests as a function of candidate predictors

	F	P	LS Means	Change in drug use
Sentencing Court	5.12	0.0247	Crown (65) Magistrates (146)	- 10.7 + 7.1
Residence at time of sentence	0.64	0.4254	Community (115) RIC (96)	+ 1.3 - 4.9
Order length served	5.01	0.0263	N/a	n/a
Sentencing Court* Residence at time of sentence	5.51	0.0199	Crown / Community (21) Crown / RIC (44) Magistrate / Community (94) Magistrate / RIC (52)	- 16.7 - 4.8 + 19.3 - 5.1

LS Means were evaluated at time = 268 (9 months)

n.b. only 211 observations were used in this analysis due to missing data on sentencing court and residence at time of sentence

A positive association was found between the change in drug use and order length served. The longer an offender was on an order, the greater the increase in percent negative drug tests, suggesting the longer an offender is in treatment the greater their reduction in drug use. However, this could also be down to self-selection whereby those who would ordinarily do better on the order remain on it for longer.

An interaction was found between sentencing court and residence at time of sentence. This showed that offenders with the greatest 'improvement' in their drug use (i.e. an increase of 19% in percent negative tests) were those

sentenced in a Magistrates Court who started their order from the community. However, this group of offenders started with the lowest percent negative drug tests (11%) and ended with the lowest percent negative tests for the final month of their order (29%). This is not entirely surprising given that offenders starting orders from the community are likely to have higher levels of drug use at the start of their orders (i.e. lower percent negative drug tests) and therefore have more room for improvement.

Offenders who showed the least ‘improvement’ (decrease of 17% in percent negative tests from 46%, i.e. an increase in drug use) were those starting their order from the community, sentenced in a Crown Court. For an offender to be sentenced at Crown Court, their current offending, or offending history, would need to be serious enough to warrant the greater sentencing powers of the Crown Court. These perhaps are then the most chaotic of drug users.

Offenders starting their order following a period RIC had the same outcome (5% reduction in percent negative tests, i.e. an increase in drug use) regardless of where they were sentenced. Again, it would be expected that offenders starting their order following a period RIC would have lower drug use (i.e a higher percent negative drug tests) due to being in custody and having limited access to drugs. There is therefore some expectation that there would be some increase in drug use once released to the community.

As the drug test results preceded the order outcome it was not possible to model change in drug use on a DTTO as a function of DTTO outcome (as the

drug tests preceded the outcome). However, DTTO outcome was also significantly associated with the change in drug use (see table 5). As one would expect, those whose DTTO expired or was terminated early for good progress showed an increase in percent negative drug tests (20%), and those whose order was revoked and the offender resentenced showed a decrease in percent negative drug tests (3%). The two groups started their DTTOs with similar levels of percent negative drug tests (the revoked group started at 30% and ended at 28%, the expired group started at 32% and ended at 52%).

Table 5: Analysis of the association between DTTO outcome and percent change in drug use

Predictor	beta	95% CI (beta)	p	r-squared
DTTO Outcome* Expired v Revoked	22.7	(9.4, 35.9)	0.0009	0.05

If we look at offenders for whom we have data for most of the 12 month period (n=56, Table 6), there is a slight improvement in percent negative tests, from 29% in the first month to 35% in the 12th month. Month 12 was not necessarily the end of the order for this group, as their mean time actually served on the order was 14.1 months. 86% of these offenders successfully completed their DTTO, whilst 14% had their order revoked.

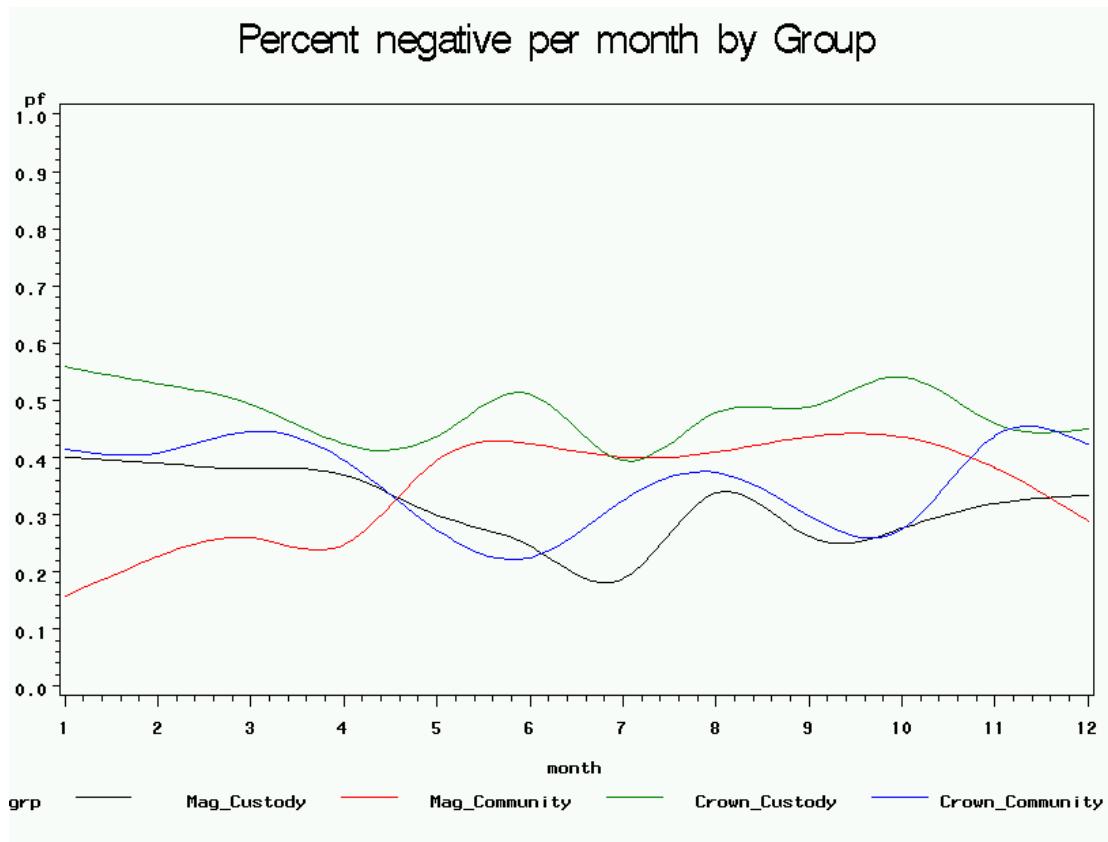
Table 6: Percent Negative Drug Test by Month of DTTO for those on a DTTO for at least 12 Months

	Drug tests for at least 12 months	
Month of order	N	Mean percent negative drug tests (sd)
1	54	29% (40)
2	54	32% (41)
3	52	34% (41)
4	50	34% (40)
5	50	34% (43)
6	52	37% (43)
7	50	32% (41)
8	51	35% (41)
9	51	38% (45)
10	51	34% (43)
11	53	38% (44)
12	56	35% (46)

It is also possible to see changes in drug use for the different sentencing courts (Crown versus Magistrates) and residence at time of sentence (custody versus community) for this group as found in the statistical model. This shows the large amount of variability in drug use over the 12 months (see figure 4). Offenders sentenced in the Magistrates Court, starting their order from community demonstrated the greatest reductions in drug use (i.e. increase in

percent negative drug tests), especially in the first few months of the order. All offenders with relevant data are included.

Figure 4: Percent Negative drug tests over time as a function of sentencing court and location (n=288)



Qualitative Results

Staff opinions on drug testing differed according to when they were interviewed. For those interviewed at the start of the project or on appointment to the DTTO team (n=8), five viewed drug testing positively saying “*its helpful when challenging offenders about their drug use*” (SC1). Three acknowledged that although drug tests were generally useful, there needed to be clarification as to

their purpose and how to interpret results. One staff member felt that drug tests were of limited value conducted merely to fit in with public perception of what should be done. Five staff expressed disappointment that individual drug test results were unable to show the amount of drugs used “*the tests only show pass or fail, could be more in depth*” (SP4). One considered urine testing to be “*degrading*”. Although urine tests were unobserved, two staff members were surprised at offenders’ compliance with testing with perceived low levels of cheating.

Those with more experience of drug testing on DTTOs (interviewed more than a year into the project, n=9), had lower expectations than new staff, although almost half (n=4) still viewed drug testing positively: “*it’s absolutely vital; testing is a vital part of treatment. Court, victim and public are allowed to expect people to be held accountable*” (RC6). The change to saliva testing was particularly viewed as an improvement on urinalysis as it allowed observation of samples being taken. However, three staff members expressed concern at the time taken to obtain test results thereby delaying treatment planning and preparation of court reports. Despite on-site testing facilities, the majority of samples were sent for laboratory analysis to save staff time, resulting in a time lag between testing and receipt of the result.

One staff member gave instances of drug test results not being fed back to offenders and a further two felt that test results were fed back too late to be of any clinical use; that is, offenders were not challenged about positive drug results or were not held to account for these results, “*I think it should be made*

clear that if you test positive you will be breached, especially if you are on a methadone script. I don't think we should be giving scripts to people who are still using without even giving them a slap on the wrists" (EC1).⁴ Three staff members suggested that testing should become part of case management appointments, conducted at the beginning of appointments and analysed on-site to give a real picture of offenders' drug use.

Three experienced staff members also expressed concern that predictable testing appointments led to manipulation of the system by offenders: "*All the offenders know how many days not using will lead to a clean test; they talk about giving negative results rather than being clean*" (EP3). They suggested that increasing the reliability of testing might be achieved through more random or ad-hoc testing.

Discussion

This current chapter has examined the results of drug tests from offenders on a DTTO in one UK probation area. The data were considered to be the best available estimate of the prevalence of opiate use among those on a DTTO. Previously, only one other DTTO evaluation (Eley et al., 2002) had used drug testing data in this way before, probably due to the time taken to organise and analyse the data and problems with missing data.

⁴ Whilst initially it was expected that continued positive drug tests would lead to breach, in practice this did not happen. As can be seen in Study 1 no offenders were breached solely for positive drug tests results. However, this staff member believes that continued illicit drug use on top of a methadone prescription should result in a breach.

The results have shown that changes in drug use, (indicated by change in percent negative drug tests between first and last month of the order) were related to the sentencing court and whether offenders started their order following a period RIC or the community. Offenders sentenced from the community showed the greatest improvement in their drug use but these offenders started with the heaviest drug use. Unsurprisingly, offenders whose DTTO expired naturally or was terminated early for good progress showed significantly greater changes in their drug use than offenders whose DTTO was revoked.

Time spent on a DTTO was positively correlated with change in percent negative drug tests during the order with mean increases of 14% negative tests by month eight of an order. This could support the notion that the longer clients can be retained in treatment the better their outcomes will be (Gossop, 2005b). However, it is possible that those who are likely to do better on an order will remain on an order longer and show the best gains, i.e. these results could be due to self-selection.

The findings of this study are slightly more conservative than those found by other evaluations of DTTOs using self-report data (e.g. McSweeney et al., 2007, Turnbull et al., 2000, Wiggans & Libby, 2002). There are two possible reasons for this, firstly self-report data tends to be biased towards those who are still in contact with treatment services and prepared to attend for a follow up research interview in order to assess changes in drug use. Drug test results, however, are available for all people on an order regardless of length of treatment.

Secondly, as mentioned previously, self-report data may not be entirely reliable with such a chaotic group of drug-users. It should be noted, however, that drug testing only provides a measure of changes in frequency of drug use, not amount of drug use.

Despite the flaws in the present data, such as the low frequency of drug testing, an unknown amount of missing drug test results, and evidence suggesting it underestimates the true prevalence of opiate taking among the population studied, (Study 2), it is perhaps the most reliable estimate currently available of drug using behaviour in a group of offenders on a drug treatment order not dependent on self-reported data. It at least serves to provide a snapshot of current drug taking behaviour as results were available for the majority of months an offender spent on an order (for positive order outcomes, test results were available for 81% of months spent on a DTTO and 66% for negative order outcomes).

Missing drug test data are a huge problem in drug treatment orders, largely because offenders fail to attend appointments or case managers fail to offer sufficient testing opportunities. The current study did not obtain sufficient data to indicate why the target of at least two tests per week was not achieved. The Home Office (2004b) evaluation found that only 9% of people who failed to attend drug testing appointments whilst subject to a Drug Abstinence Order/Drug Abstinence Requirement reportedly did so due to concern at being breached, presumably for testing positive for illicit drugs (Home Office, 2004b). Some studies have interpreted failed attendance at a drug test appointment as

a positive drug test result (Barker, et al., 2002). However, there could be legitimate reasons for missing drug test appointments unrelated to drug taking behaviour. In future more inclusive data recording systems should be established to include number of and reasons for non-attendance.

It would have been interesting to examine other variables in relation to decreased drug use on the orders, (e.g. mental health and social exclusion), but as this project was funded by one probation service it was necessarily limited to their requirements and data, and that which was readily available in probation records.

Both offender and staff opinions on drug testing reported here and elsewhere (Study 2; McSweeney, 2008, Ricketts, Bliss, Murphy, & Brooker, 2002) suggest that drug testing is generally thought of as positive, helpful and motivating. However, the opportunity for offenders to manipulate drug test results through altering their drug use to avoid drug testing days needs remedying as does the lack of accountability for offenders with positive drug test results. Methods of arranging drug testing appointments in the study area varied over the evaluation period: drug testing was either regimented through use of offenders' weekly diary sheets; or on a drop-in basis in accord with twice-weekly testing. Clearly these systems were open to offender manipulation through abstaining from drugs the day before a drug test appointment – whether scheduled or drop-in. If drug testing in treatment services is to contribute to the reduction in drug use there needs to be an unpredictable and truly random system of drug testing under the control of case managers, not offenders.

Staff interviewed in the current study believed positive drug tests should result in sanctions being placed on offenders. Indeed, both the Home Office evaluation (2004b) and Carver (2004) suggest that drug testing only has an effect on drug taking behaviour if paired with sanctions. Service users have also called for a clearer threat of jail for consistent positive tests (UK Drug Policy Commission, 2008b). Carver proposes immediate sanctions, without which he feels drug testing becomes counter-productive, sending messages to drug users that there are no consequences for their continued drug use. Suggested sanctions could include increased contact hours for a limited period of time or financial penalties. Unfortunately however, if sanctions are tied to positive drug test results then more non-attendances may occur due to offenders' fear of punishment. A possible solution is to equate missed appointments for drug testing as positive for drug use, thereby instigating punishments (as in Barker, Horrocks, Kelly, & Robinson, 2002). However, offenders may have genuine reasons for failing to attend appointments that are unrelated to their drug use. Offenders are already punished for failing to attend an appointment, instigating further punishment based on a possibly incorrect assumption may simply serve to alienate offenders and damage the therapeutic relationship.

Good practice indicates that drug testing should be done within treatment sessions in order for testing to become part of treatment and enable results to be dealt with immediately and effectively. Yet, evidence suggests that it does not matter who carries out the drug testing providing they are properly trained to

conduct tests, understand the purpose of testing, understand issues relating to problematic drug use and treatment, are able to motivate offenders regarding their drug use, are in a position to sanction or inform those continuing with drug use, and are of sufficient standing to be able to give meaningful praise (Carver, 2004; Home Office, 2004b). The tester must be able to work opportunistically with offenders while waiting for results and then communicate the results to the treatment worker in order to allow prompt constructive use of the results (Home Office, 2004a).

Drug testing will remain for offenders on community orders under DRRs. As the current study has demonstrated, albeit on DTTOs, drug test results can be used as evidence for someone's degree of compliance with a drug treatment order. However, given the high costs of drug testing within the criminal justice system (Home Office, 2004a), it seems important to maximise the use of the results to aid the success of treatment programmes.

The idea of enforcing sanctions for positive drug tests is also used in contingency management (CM). CM is based on extensive literature which demonstrates a role for operant conditioning in the initiation and maintenance of drug use, including abuse and dependence (Deneau, Yanagita, & Seavers, 1969; Schindler, Panlilio, & Goldbery, 2002; Bigelow, Griffiths, & Leibson, 1975; Higgins, Heil, & Lussier, 2004). CM interventions promote behaviour change through the use of positive and negative reinforcements and sanctions dependent on individuals meeting therapeutic goals or the occurrence of undesirable responses e.g. continued drug use (Higgins, Silverman, & Heil,

2008). In CM failed drug tests could result in a positive or negative punishment (e.g. a verbal reprimand, or the removal clinic privileges such as take home prescriptions). Unsurprisingly, reinforcement interventions are preferred over punishment interventions by patients and staff. Critical parameters have been identified that influence the effectiveness of CM interventions. Of relevance to the findings of our study are the parameters of certainty and celerity. Certainty refers to a ratio of sanctions to infractions where 1:1 would be each infraction resulting in a sanction or 2:1 would be two infractions resulting in a sanction. Smaller ratios have greater effects on changing behaviour (Azrin & Holz, 1996; Martin and Pear, 1999; Van Houten, 1983). In the case of drug tests this could equate to a sanction for each failed drug test or treatment staff determining an appropriate ratio and ensuring that offenders are aware that there will be consequences for a certain number of positive drug tests. Celerity refers to the immediacy of the sanction or reward, as it has been shown that the effects of sanctions and rewards may begin to degrade within hours or days (Azrin & Holz, 1996; Taxman, 1999). This is further evidence for the use of immediate sanctions for positive drug test results. Contingency management has been shown to be effective in the treatment of drug misuse (NICE, 2007) and has been used as part of drug court interventions in the US (Marlowe & Wong, 2008). However Marlowe and Wong (2008) express concern that in criminal justice settings there is a focus on the punishment aspects to the detriment of reinforcing desired behaviours (Burdon, Roll, Prendergast, & Rawson, 2001; Marlowe & Kirby, 1999). It is important to reward positive behaviours in order to maintain treatment effects over time (Marlowe & Wong, 2008). This use of structured, defined reinforcers for positive behaviours is something that will

need consideration in criminal justice initiatives in England and Wales alongside the use of punishments.

Decisions on the type of drug testing utilised in any service are inevitably based on costs including staff time rather than on evidence of accuracy. Although it is known that hair analysis gives more complete and historical data (Bean, 2004), probation services and other criminal justice system drug treatment programmes work within too tight a budget for the use of such a costly procedure. The most common drug testing methods within the criminal justice system are urinalysis and saliva testing which only show the presence or absence of drugs in the body. Drug test results on their own are therefore of limited use in dealing with offenders on non-abstinence orders where the goal is a reduction in drug use rather than immediate abstinence. However, by using percent negative tests per month per individual as in the current study, improvements over time could be demonstrated.

As drug testing data are readily available in the English and Welsh criminal justice system a study to compare the reliability of ongoing self-report measures of drug use in the criminal justice system may be advisable to assess how reliable such data are.

Recommendations

It is evident that drug test results need to be used on two levels: (1) on a punishment level, with positive drug tests resulting in sanctions; and (2) on a

treatment level, as a tool to praise improvement, motivate offenders and advise changes to the treatment programme (particularly the prescribing regime).

In order for drug test results to be used therapeutically the following recommendations are made from the current study:

- for criminal justice system staff to record the number of drug test appointments offered, non-attendance at drug test appointments, reasons for non-attendances;
- use percent negative drug tests per month as an indicator of drug use plotting this over time to demonstrate changes in the proportion of positive drug test results per offender;
- tie percent negative tests per month into reports to the courts and treatment plan reviews to aid in setting targets for improvement;
- use reports of individuals' percent negative drug tests, per month plotted over time, motivationally with offenders as a visual representation of achievements.

In order for drug test results to be used for punishment, each positive drug test result should be dealt with individually and immediately in order to deliver instant and appropriate sanctions.

Conclusion

Problems with drug testing data are multiple, but worth tackling if they are to be used for good purpose within the criminal justice system. More consideration needs to be given in future to the recording and use of drug testing data in order to procure a more accurate picture of offenders' drug use whilst on an order.

The current study has shown that changes in offender drug use can be demonstrated by using drug tests and concludes that several feasible changes need to be made to maximise the utility of drug testing and the resulting data, thereby justifying the costs of such an expensive commodity.

Chapter 6

Study 5 - Drug Treatment Outcomes in the Criminal Justice System: What Non Self-Report Measures of Outcome Can Tell Us¹

Introduction

Drug Treatment and Testing Orders (DTTOs), rolled out in 2000, were the first major example of coerced drug treatment in England and Wales. DTTOs were superseded by Drug Rehabilitation Requirements (DRRs) in 2005. DRRs incorporate all of the elements of a DTTO (i.e. drug treatment, drug testing, court reviews and compulsory attendance), but are designed to have greater flexibility enabling orders to be tailored to deal with both the needs of individual offenders and the seriousness of their offence(s). DRRs also aimed to make drug treatment within the criminal justice system available to offenders earlier in their drug using careers. A further expansion of drug treatment in the criminal justice system in England and Wales occurred with the introduction of the Drugs Intervention Programme (DIP) in April 2003. Drug treatment is now being expanded within prisons under the Integrated Drug Treatment System introduced in 2006 to provide clinical and psychosocial support including substitute prescribing and detoxification support. Drug treatment in the criminal justice system in England and Wales aims to reduce drug related offending by engaging with drug users at all stages of the criminal justice system and moving them into appropriate treatment and support.

¹ A shorter version of this paper was published as:
Powell, C., Christie, M., Bankart, J., Bamber, D., and Unell, I. (in press). Drug outcomes in the criminal justice system: What non self-report measures of outcome can tell us. *Addiction, Research and Theory*.

Voluntary drug treatment in the UK has been shown to reduce drug use and offending. The National Treatment Outcome Research Studies (NTORS, Gossop, Trakada, Stewart, & Witton, 2006), looking at the effectiveness of community drug treatment delivered in 1995, found substantial reductions in the number of crimes committed and percentage of clients engaging in crime post-drug treatment compared to pre-drug treatment. However, despite a reduction in offending in the NTORS sample, offending was noted as continuing, and not all NTORS clients showed improvements. Approximately one fifth of methadone patients in the NTORS sample failed to show improvement on virtually all treatment outcome measures (Gossop, Marsden, Stewart, & Rolfe, 2000a). Additionally, the participants in the NTORS study were community based methadone treatment clients and residential rehabilitation clients, (i.e. a clinical sample of drug users seeking treatment voluntarily). Gossop pointed out that it is not known whether such findings would have been obtained with other samples such as drug misusers in the criminal justice system (Gossop, et al., 2006).

Evidence on the effectiveness of coerced drug treatment on offending rates in the England began to appear in 2000 with the DTTO pilot project evaluations (Turnbull, McSweeney, Edmunds & Hough, 2000). Self-reports showed a considerable decrease in offending and drug use, and even those whose orders were revoked reported a reduction in drug use post order. This led to the conclusion that DTTOs were 'promising though not proven' (Turnbull et al., 2000 p. 77). Reconviction rates a year post order were high at 80% with those

who completed their order having significantly lower reconviction rates than those whose order was revoked (53% versus 91%). However, only 30% of offenders for whom data was available had completed their order successfully and 67% of orders were revoked (Hough, Clancy, McSweeney, Turnbull, 2003). The findings suggested that for those who completed their order, reconviction rates reduced as did drug use, at least for the duration of the order. Nationally however, DTTO completion rates have been shown to vary (NAO, 2004) due to variations in the organisation and model of treatment provision employed under DTTOs between areas. Reconviction rates for all DTTOs in England and Wales in the 2003 cohort stood at 86%, although this was not broken down into 'completers' versus 'non-completers'. This reconviction rate was higher than that for any other disposal, e.g. Community Rehabilitation Orders, Community Punishment and Rehabilitation Orders and prison (Shepherd & Whiting, 2006).

The reconviction rates for the Scottish DTTO pilot schemes appeared to be lower than those in the English pilots with 66% of offenders reconvicted within 24 months of a DTTO and 48% of those who completed their DTTO having no reconviction within two years (McIvor, 2004). However, the reconviction rates for the Scottish pilots were adjusted to take account of pseudo-reconvictions² unlike the English ones, and the non-adjusted reconviction rates showed no significant difference between reconviction rates pre and post DTTO, with 82% of offenders reconvicted within two years (74% for DTTO completers).

² Pseudo convictions are convictions that appear in a time period for offences that were committed outside of that time period. For example, an offence committed before the time period began but not sentenced until after the time period began will appear as a conviction. Similarly however, some offences could be committed in the time period under examination but not sentenced until after the time period has lapsed and hence would not appear as a reconviction in the study.

More positive outcomes for English criminal justice drug treatments have been based on self-report data. McSweeney, Stevens, Hunt, & Turnbull (2007) found that coerced drug treatment clients showed considerable reductions in substance use and offending behaviours between intake and six month interviews, which were sustained between interviews at six and 18 months. There were similar reductions for clients entering drug treatment voluntarily. These findings were consistent with findings from a wider ranging European study into “quasi-compulsory” drug treatment (Schaub, Stevens, Berton, Hunt, Kerschl, McSweeney et al., 2010). However, only 52% of eligible clients were interviewed at treatment intake. The remainder either failed to present for treatment or dropped out of treatment before the interview so this sample is biased towards those who had already chosen to engage with the treatment on offer.

In a casefile study looking at client outcomes on the Drug Interventions Programme (DIP), Best, Day, Homayoun, Lenton, Moverley, and Openshaw (2008) found similar outcomes to Hough et al., (2003). The minority of clients achieved positive outcomes. However, heavier drug users were retained in treatment for longer than those using opiates and crack less frequently or in lower quantities.

In 2008 a UK National Treatment Agency for Substance Misuse (NTA) report used Police National Computer (PNC) data to examine changes in offending following substitute prescribing treatment for drug misuse, including criminal justice system treatments (Millar, Jones, Donmal, & Roxborough, 2008). They

looked particularly at offenders charged with acquisitive offending in the year prior to receiving a prescription for methadone and found a reduction in the number of offenders charged with such offences following prescribing commencement. Sixty-two percent had not been charged with further acquisitive offences. Changes in offending were shown to be related to length of treatment, with longer treatment (>10 months) leading to greater reductions in offending. However, the sample was mostly low level offenders: 54% had only one trigger offence in the year prior to treatment; and only 15% of the sub-sample had been convicted of more than three trigger offences in the year before prescribing treatment started. There was no indication of whether or not these 15% remained in treatment, although the authors indicated the existence of a group of more persistent offenders who showed no changes in the rate of their offending. They also acknowledged that their sample of offenders who remained in the community may not have been representative of those who committed more frequent or more serious offences who may be more likely to have been imprisoned, as their study excluded all offenders who were known to have spent time in custody in the study period in order to allow equal opportunity to offend.

The Drug Treatment Outcomes Research Study (DTORS) (Jones et al., 2009) aimed to update NTORS taking account of changes in drug treatment since 2000, including drug treatment in the criminal justice system. Using self-report measures, they found reductions in drug use with mean weekly spend dropping from £169 to £64 at three to five months and to £63 at 11 to 13 months, and the proportion of treatment seekers using heroin, crack, cocaine and amphetamine

decreasing by 50%. In terms of offending, 69% of treatment seekers who reported offending in the four weeks prior to study start had not committed any offences in the four weeks prior to follow up at 11 to 13 months. Those who continued offending reportedly reduced their volume of offending or the costs associated with it.

DTORS made attempts to compare drug treatment outcomes for those referred into treatment by the criminal justice system with voluntary treatment seekers and found limited differences between CJ referrals and other referrals on treatment retention and offending. Though, among those who reported continued use of heroin 11 – 13 months after presenting for a new episode of treatment, criminal justice referrals reported using larger amounts of heroin more regularly than non criminal justice referrals. However the ‘criminal justice system referrals’ group was based on referral source and included offenders on DRRs, those tested on arrest and those referred by any member of the criminal justice system. These were therefore not necessarily in drug treatment in the criminal justice system, they could have been referred to voluntary drug treatment. Indeed, offenders on DRRs only accounted for 55% of the CJ referrals (Jones et al., 2007). Attempts to break down the CJ referrals group into smaller subgroups failed due to limited numbers in the groups (Jones et al., 2009). Perhaps if it had been possible to separate out and compare those on court mandated treatment from those merely referred by an agent of the criminal justice system, the conclusions would have been different.

Numerous statistical models have now been constructed to examine relationships between drug treatment and outcomes in terms of drug use and offending behaviour. McIntosh et al., (2007) used data from DORIS – Drug Outcome Research in Scotland, an evaluation of the main treatment services available in Scotland 2001/2002. Using self-report data for offending and drug using behaviour, they were able to provide further evidence of the reduction in offending following drug treatment. Specifically they stated, “in so far as drug treatment is effective in reducing rates of crime in recovering drug addicts, it does so, not by altering their criminal activities directly, but by reducing their consumption of illegal drugs and thereby the need for them to engage in crime to sustain their habit” (McIntosh et al., 2007, p. 382). Similarly, other studies have found drug consumption to be a better predictor of criminal activity than exposure to treatment (Gossop, 2005a; Gossop et al., 2000b; Keane, 2005). McIntosh et al., however used self-reported abstinence as their drug use outcome and reported an absence of research generally on the effects of variable reductions in drug consumption as opposed to periods of abstinence. This is clearly an important area for research as drug treatment in England and Wales is currently largely based on harm reduction rather than abstinence.

Many of the studies reviewed above have been based on self-report data which, have been shown to be generally reliable for both drug use and offending (Graham & Bowling, 1995; Farrington, 1989; Barnea, Rahav, & Teichman, 1989). However, the reliability of self-reports of drug use have been shown to vary dependent on context. For example, self-report is weaker in chaotic and young drug users than in stable and older addicts (Kilpatrick, Howlett,

Sedgewick, & Ghodse, 2000; Magura, Goldsmith, Casriel, Golstein, & Lipton, 1987). In dealing with ‘chaotic’ users, Kilpatrick et al., (2000) suggested the use of urinalysis in addition to self-report. Additionally, Finch and Strang (1998) pointed out that little was known about the reliability of self-report measures of drug use among participants in the criminal justice system. Reliability of self-reports of offending within a criminal justice system setting have been demonstrated, although where property offences were involved, the correlation between self-report and official records was weaker, with more probationers being found guilty of property offences than reporting having committed a property offence (Farrell, 2005). These issues suggest self-reports of drug using offenders in the criminal justice system should be treated with some caution as treatments in the criminal justice system were established to tackle the problem of chaotic drug users committing acquisitive crimes. Therefore, consideration of another measure other than self-report measures may show a different picture of treatment outcome. Official records also have their own limitations, however, largely that not all offences committed lead to a conviction (on average only approximately 2% of offences committed lead to conviction, Hoods & Sparks, 1970; Home Office, 1999).

Non self-report data for drug use and offending behaviour were available from an evaluation of a stand alone DTTO team between 2001 and 2004. Throughout the evaluation, drug testing results were collected on all offenders subject to an order. While drug testing data from DTTOs is problematic in several respects (see study 3), it remains a valuable indicator of drug use, able to demonstrate a reduction in or abstinence from illicit drug use for those in

coerced drug treatment. The current chapter reports an examination of reconviction rates in relation to individuals' drug use whilst on a DTTO.

The aim of study 5 was to use non self-report measures of drug testing and reconviction to examine how well a criminal justice system drug treatment service (DTTOs) met their two aims: i. to reduce offending behaviour and ii. to reduce drug use.

Hypotheses

Based on theory behind coercive drug treatment, a number of hypotheses were tested:

- 1) Conviction rates post treatment will be lower than pre treatment;
- 2) Reductions in non self-report measures of drug use will be a significant predictor of reduced offending rates, and;
- 3) Proportions of offenders convicted of acquisitive crimes will reduce post treatment.

Methodology

Participants

Data were requested from the Home Office Offenders Index (OI) for all offenders sentenced to a DTTO in the study area between November 2000 and December 2002 (n=189 offenders). It was possible to obtain data on 183 of the 189 (96.8%) offenders for whom data were requested. The remaining six offenders were unable to be identified in the OI due to a lack of information available on the OI or differences in offender data held by the researcher and

the OI. Those 183 offenders were no different in profile from the whole sample of offenders sentenced to a DTTO in the evaluation period (see Table 1).

Similarly, there was no reason to believe that the six offenders whose data could not be obtained were any different to the rest of the sample.

Table 1: Offenders Index Sample outcomes compared to other DTTOs commenced in study area during evaluation period

	OI Sample (n=183)	Offenders not in OI sample (n=148)	Significance testing
Mean age at order start (years)	26.20 (sd=5.85)	27.19 (sd=6.05)	t(138)=1.51 p=0.13
Gender			
Male	151 (83%)	129 (87%)	$\chi^2(1)=1.36$
Female	32 (17%)	19 (13%)	p=0.24
Ethnicity			
White	174 (90%)	129 (95%)	$\chi^2(1)=2.91$
Non-white	9 (10%)	14 (5%)	p=0.87
Employment Status			
Economically active	11 (7%)	9 (7%)	$\chi^2(1)=0.03$
Non-economically active	143 (93%)	126 (93%)	p=0.87
Sentence length (months)	15.33 (sd=4.86)	14.36 (sd=4.60)	t(329)=7.86, p=0.23
Order outcome			
Order expired or ended for good progress	63 (30%)	30 (37%)	$\chi^2(1)=1.47$ p=0.23
Order revoked	106 (70%)	70 (63%)	

Measures

Reconviction rates - The OI is a computerised database containing criminal histories of all offenders convicted of a standard list offence in England and Wales since 1963. While the OI is known to have limitations in its accuracy (Friendship, Thornton, Erikson, & Beech, 2001), it is among the most reliable sources of information on reconviction rates. Reconviction rates were

examined for two years from the day of sentence to an order on the basis that, for the majority of offenders (94%), treatment as part of an order started within two working days. The average length of order served for offenders in the study (calculated from order commencement and end date³) was 278.5 days ($sd=148.78$). Eighty percent of orders had ended within one year. Therefore, for the majority of offenders in the study, in the two-year time period following order commencement, at least one year will be post treatment. This time period was chosen to allow for a period of two years to have elapsed for a large enough sample of offenders to have accrued. Frequency of convictions for the two years after treatment started were compared to frequency of convictions in the two years up to and including the date of sentence. This method of analysis was chosen due to the aim of DTTOs being to reduce rather than stop offending (HM Government, 1998a).

The OI data does not include information on the date an offence was committed, only on date of conviction for the offence, so it was not possible to identify any pseudo-reconvictions i.e. offences committed before the time period began but not sentenced until after the time period began will appear as a conviction. Similarly, offences could be committed in the time period under examination but not sentenced until after the time period has lapsed and hence would not appear as a reconviction in the study. Only standard list offences were included in the analysis in order to reduce bias, as non-standard list offences on their own do not lead to a conviction.

³ This takes no account of actual time in contact with the team, (e.g. an offender could be out of contact with the team prior to a breach hearing).

Measures of drug use - Urine or mouth swab tests, taken throughout an order for all offenders on a DTTO, were used to calculate an overall percentage of drug tests that were negative for illicit opiates during time on an order. A change score representing changes in illicit drug use whilst on an order was also calculated by subtracting the percent negative drug test results in the final month of an order from the percent negative drug test results in the first month on an order (see study 4 for further information). All references to changes in drug use refer only to illicit opiate use.

Order outcome – order outcome was reduced to two possible outcomes: positive DTTO outcome included order expired or terminated early for good progress, and negative DTTO outcome included order revoked and offender re-sentenced.

Order length served in days – this was the difference in days between order commencement date and order end date.

Offender Group Reconviction Scale (OGRS) – OGRS scores were calculated by probation staff for each offender at the time of assessment for an order. OGRS scores are predictors of reoffending based on static risks – age, gender and criminal history (NOMS, 2008).

Comparison group

The original evaluation project proposal included a control group of offenders assessed as suitable for an order but not sentenced to one purely due to funding restrictions on the number of treatment places available. However, in practice, all offenders assessed as suitable for an order were actually sentenced to one and therefore there was no comparison group available. Due to the nature of the study it was considered inappropriate to request a matched group for comparison from the OI as the OI contained no measure of drug use. While it would be possible to match offenders on demographics and offending behaviour, no account could be taken of drug use.

Statistical Analysis

Analysis varied depending on the hypotheses tested. Hypotheses 1 and 3 were comparisons between rates of offending two years before and after DTTO start using paired t-tests and McNemar's test. Hypothesis 2 used univariate analysis to identify possible predictors of reconviction frequency, which were then entered into a multivariable analysis with the frequency of convictions two years post DTTO as the dependent variable. OGRS scores were also included in the multivariable analysis as these were designed to be a predictor of reconviction rates. Values of the deviance and scaled deviance should be the same and close to 1 in each case in order to indicate a good fit between the data and the model.

Results

Analysis 1: Comparison of conviction rates before and after the start of an order

The distributions of number of convictions before and after the start of the order were both positively skewed and had similar shapes (see Figures 1 and 2).

There were 13 offenders post order start with no convictions giving a reconviction rate of 93%.

Figure 1: Distribution of convictions two years prior to order start.

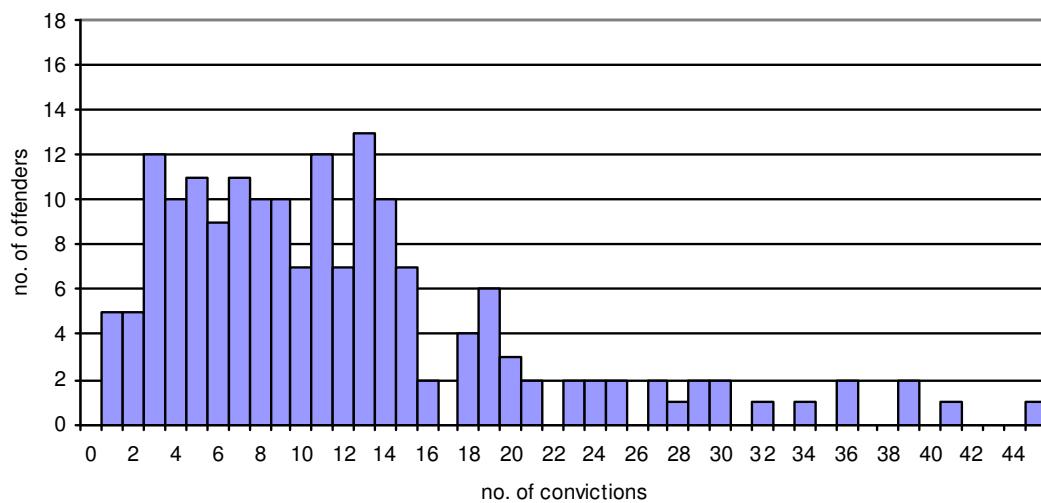
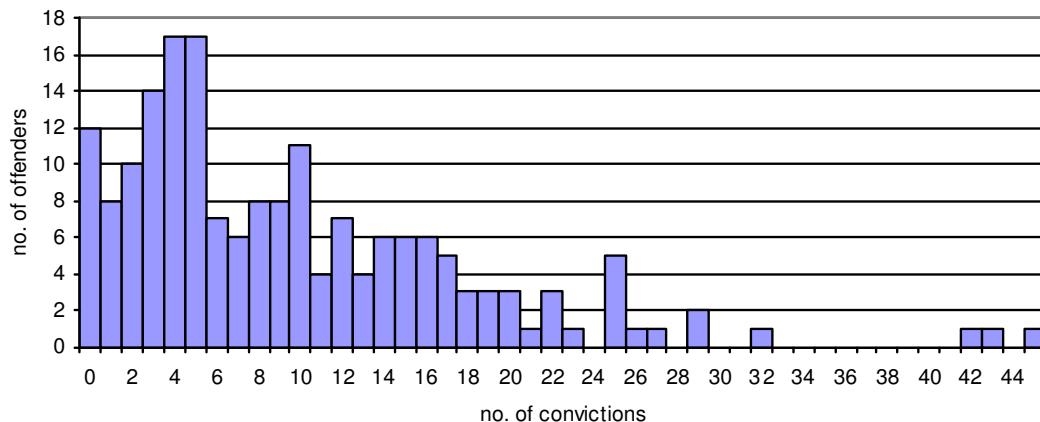


Figure 2: Distribution of convictions two years after order start.



The mean number of convictions in the two years prior to the start of an order was higher than the mean number of convictions two years from the start of an order (mean=12.01, SD=8.6 and mean=9.39 SD=8.0 respectively) (see Table 2). A paired t-test showed that the difference was significant ($t=3.839$, $df=182$, $p=0.0002$) supporting the theory that coerced drug treatment reduces crime.

Table 2: Mean number of convictions before and after start of order

	N	Mean	Median	SD
Convictions 2 years prior to DTTO	2198	12.01	10	8.59
Convictions 2 years post DTTO	1720	9.39	7	7.97

Table 3 shows the pattern of reduction in the mean number of offences for individual offenders. In total 112 offenders (61% of the sample) showed fewer convictions in the two years after starting treatment compared to before the order, with a mean reduction of 7.96 offences. Twelve offenders (7%) showed

no change in the frequency of convictions and 60 offenders (33%) actually showed a higher frequency of conviction in the two years after starting their treatment.

Table 3: Changes in conviction frequency for individual offenders (n=183)

	No. of offenders	Mean change in convictions	Standard deviation	Maximum change
Reduction in convictions after 2 years	112	-7.91*	-7.30	-41*
No change in number of convictions	12	0	0	0
Increase in number of convictions	60	+6.66	4.86	+25
Total	183	-2.69	9.25	

* a negative figure denotes a reduction in conviction rate

Analysis 2: Univariable predictors of conviction frequency two years after the start of an order

Univariable analyses were conducted initially to find the best set of predictors of conviction frequency two years after the start of an order. A number of significant predictors were found as shown in Table 4: order outcome (positive versus negative outcome); order length served; and overall percent drug free tests whilst in drug treatment. Additionally, age, residence at time of sentence and gender were also significant univariable predictors of reconviction rate.

Table 4: Univariable predictors of conviction frequency 2 years after order start

Variable	Parameter Estimate (β , 95% CI)	Incident Rate Ratio (Exp β , 95% CI)*	p
Age (continuous)	-0.03 (-0.06, -0.01)	2.64 (2.56, 2.69)	0.008
Age Group (<=25 versus 25+)	0.21 (-0.05, 0.46)	1.23 (0.95, 1.59)	0.12
Gender (male versus female)	-0.37 (-0.72, -0.03)	0.69 (0.48, 0.97)	0.04
Employment Status (unemployed versus other)	0.0006 (-0.06, 0.06)	1.0006 (0.94, 1.06)	0.98
Trigger Offence (theft versus other)	0.14 (-0.12, 0.41)	1.15 (0.87, 1.51)	0.28
Sentencing Court (Magistrates versus Crown)	-0.23 (-0.52, 0.06)	0.79 (0.59, 1.06)	0.12
Residence at time of sentence (custody versus community)**	-0.15 (-0.28, -0.02)	0.86 (0.75, 0.98)	0.03
Order Outcome (positive versus negative DTTO outcome)	0.77 (0.51, 1.02)	2.16 (1.66, 2.78)	<0.0001
Sentence Length (3 Categories: 0-12 months, 12-18 months, 18+ months)	-0.01 (-0.2, 0.18)	0.99 (0.82, 1.2)	0.92
Order Length Served (days)	<-0.0001 (<-0.0001, - <0.0001)	<-0.0001 (<-0.0001, - <0.0001)	<0.0001
Overall Percent Drug Free Tests on Order	-0.64 (-1.05, -0.23)	0.53 (0.35, 0.8)	0.003
Change in drug use (difference between first and last months drug test results)	0.0006 (-0.003, 0.004)	1.0006 (0.997, 1.004)	0.68
Frequency of convictions 2 years pre-DTTO (continuous)	0.04 (0.02, 0.06)	1.04 (1.02, 1.06)	<0.0001
Days to First Offence (continuous)	-0.0008 (-0.002, 0.005)	0.999 (0.99, 1.05)	0.27
OGRS score (continuous)	0.002 (-0.002, 0.005)	1.002 (0.99, 1.005)	0.25
Address (City versus County)	0.025 (-0.28, 0.33)	1.03 (0.75, 1.39)	0.87

* The incident rate ratio is the ratio of two incidence rates. For a categorical predictor this is the ratio of the incidence rate for one group compared to another group or for each group compared with the reference group. For a continuous predictor, this is the increase in the incidence rate for a one unit increase in the predictor.

**Residence at time of sentence – whether an offender started an order following a period RIC or from the community was included on the basis that those starting an order following a period RIC may have lower levels of drug use at order start though their frequency of conviction may be lower in the 2 years prior to commencing a DTTO due to having spent a proportion of that time in custody.

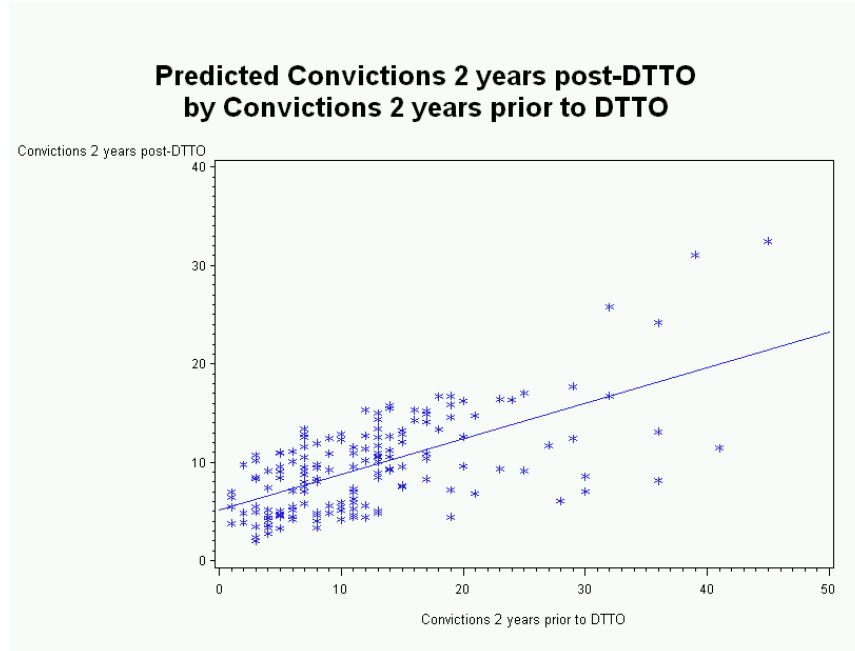
In the final multivariable model, only three variables significantly predicted frequency of conviction after order commencement: frequency of previous convictions; DTTO outcome (positive or negative); and overall percent drug free tests whilst in treatment. In Table 5 the parameter estimates are exponentiated (Exp) to give Incidence Rate Ratios.

Table 5: Multivariable Predictors of Convictions post order

Predictor	Parameter Estimate (β)	Incident Rate Ratio ($\text{Exp } \beta$, 95% CI)	P
Significant			
Frequency of convictions 2 yrs pre DTTO	0.026	1.03 (1.01, 1.04)	0.0004
Order outcome - Positive versus Negative	0.59	1.8 (1.31, 2.5)	0.0003
Overall percent drug free tests on DTTO	-0.0005	0.9995 (0.9991, 0.9999)	0.016
Non-significant			
Gender - Male v Female	0.24	1.27 (0.9, 1.79)	0.17
OGRS	0.002	1.002 (0.999, 1.004)	0.27
Residence at time of sentence Custody v Community	0.09	1.1 (0.85, 1.41)	0.47
Time	-0.0000	0.999 (0.99, 1.00)	0.49
Age	-0.003	0.997 (0.975, 1.02)	0.81

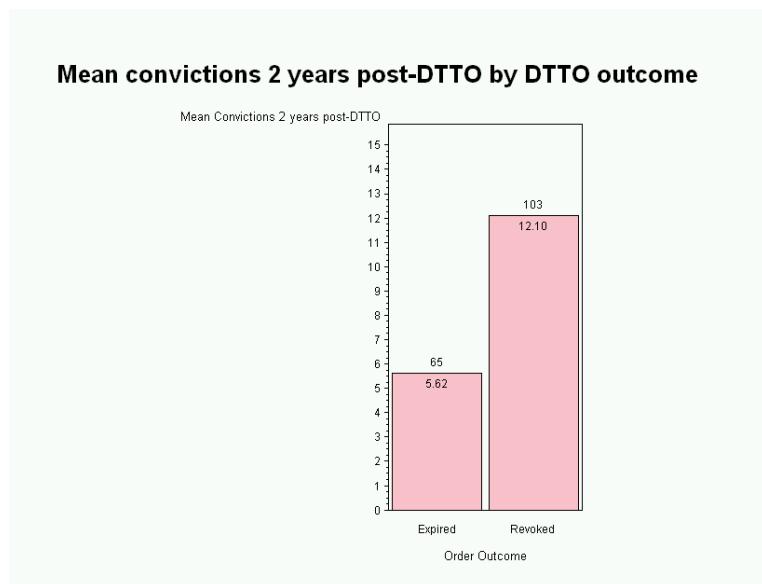
It is unsurprising that the frequency of convictions in the two years prior to order commencement predicts frequency of reconviction in the two years after treatment started, as those with the highest number of convictions prior to order start would perhaps be the most entrenched offenders. In the current study, for every extra prior conviction, the post conviction rate increased by a factor of 1.03 as shown in Figure 3.

Figure 3: Predicted post convictions as a function of pre convictions.



Those whose order was revoked had around twice the number of reconvictions after starting their order than those whose order was completed or terminated early for good progress (Incidence rate ratio = 1.8, and see raw data in Figure 4). It might well be expected that offenders who completed an order would have lower frequency of reconviction.

Figure 4: Number of reconvictions by DTTO outcome.



Percent drug free tests whilst on an order significantly and independently predicted frequency of reconviction. The multivariable model showed that for every 1% rise in negative drug tests over the whole order, the post order start conviction rate would decrease by 0.0005 (see Figure 5 for raw post-order start conviction rates, and Figure 6). This demonstrated clearly the link between continuing drug use and reconvictions. However as this was a measure of drug use over the whole order, it simply confirmed that those who used fewer drugs whilst in treatment had a lower reconviction rate after entering treatment.

Figure 5: Based on raw data, the decrease in post DTTO convictions as a function of percent drug free tests

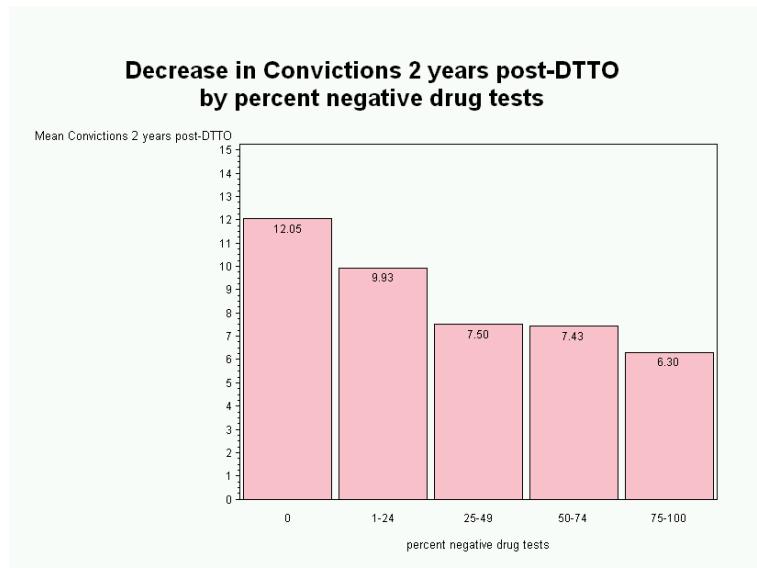
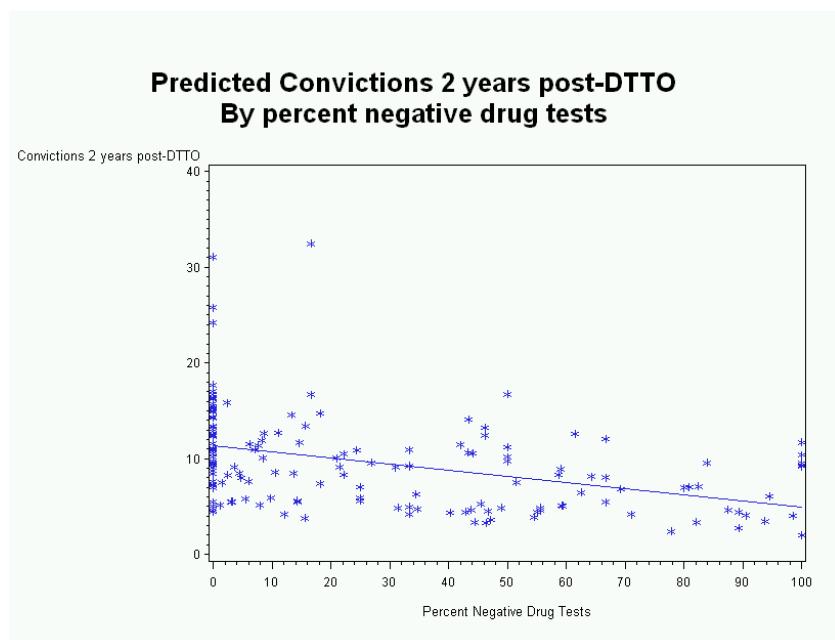


Figure 6: Predicted post convictions as a function of percent drug free tests



The relationship between drug use and reconvictions remains unclear, however, as those offenders who had no reconvictions after commencing treatment showed varied changes in their drug use. Some offenders showed a reduction in drug use while others continued in their drug use. Only two had negative drug tests throughout their treatment.

It is interesting to note that OGRS did not predict frequency of conviction two years post DTTO. This could perhaps be due to the effect of drug use in this group of offenders as while OGRS takes account of previous offending it includes no measure of drug use which this analysis has shown to be a significant predictor of reconviction.

Analysis 3: Were there changes in the types of offences pre and post DTTO?

Anecdotal evidence from drug treatment staff suggested that whilst some offenders were continuing to offend, the types of offences they were committing was changing. Table 6 (see next page) shows the proportion of offenders on an order convicted of different types of offences before and after order commencement. Whilst there was a reduction in the proportion of offenders convicted of all types of offences listed (in line with the overall reduction in conviction rates), only some types of offences showed a significant reduction in the proportion of the offenders convicted. McNemars test for the significance of changes showed a significant reduction for the proportion of offenders convicted of vehicle related offences ($\chi^2(1)=38.37$; Exact p=<0.01); driving offences ($\chi^2(1)=31.07$; Exact p=0.049); drugs offences ($\chi^2(1)=10.88$; Exact p=0.03); and

other offences (which included breach of order, absconding on bail, criminal damage) ($\chi^2(1)=10.14$; Exact $p<0.01$). Notably, acquisitive offences (theft, burglary and fraud/forgery) showed no significant reductions.

Table 6: Comparative proportions committing offence before and after the start of the coerced drug treatment

Offence type	Pre treatment		Post treatment	Percent change	<i>p</i> *
	No. offenders	(%)	No. offenders	(%)	
Burglary	72	(39%)	65	(36%)	-3% 0.427
Theft	160	(87%)	149	(81%)	-6% 0.061
Vehicle Related offences	46	(31%)	30	(16%)	-16% 0.009
Fraud/Forgery	31	(17%)	26	(14%)	-3% 0.458
Driving offences	75	(41%)	6	(33%)	-8% 0.049
Drugs offences	57	(31%)	40	(22%)	-9% 0.030
Violent offences	63	(34%)	53	(29%)	-5% 0.260
Public Order offences	31	(17%)	20	(11%)	-6% 0.080
Breach of order	9	(5%)	4	(2%)	-3% 0.267
Other offences	121	(66%)	95	(52%)	-14% 0.003

* McNemars test

Discussion

The current study aimed to examine non self-report measures of drug use and offending to assess how well one example of drug treatment in the criminal justice system may have reduced offending. The study found high overall reconviction rates but the majority of offenders (61%) showed some reduction in offending (mean reduction of 7.99 offences per offender). Whilst these results suggest that frequency of conviction following drug treatment commencement were perhaps higher than would have been hoped, two factors need to be

considered in the interpretation of this figure. Firstly, whilst no account has been taken of pseudo-reconvictions, it is known that 19 offenders on a DTTO in the study area between April 2000 and March 2004 were sentenced after they started their order for offences committed prior to starting their order. However, the data were not available for the current sample. Secondly, DTTOs were targeted at the most prolific offenders and it was always expected that offending would take some time to reduce in line with reductions in drug use. Thus, when treated on a harm reduction basis as in the study area, some continued offending may be expected initially as individuals are stabilised on a substitute prescription and illicit drug use reduces. In abstinent based treatment a much quicker reduction in offending would be expected.

Lower frequency of reconviction were found for offenders with lower numbers of convictions prior to starting treatment, offenders with a positive order outcome (completed order or order terminated early for good progress) and those who returned more negative drug tests whilst in treatment. However, there were no significant reductions in the proportion of offenders committing acquisitive offences before and after starting treatment.

McSweeney et al., (2007) however pointed out that the reconviction rates need to be considered in relation to the reconviction rates for other drug treatments and not be viewed in isolation. Seventy-four percent of those in voluntary drug treatment in the NTORS study who had been convicted at least once prior to entering treatment had at least one conviction in the period after treatment commencement (Gossop et al., 2006). Reconviction rates for drug treatments

in the criminal justice system are higher than this but considering offending drug users have more complex treatment needs than non-offending drug users, the reconviction rates found in this study are perhaps not as surprising as they first appear.

The current study is the first to use non self-report measures of both drug use and offending to examine treatment outcomes and the findings support those of Turnbull et al., (2000) and Hough et al., (2003). Turnbull et al., (2000) used self-reports of drug use and offending, and although Hough et al., (2003) used non self-report measures of offending no attempts were made to link these with drug use. Combining non self-report measures of drug use with reconviction data has shown that those with lower drug use whilst on a DTTO commit less offences post DTTO. This is in line predictions made by McIntosh et al., (2007) and McMurran (2007) that those with lower overall drug use will show significant reductions in reconvictions. There was, however, no indication in the current study that those who reduced their offending were the same people that reduced their drug use whilst on a DTTO. An analysis using change in reconviction rates as the independent variable would assess for this. Certainly, based on table 3, this study found that a larger proportion of offenders reduced their offending rate than showed reductions in their illicit drug use. It is possible, however, that some offenders reduced their drug use in anticipation of commencing an order. As data were only available for drug use following order commencement we do not know if offenders changed their drug use immediately prior to starting an order.

The current study found that those with less previous convictions and those who finished their orders showed greater reductions in offending – thus supporting others' findings (Best et al., 2008; Hough et al., 2003; McSweeney et al., 2007). But the drug treatment under examination here was an alternative to custody, aimed at offenders with entrenched drug using and offending careers who in the main, showed limited reductions in offending. Whilst successful at treating offenders with lower rates of conviction prior to DTTO sentence and lower overall drug use on an order, perhaps the treatment under examination here was not as effective for offenders with greater numbers of previous convictions and higher levels of drug use. This will be considered further in the full thesis discussion in chapter 7.

A number of studies have found a group of offenders who were more resistant to treatment (Best, Day, Hoayoun, Lenton, Moverley, & Openshaw, 2008; Gossop et al., 2000a; Millar et al., 2008) as did the current study. Best et al., (2008) suggested that the Drug Interventions Programme in the criminal justice system was picking up both 'primary drug users' and 'primary offenders' as identified by Nurco (1998) but it is only retaining primary drug users, not primary offenders. They proposed that a more individualised approach was therefore required for treatment to improve chances of retaining all drug using offenders in treatment. Perhaps the groups of drug users resistant to treatment found in the current and other studies, were also primary offenders. More research should be carried out into this group in order to see what treatment would result in reduced reconviction rates.

The 2008 NTA report, using non self-report measures of reconviction rate for offenders in community drug treatment, suggested that offending reduced by approximately half, with a slightly smaller reduction for those committing acquisitive crimes prior to starting treatment (as found in the present study). However, in order to limit the effect of imprisonment on re-offending, all offenders known to have been in custody in the year prior to or after treatment were removed from the study. As the authors of the NTA report acknowledged, this removes a number of offenders (though the report gives no indication of how many) and also biases the data to lower rate offenders. The dataset under examination in the current study represented exactly those who were likely to enter custody for further offences as the orders were aimed at these offenders, which perhaps explains the more limited reduction in offending. Though it must be noted that no information was available on the amount of time spent in custody during the two years prior to DTTO start and two years follow up in the current study, hence some offenders may have had limited opportunity to offend. This could have resulted in lower reconviction rates for such offenders. Future analysis should attempt to consider this.

Whilst reductions in offending and drug use were limited in the current study, what was not apparent from these measures were other possible benefits to the drug users themselves and the community around them. Ricketts, Bliss, Murphy, & Brooker, (2005) found definitions of success on a DTTO given by offenders on the orders were not simply limited to drug use and crime. Additionally, in interviews with the drug treatment staff (study 3) it was clear that

reductions in offending and drug use were not the only benefits to come out of the orders. DTORS included measures of treatment retention, social functioning, and health in addition to offender drug use, thus enabling a clearer picture to be drawn of the benefits of treatment (Jones et al., 2009). Additionally, in depth interviews provided valuable insight into what did and did not seem to work in treatment from the perspective of both treatment seekers and providers (Barnard, Webster, O'Connor, Jones, & Donmall, 2009). Indeed, Orford (2008) suggested that a new approach should be taken to outcome studies and a variety of sources should be used to gather information including qualitative research involving patients and practitioners.

It is important to acknowledge in all drug treatment outcome studies that no drug treatment service stands in isolation. Drug users in treatment in the criminal justice system may have previously been elsewhere for treatment⁴ and drug users may go elsewhere for treatment after leaving criminal justice system drug treatment. Some may be transferred to alternative treatment on completion of a criminal justice system treatment or self-refer at a later date. Local unpublished data suggest that as many as 68% of drug users entering drug treatment in the criminal justice system locally between 2000 and 2004 had previously received other drug treatment. Additionally, referrals from criminal justice system and Arrest Referral accounted for 15% of all referrals to a local non Criminal Justice drug treatment agency between April 2001 and March 2005. This takes no account of drug using offenders who self-referred into treatment. Reconviction rates taken for two years after starting treatment

therefore need to take account of all treatment undergone in the follow-up period. With the plethora of drug treatments now available, without following individuals' treatment paths for the whole two years of a reconviction study, it is not possible to measure the effect on offending or drug use of one individual form of treatment. This is an issue that needs to be considered in all drug treatment reconviction studies.

The data from the current study need to be treated with some caution. McSweeney, Turnbull, and Hough (2008) identified variability in DTTO/DRR outcomes dependent on the context in which they were applied (differences between areas in the profile of offenders being sentenced, treatment availability, quality and delivery, treatment orientation, responsiveness of interventions, and enforcement practices). The current study examined a single stand-alone drug treatment service in the criminal justice system the focus of which was on controlling offending and drug use rather than achieving abstinence. There was no comparator group from a different area using an alternative treatment model.

In addition the limitations of the measures themselves – reconviction rates and drug test results - have already been discussed here and elsewhere (Study 2; Study 4). These are measures of people caught offending and using drugs and are not definitive measures. Not all offences lead to convictions (Hoods & Sparks, 1970; Home Office, 1999) and not all drug use is picked up by drug testing (study 4). Additionally, in the current study drug testing data were only available for the duration of an offender's time in treatment and did not give any

⁴ although criminal justice system drug treatment in England and Wales was intended to access

indication of how drug use may have changed in the days prior to order commencement or once the treatment under examination ended. Changes in drug use after the end of an order may have affected offending behaviour within the two-year reconviction period.

Recommendations

Based on the current findings, the recommendations from the current study are largely research oriented:

- Non self-report measures should be used alongside self-report measures when looking at treatment outcomes in chaotic, offending drug using populations;
- Offender and staff views on outcomes other than drug use and offending behaviour should be used to get a fuller picture of the effects of treatment;
- All drug treatment outcomes studies looking at offending rates with an elongated follow-up period need to consider the effect of drug users entering alternative drug treatments on their outcomes measures;
- Further investigation is needed into those groups whose drug using appears resistant to treatment;
- The relationship between drug use and crime and the assumption that reducing drug use will reduce crime needs further examination since, while reconviction rates have been shown to be related to continuing drug use, reductions in drug use do not appear to necessarily lead to a reduction in crime.

Conclusion

Coercive drug treatment in England and Wales has been shown to reduce offending (Best et al., 2008; McSweeney et al., 2007). The current study supported such findings using, for the first time, non self-report data. It was unclear from the current study whether those who had lower frequency of convictions post treatment were the same people that reduced their drug use, and this may warrant further examination. Additionally, as in other treatment outcome studies, there was a group seemingly resistant to treatment, who showed limited changes in drug use and offending. More research is needed to examine this group.

Chapter 7

Discussion

The current thesis considered one example of the new initiatives of drug treatment in the criminal justice system, Drug Treatment and Testing Orders. These were the first example of coerced drug treatment in England and Wales and were introduced nationally in 2000. The five separate studies making up this thesis aimed to examine a range of aspects of the new drug treatment, combining quantitative and qualitative research methods. It is therefore important to firstly consider the aims and summary findings of each study.

Study 1 – DTTO monitoring and outcomes data

The main data (Study 1) aimed to examine assessment, referral and take-up rates for DTTOs in the evaluation area up to March 2004 and also assess to what extent DTTOs catered for a new group of drug misusing offenders who would not previously have been in contact with treatment services. The data showed that 555 referrals were made for a DTTO in the evaluation period and these referrals resulted in 517 assessments with 75% of these being assessed as suitable for a DTTO. Four hundred and twenty-nine DTTOs were commenced in the evaluation area up to March 2004. As offenders could be sentenced to more than one DTTO, this related to 331 offenders, (average age 26.7 years, 85% male, 92% white). Offenders had committed an average of three offences per order. Seventy-four percent of offenders breached a DTTO at some point, though only 18% of breaches resulted in DTTOs being revoked outright and a further 28% of breaches were heard with further offences.

Examination of orders that should have completed by the 30th September 2004 (n=308) showed that 33% had expired naturally or been terminated early for good progress, 57% were revoked early for further offences and/or breach, 6% of orders expired whilst offenders were out of contact with the team, 3% were revoked for other reasons, and for less than 1%, the offender was deceased. Offenders whose DTTO expired naturally or was terminated early for good progress were significantly older at the start of their order than those whose DTTO was revoked.

Information on drug treatment history was available for 43% (n=151) of offenders sentenced to a DTTO in the evaluation period: only 16% of these had not been for drug treatment elsewhere. Eighteen percent were receiving drug treatment elsewhere immediately prior to being sentenced to a DTTO and a further 7% were on a waiting list for treatment immediately prior to sentence.

Study 2 – Lessons learned from offenders on DTTOs

Study 2 aimed to sample offenders' opinions about their expectations of the order and the perceived overall impact of the order: 143 semi-structured interviews were conducted with 107 offenders. Offenders' main reason for agreeing to a DTTO was wanting to become drug free and they were generally positive about the orders, reporting that they had received the type of help or treatment they wanted. Court hearings and drug testing were reported to help to maintain motivation. Some negative aspects were raised by some offenders: having to attend too many appointments; having long gaps in the day between

appointments; discussing drug use in groupwork sessions reportedly causing cravings; unmotivated offenders on the order were reported to be unhelpful; substitute prescribing was considered by some to be limited; and high National Standards meant it was very easy to breach the orders. Some interviewees were able to make suggestions for improvements and the key suggestions were: getting the orders to focus on treatment per se rather than punishment; and being given several chances to succeed on an order. Despite being on a court order, most offenders seemed to be motivated to address their drug use and liked aspects of the orders that worked to increase motivation such as court hearings, the breach process and drug testing.

Study 3 – Experiences of staff, partnership agencies delivering and working alongside DTTOs and DTTO sentencers

Study 3 aimed to sample DTTO staff, staff from other local treatment agencies, who were expected to have contact with the DTTO team or be affected by DTTOs about their opinion on the overall impact of DTTOs. Alongside this opinions were sought from magistrates and judges in the area who had sentenced offenders to DTTOs and the local commissioners of the DTTO project. This was done by conducting 41 semi-structured interviews with a sample of 24 DTTO staff and 17 staff from other local agencies. DTTO staff were interviewed at three different time periods: when staff started with the DTTO team, when staff had been in post for a year, and when staff left the DTTO team. Other agency staff were interviewed when DTTOs first started and at the end of the evaluation period when DTTOs had been running for approximately four years.

While both DTTO staff and staff from other local agencies were optimistic about the outcomes of DTTOs as the orders were first being established, they were less so by the end of the evaluation or on leaving the DTTO team. DTTO staff felt the main aim of DTTOs was to reduce offending and considered the project to be successful on this front. Meanwhile, staff from other agencies and sentencers felt that DTTOs should be reducing drug use and felt that DTTOs were not necessarily successful on this front.

Offender motivation was identified by DTTO staff as being key to an offender's success with lack of motivation being the main reason given for offenders breaching the orders. Assessment of motivation was thought to be all important when assessing an individuals' suitability for an order.

Relationships between the DTTO team and other agencies were reported by both staff groups to be good, especially between individual members of staff. Staff did identify some issues however, such as differing treatment philosophies and DTTOs resulting in increased workloads for other agencies, particularly the local drug treatment service.

Study 4 – Drug testing in the criminal justice system: Solutions to a costly commodity

Study 4 aimed to use drug testing data to examine changes in offenders' drug use whilst on a DTTO and to examine the opinion of the DTTO staff who administered the drug tests to explore their experiences of drug testing in the

criminal justice system in England. The drug test results data were limited, with 54% of offenders having tests available for five months or less, due to offenders breaching or dropping out of contact with the DTTO team. However the collected drug testing results were taken to be the best data available, enabling examination of a snapshot of drug use whilst on a court order. Only 18% of offenders (n=40) had all negative drug test results throughout their order, 30% of offenders showed a reduction in drug use (i.e. an increase in percent negative drug tests), 30% of offenders showed no changes, and 22% showed an increase in drug use (indicated by a decrease in percent negative drug tests) from the beginning to the end of their order.

Predictors of change in drug use included: length of time on an order; sentencing court and whether an offender started the order from custody or community. The longer an offender was on an order, the greater the decrease in drug use (i.e. percent negative drug tests). Offenders sentenced at magistrates court who started their order from the community showed a greater improvement in their drug use, though these started the order with the highest levels of drug use (lowest percent negative drug tests) and also ended with the highest levels of drug use (again indicated by the lowest percent negative drug tests). In contrast, offenders starting their order from the community but sentenced in crown court showed the least improvement in drug use. Offenders sentenced following a period RIC by either crown or magistrates court showed a small increase in drug use (i.e. a reduction in percent negative drug tests). Offenders with a positive order outcome (i.e. DTTO expired or terminated early for good progress) showed a greater reduction in drug use (i.e. reduction in

percent negative drug tests) than those whose order was revoked and the offender resentenced.

DTTO staff interviewed as to their opinions on drug testing felt that generally, drug testing was beneficial and an essential part of treatment. There was however concern regarding the time taken to get the results of drug tests and the limited use that was made of the results. Staff felt that drug test results should be used to challenge offenders, though this was not happening at the time of the interviews. There was also concern that the drug testing system was open to manipulation, as offenders knew when they were going to be tested and hence were able to reduce their drug use in order to affect the test results.

Study 5 – Drug test outcomes in the criminal justice system: What non self report measures of outcome can tell us

Study 5 used non self-report measures of drug testing and reconviction to examine how well DTTOs met their two aims: to reduce offending behaviour and to reduce drug use. A number of hypotheses were identified and answered.

Ninety-three percent of offenders on a DTTO for whom reconviction data were available had been reconvicted, though the mean number of convictions had reduced by 1.4 convictions per offender in the two years following treatment commencement compared to the two years prior to treatment start. Sixty-one percent of the offenders showed a reduction in offences in the two years after

treatment started compared to two years prior to treatment start. A lower number of previous convictions, a positive outcome of the order, and overall lower drug use whilst in treatment were all found to significantly predict lower rates of convictions after the order commenced. There were no significant reductions in the proportion of offenders committing acquisitive offences before and after commencing treatment.

Developments in coerced drug treatments since the start of DTTOs

Since the introduction of DTTOs in 2000, and the start of the current research, the drug treatment system in England has expanded considerably. Alongside this, there has been an increase in drug treatment literature, both empirical and commentaries. While some of the literature was mentioned above in the relevant chapters, the aim of the discussion below is to consider the results of the studies presented in the current thesis in light of new and previously existing literature and to consider implications for future practice and research. Initially, it is important to update the reader on what has been happening in the world of criminal justice drug treatments since 2000. Following this, the findings from the current studies and others are examined to assess whether coerced drug treatment in England and Wales is effective and worth continuing and if so, what can be learnt from current research evidence and how current treatment practices be applied to coerced drug treatments.¹

¹ Despite recent developments in prison drug treatments, this discussion only considers community criminal justice drug treatments as this was the focus of the research conducted in the current thesis.

What happened to drug use prevalence since 2001?

The British Crime Survey 2009/10 (Hoare & Moon, 2010) showed that overall, there had been no changes in reported heroin, methadone and crack cocaine use in the general population in Britain since 1998. Though there was an increase in the use of crack cocaine up to 2008 this decreased again before the 2009/10 BCS. As mentioned in the introduction, however, the British Crime Survey is limited due to the method of data collection which excludes a number of groups likely to contain high proportions of drug users, such as those with chaotic lifestyles who are rarely home, the homeless, and those in institutions such as prisons and student halls of residences.

Since the introduction of DTTOs more work has been done to try and measure the size of the drug using population in treatment, and criminal justice settings. Hay, Gannon, MacDougall, Millar, Williams, Eastwood and McKeganey (2008) conducted a three year study between 2004 and 2007 to estimate the prevalence of problem drug use (defined simply as use of opiates and/or crack cocaine). They used Capture Recapture Methods and Multiple Indicators Methods (see Hay, Gannon, MacDougall, Eastwood, & McKeganey, 2006 for details) to look at data collected from drug treatment, probation, police and prison sources. Three 'sweeps' of the population were conducted looking at 15-64 year olds known to be using heroin, methadone, other opiates or crack cocaine. In 2005/06, at the end of the evaluation reported in the current thesis, they estimated there to be a total of 332,090 problem drug users in England (9.97 per thousand of the population aged 15-64 years) (Hay, Gannon, MacDougall, Millar, Eastwood and McKeganey, 2007). In the East Midlands,

where the current evaluation was conducted, the rate of problem drug use was estimated to be 8.75 per thousand population. It must be noted however that there is a hidden population of drug users who do not appear in drug treatment, police, prison or probation records. While the Capture Recapture method attempted to estimate the size of this hidden population in order to get an overall measure of drug users the actual size of this hidden population remains unknown.

Boreham, Cronberg, Dollin, and Pudney (2007) conducted further sweeps of the Arrestee Survey between 2003 and 2006. In the Arrestee Survey, people aged 17 years and over, arrested on suspicion of committing an offence were invited to take part in a 20 minute computerised interview and provide an oral fluid sample (69% of those invited to participate took part in the study). In 2005/06, 52% of these respondents reported having taken one or more drugs in the month prior to arrest with 26% reporting taking heroin, crack or cocaine in the previous month (slightly lower than in 2003/04). The pattern of drug use also showed a decrease in the use of heroin and crack together and, as in the British Crime Survey (2005/06 – Roe & Man, 2006), there was an increase in the use of powder cocaine. An interesting finding was that the prevalence of having had treatment for heroin in the last 12 months increased from 34% in 2003/04 to 41% in 2005/06 (treatment rates for crack, powder cocaine and alcohol appeared to have remained consistent over this same time period). Boreham et al., (2007) found that of those using heroin regularly (five times a week or more) only 32% were currently in treatment, 60% said they would like treatment, though it is unclear what proportion of these would take up a treatment place

were it offered to them. However, the Arrestee Survey remains subject to bias – only 33% of those eligible to participate in the project were approached to participate due to having to fit the study around the police process and the exclusion of those who posed a safety risk or were deemed unfit to interview. Additionally, only 69% of those approached chose to participate which was only 23% of all eligible participants. Nevertheless, a total of 8,027 participants were interviewed. The Arrestee Survey does however suggest that more drug using offenders were entering drug treatment, perhaps due to the increase in the availability of drug treatment within the criminal justice system. They found a higher rate of previous treatment than found in Study 1 where only 18% of offenders sentenced to a DTTO were in treatment immediately prior to being sentenced to a DTTO. This higher rate could be the result of the increase in availability of drug treatment in the criminal justice system. It could also be that those who were in or had recently been in drug treatment were more willing to participate in the Arrestee Survey hence the high previous treatment rate.

What has happened to drug treatment since DTTOs?

Three years after the start of the evaluation reported in the current thesis, the Criminal Justice Act in 2003 brought in the Drug Interventions Programme (DIP) which aimed to make clients' treatment journeys through the criminal justice system seamless. The DIP (started in April 2003) introduced a range of interventions, by means of Criminal Justice Integrated Teams (CJIT), intended to encourage and retain clients in treatment by providing access to treatment for offenders at any point in the Criminal Justice System. In practice initially this included: access to Arrest Referral Workers; drug testing when charged with

trigger offences (in DIP intensive areas); enabling Restriction on Bail for a drug assessment; and treatment if tested positive for Class A drugs (initially only available in three areas). The Tough Choices Agenda in 2006 (HM Government, 2005) added to this by bringing compulsory drug testing for certain trigger offences forward to the point of arrest, made drug treatment assessment mandatory for all testing positive for drugs, and expanded Restriction on Bail nationally. The role of CJIT was to case manage offenders referred to treatment, co-ordinating agencies and services in order to provide 'joined up' treatment and support, thereby preventing drug users from 'falling through gaps' in the system (Skodbo, et al., 2007). CJIT served to provide drug treatment within the criminal justice system to drug users earlier on in their drug using careers, this was a positive step as it had been suggested by interviewees in the current thesis (Study 2) prior to the roll out of CJIT. Also, it meant that drug treatment could commence whilst an offender was waiting to be sentenced rather than making offenders wait until they were sentenced so making the most of any motivation to change being brought about by facing consequences for their drug related offending. Again, offenders in Study 2 reported that drug treatment should be available immediately to maximise on motivation.

Whilst a national evaluation of CJIT was conducted (Institute for Criminal Policy Research et al., 2007), due to problems recruiting clients for inclusion in the impact assessment, the findings were limited and the report was never fully published although was made available online. Using self-report only, they found that for the offenders recruited into the study there were significant reductions in drug use and offending when compared to one month prior to their

involvement with CJIT. These findings however, were based on 703 participants, almost 80% of whom had been in contact with CJIT for at least one month prior to interview. Hence, the findings were biased toward those offenders staying in contact with CJIT services. One would expect those who did not stay in contact with treatment within these first few months to have less favourable outcomes. In contrast to our findings, where only 7% of offenders referred for a DTTO did not go on to complete an assessment, the CJIT evaluation found a high attrition rate between initial contact with CJIT and completion of an assessment. This perhaps illustrates the strength of the coercion DTTO clients were under. However, the CJIT evaluation found that a high proportion of those drug misusing offenders taken onto the CJIT caseload were successfully encouraged into drug treatment (Institute for Criminal Policy Research et al., 2007).

Some small scale evaluations of DIP have started to emerge: Keene, Stenner, Connor, and Fenley (2007) again found high drop out rates (only 57% successfully engaged, defined as benefiting from one or more substitute prescriptions) and only 32% of all clients in this study stayed in treatment for six weeks or more. Again, this contrasted with findings in the current thesis where only 7% of offenders failed to attend for assessment (Study 1) and after order commencement, only 4% of offenders failed to engage long enough to get substitute prescribing (Study 4). Drug treatment under DIP was not coerced, after assessment entry into treatment was entirely voluntary though engagement in drug treatment may have affected eventual sentencing. This

may explain the difference in drop out rates to those found in the current thesis where treatment was coerced.

Qualitative interviews with clients on DIP (Keene et al., 2007) found that they valued the ease and speed of access to services and the helpful supportive nature of the staff (though these were clients who had stayed in treatment longer than average – on average 14.6 weeks). Best, Day, Homayoun, Kenton, Moverley and Openshaw (2008) conducted a case note analysis and found that, similar to the current studies, a minority of cases resulted in positive outcomes. Additionally, over a quarter of cases were retained to around six months. The drug testing data reported in Study 4 suggests that 46% of DTTO clients were retained on an order till around six months. The fact that DTTOs in the current study show a lower attrition rate at assessment, and longer retention rate in treatment than on DIP may be demonstrating the role of coercion in retaining offenders in treatment.

What makes good drug treatment?

Research has shown that, when combined with substitute prescribing, psychological therapies are more effective than substitute prescribing on its own (Abbott, Weller, Delaney, & Moore 1998; Griffith, Rowan-Szal, Roark, & Simpson, 2000; McLellan, Arndt, Metzger, Woody, & O'Brien, 1993). NICE guidelines for drug misuse issued in 2007, recommended the use of evidence based interventions for drug misuse alongside substitute prescribing (NICE, 2007). In 2009 the National Treatment Agency for Substance Misuse (NTA) issued a framework for psychosocial interventions for drug misusers (Pitling,

Hesketh, & Mitcheson, 2009) based on the NICE guidelines. This document aimed to support services in the effective delivery and evaluation of the recommended interventions. They classified Interventions as high or low intensity in line with a stepped care approach whereby the least intrusive, most effective intervention should be used. High intensity interventions were to be used with those who did not benefit from low intensity or interviews or those who, due to the severity of their disorder or past failures to benefit from treatment, were judged to require immediate treatment with a high intensity intervention. Low intensity interventions on the other hand could be delivered by non drug treatment specialists such as probation officers and these focused on motivation and treatment engagement to reduce drug use, namely Motivational Interviewing (MI) (Miller & Rollnick, 2002) and Contingency Management (CM) (Griffith, Rowan-Szal, Roark, & Simpson, 2000). High intensity interventions were defined as formal psychological therapies to be delivered by a specialist psychological therapist and included Behavioural Couples Therapy (Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002). Two additional psychosocial interventions have since been put forward by the NTA as part of a suite of documents aimed to "equip clinicians and drug workers with the latest and most effective tools for working with drug users" (National Treatment Agency, NTA, 2008, p. 2). These interventions were the International Treatment Effectiveness Project (ITEP) (NTA, 2008) and the Birmingham Treatment Effectiveness Initiative (BTEI) (Day, Best, Bartholomew, Dansereau, & Simpson, 2008). In the studies in the current thesis a high staff turnover rate within the DTTO team was noted. As a result of this the specialist drug workers initially in the DTTO team left within 18 months of DTTOs starting

resulting in a treatment team of prescribing GPs, Probation Officers and Probation Service Officers (see Study 1 for a full description). While some probation staff had undergone initial MI training the remaining probation staff were not specialist drug workers and had minimal training in psychosocial techniques to address drug use. It has since been shown that 2-day MI training, similar to that undergone by probation officers in this evaluation, on its own is insufficient to guarantee effective implementation of MI (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004).

Research has shown that therapist competence, performance and training are significant contributors to variances in outcomes for psychosocial interventions (Miller, et al., 2004; Okiishi, Lambert, Eggert, Nilsen, & Dayton, 2006). In an attempt to address this, the NTA framework (Pitling et al., 2009) included a competency framework for staff delivering the intervention. Additionally, adequate supervision has been found to be required in order to maximise the benefits of the interventions (Miller, Zweben, DiClemente, & Rychtarik, 1995; Stitzer & Kellogg, 2008), and Pitling et al., felt that services delivering psychosocial interventions need to ensure competent staff are in post to deliver supervision. To aid this, they set out competencies for supervision for each of the psychosocial interventions. Roth and Pilling (2008) stated that supervision is an essential element of all psychosocial interventions and should not be seen as an optional extra. Drug treatment in the criminal justice system should consider the staff competency framework and the competencies for supervision to ensure that staff are suitably trained and supervised to deliver these evidence based psychosocial interventions. While initially, the DTTO staff on the orders

under examination in the current thesis, were supervised by a drug treatment specialist, after the first year supervision was delivered by generic probation officers (POs and Senior Probation Officer). Criminal justice drug teams may need to review their supervision arrangements in line with Pitling et al's., (2009) competencies.

The restructuring of community sentences within the criminal justice system under the Criminal Justice Act (2003) replaced DTTOs with Drug Rehabilitation Requirements (DRRs) for all offences committed after 4th April 2005. DRRs were intended to have a greater degree of flexibility than DTTOs, enabling the needs of offenders to be balanced against the seriousness of offence committed (NOMS, 2005a). The flexibility came through DRRs being low, medium or high intensity determined by the number of contact hours, an individual was required to attend. However, the ability to deliver these different intensity orders varied across areas (HMiP, 2006). Huge investment continued to be made into DTTOs and DRRs: in 2001/2, 4,854 DTTOs were commenced; in 2007/8 16,607 DRRs were commenced (NOMS 2008); and the 2010 UK Drug Strategy announced continued investment in DRRs (HM Government, 2010).

Aside from the ability to create orders of differing intensity, DRRs differed from DTTOs in only a couple of ways: under a DRR, court review hearings were only compulsory for orders over 12 months and optional for those of 12 months or less and courts must make a penalty for offenders in breach of their order. In Study 2 of the current thesis, many interviewees reported the court reviews to

be positive and motivating, thus reducing the requirements for court review hearings would limit the orders by removing something that offenders found useful. Court reviews are time consuming but they aid in maintaining motivation for offenders (Study 2; McSweeney, Stevens, Hunt, & Turnbull, 2008; Meiklejohn, 2005). In requiring the courts to make a penalty for offenders in breach of their order (e.g. adding requirements to the order, extending the order or revoking and resentencing the offender), McSweeney et al., (2007) expressed concern that this limited the flexibility of the orders and reduced the opportunities for offenders to 'have another go' at the orders, something that offenders in the current thesis valued (Study 2). This is especially important given the growing evidence that clients need more than one attempt at drug treatment before being successful (Best, Ghufran, et al., 2008; Dennis, Scott, Funk, & Foss, 2005; Gossop, 2005a; NTA, 2009). McSweeney et al. (2007) also felt that the pressure on the court to make further penalties for order breaches undermined the professional judgement of probation officers. DRRs also raise ethical concerns for the current author as one of Gostins' (1991) seven conditions of ethical treatment is that the treatment is no more restrictive than the alternative sentence (Gostin, 1991). Under a DRR, the treatment is not more restrictive, although the punishment for breaching the conditions of the treatment could result in more restrictive sanctions (e.g. extra hours or custody).

Best, Wood, Sweeting, Morgan, and Day (2010) conducted a case note audit to examine what actually took place in DRR treatment sessions. Conducted within one DRR team, they found that clients had regular contact with their DRR drug treatment key worker with the last contact lasting on average 28 minutes. Once

drug testing, compliance and prescribing issues had been addressed, on average only 12 minutes of the session remained for proven effective treatments such as psychosocial interventions, care planning, and harm reduction. As this was based on clinicians' self report which is known to be unreliable (Miller, 2007), and examined treatment sessions within only one DRR team, the findings must be treated with caution, but they do clearly give cause for concern. This finding is in spite of the team delivering solely the drug treatment element of the orders, with the criminal justice components of the order being delivered by the local probation service. The aim of DTTOs and thereby DRRs is to provide treatment to drug users, but it appears that this treatment consists largely of administering the orders and providing substitute medication, with little use of psychosocial interventions proven to work on reducing drug use. While the content of keyworkers one-to-one sessions were not known for the DTTO team under consideration in the current thesis it is known that sessions occurred regularly and were scheduled to last around an hour though the actual session length is unknown. Given that keyworkers in the current study performed a dual role of enforcing the probation aspects of the orders and delivering drug treatment and interventions (Study 3) it is likely that even less time would have been spent delivering evidence based interventions.

Alongside the restructuring of the sentences in 2003, came a restructuring of the probation service as it merged with the prison service to become the National Offender Management Service (NOMS). As part of this, a new system of case management was introduced – the offender management model - whereby an offender manager was allocated to each case who was then

responsible for “steering an individual offender through any single period of engagement with the NOMS services” (NOMS, 2005b). The introduction of NOMS had implications for DTTOs and DRRs, particularly for any operating under a similar model to those evaluated in the current thesis. Instead of one person delivering all of the treatment and interventions as was the case in some areas previously, under the offender management model, the offender manager would refer offenders onto other workers to carry out treatment - a model similar to that used for DTTOs in many areas. This therefore would require considerable liaison and good communication to ensure offenders were receiving the treatment they required and felt adequately supported, something that was found to be lacking within the current evaluation (Study 2). Previously, in the DTTO team reported in the current thesis, case managers carried out the majority of the interventions, both those related to offending and drug related work. Interagency communication was noted as being poor in the DTTO pilots (Turnbull et al., 2000) and many areas have still found this difficult to address.

Dedicated drug courts (DDCs) were first piloted in England in December 2008 in Leeds and West London. DDCs aimed to handle cases relating to drug misusing offenders from conviction through sentence to completion or breach of the order. Offenders sentenced to a DRR in a DDC area would attend the DDC for sentencing and for the court reviews conducted as part of their order. DDCs aimed to make the court more involved in criminal justice drug treatments by ensuring continuity of magistrates and district judges throughout the period that an offender was before the DDC and providing training for sentencing and court staff to help them understand the lifestyles and needs of drug users. Offenders

interviewed in Study 2 reported that they found court reviews to be beneficial and motivating so developing those areas of the orders further could prove beneficial. Continuity of magistrate was not considered as part of the current thesis but the development of a relationship with a magistrate through monthly court review hearings could mean that the positive impacts of being praised by a magistrate (as reported in Study 2) are even greater.

The original two pilot sites for drug courts were subject to an evaluation (Matrix Knowledge Group, 2008) which included an examination of the effect of continuity of magistrates (i.e. offenders having at least one magistrate present from their original sentence or a magistrate that had been present at at least three other reviews). The evaluation found that continuity of magistrate had positive effects on the offenders' behaviour including: a reduced likelihood of missing a court appearance; reduced likelihood of providing a positive heroin test; an increased likelihood of successfully completing their sentence and lower likelihood of reconviction (Matrix Knowledge Group, 2008). However, break-even analysis found that DDCs were costly and in order to break even on costs drug users would have to remain drug and crime free for five years following the end of their sentence. Based on the positive findings of the initial pilot evaluation (Matrix, 2008), DDCs were expanded to four more areas in England early in 2009. Further evaluation of these pilots was being considered, though at the time of writing there was concern that the effects sizes may be too small to make a study viable (Ministry of Justice, 2010).

Recovery Movement

Alongside changes in drug treatment policy, the recovery movement has been gaining voice in the UK. The recovery movement is based on the premise that recovery from drug use is possible though there are different definitions of what recovery actually means. Recovery has been defined as “voluntary sustained control over substance use which maximises health and well being and participation in the rights, roles and responsibilities of society” (UK Drug Policy Commission, 2008a, p. 6). Others have defined recovery in terms of a process leading to complete abstinence from drugs. For example, the Scottish Government defined recovery as, “a process through which an individual is enabled to move on from their problem drug use towards a drug free life and become an active contributing member of society” (2008, p. vii). However, it is widely acknowledged that recovery is an individual process and it may be up to the individual to define what ‘recovery’ and ‘living well’ means to them (Yates & Malloch, 2010). Offenders in Study 2 entered treatment on a DTTO hopeful that they would be able to address their drug use whilst on the order and, as discussed in Study 3, having hope or self efficacy is associated with longer abstinence from substance use (Irving, Seidher, Burling, Pagliarini, & Ribbins-Sisco, 1998). The recovery movement, whilst increasing hope in treatment workers, may also work to increase and maintain hope in individual drug users.

Whilst it is widely acknowledged that drug users do relapse and drug use is considered to be a chronic relapsing condition, (indeed, offenders in Study 2 acknowledged that it may take two or three attempts on a DTTO before they made full use of it), evidence is emerging that for many, it is possible to

completely recover from drug use. Eighteen percent of offenders for whom drug test results were available in Study 3 had no positive drug tests throughout the duration of their order suggesting abstinence from drugs for the duration of contact with the DTTO team and 30% of offenders showed a reduction in illicit drug use. Though whether these offenders were in receipt of a substitute prescription at the end of treatment is unknown as is whether these reductions in drug use were maintained following the end of contact with the DTTO team.

Gossop (2008) referred to what he called a 'clinical fallacy', suggesting that when people do succeed in getting off drugs, they do it away from the eyes of the drug treatment services, meaning that clinicians are denied the benefits of seeing the treatment successes and instead, are continually confronted by their failures. Best, Groshkova and McTague (2009) reiterated this by saying that as those who recover move away from the drug treatment system, they are lost to research and follow up and hence treatment services and researchers wrongly continue to believe that there is no recovery from treatment. Additionally, it is possible for people to recover from drugs without ever entering the drug treatment system (Granfield & Cloud, 2001).

Advocates of the recovery movement believe that it is possible to recover from drug and alcohol dependence, that there is hope for drug treatment addicts and that treatment approaches should be refocused with this in mind (UK Recovery Federation, 2010). There is concern that continued methadone maintenance is actually detrimental to drug users. Substitute prescribing on DTTOs under consideration in this thesis was largely methadone based. While attempts were

made initially to reduce prescribing once illicit drug use had stabilised, methadone maintenance prescribing was common. Maintenance prescribing has a stigma of failure attached to it (Hunt, Lipton, Goldsmith, Strug & Spunt, 1985) and Best (2009) claimed this stigma contributes to learned helplessness of clients who embrace treatment without end. Long term methadone prescribing has also been shown to result in cognitive and neurological impairment (Davis, Liddiard, & McMillan, 2002; Mintzer, Copersino, & Stitzer, 2005). The idea of recovery is not isolated to the UK or to drug use only. White is an advocate of recovery in the US and has written prolifically on the subject (White, 2004; 2007; White and Kurtz, 2007). Recovery is also being talked about in relation to mental illness (Cagne, White, & Anthony, 2007).

Part of the emphasis for the recovery movement has come from studies looking at literature into desistance from crime. Laub and Sampson (2003) and Sampson and Laub (2005) found that finding stable relationships and gaining employment were significant factors in recovery from criminality, though alongside this, the role of human agency, (i.e. the execution of choice and individual will) is still key. Individuals still have to choose to find employment or develop relationships over continuing their current lifestyle. The work of Laub and Sampson has inspired research into the notion of drug use ‘careers’ and desistence from drug use (e.g. Hser, Longshore, & Anglin, 2007).

While there are varying reasons given by recovered drug users for stopping their drug use such as maturing out of drug use (Best, Ghufran, et al., 2008) or personal problems creating a turning point (Cloud & Granfield, 2004), a key

factor identified in a number of studies in maintaining abstinence is having social support from non-drug users (Best, Ghufran, et al., 2008; Flynn, Joe, Broome, Simpson, & Brown, 2003; Hser, 2007). Offenders in Study 2 reported that mixing with drug users who were not motivated to address their drug use made it harder for them to maintain their motivation, reinforcing the idea that social support from non drug users is important. Achievement of paid employment has also been identified as an important factor in sustained recovery from drugs (Klee, McLean, & Yavorsky, 2002; Platt, 1998; Room, 1998; Westermeyer, 1989). Offenders in Study 2 reported that they struggled to find and maintain employment whilst on a DTTO due to strict National Standards. While Best, Ghufran, et al. (2008) suggested that treatment appeared to play a minimal role in achieving abstinence, Flynn et al. (2003) in a follow up of the Drug Abuse Treatment Outcome Study (DATOS), found it to be significant in helping drug users achieve recovery. Ricketts et al., (2002) study looking at the life course of DTTO found that the relative importance of treatment to individuals reduced as treatment went on so it could be that treatment is important to invididuals in the early stages of recovery but assumes a lesser role as individuals progress towards recovery. However, it is also known that many drug users recover from drug use naturally and without any need of drug treatment agencies (Granfield & Cloud, 1999).

Research into why drug users finally stop or desist from using drugs (sometimes referred to as desistance research) is limited by the use of retrospective recall, self-report, and possible bias introduced by the method of accessing recovered substance users. Attempting to contact ex-clients of

services can prove problematic, as due to their chaotic lifestyles, they may well have changed address or decline to participate in any form of study. Drug treatment agencies can also show some reluctance to allow contact with ex-clients fearing it may result in ex-clients being referred back into services and hence an increased workload. Some recovered drug users may choose to remove themselves completely from the world of drug use and drug treatment and eschew all contact with the system or drug treatment agencies in an attempt to avoid relapse or to avoid the stigma associated with being a drug user. Other recovered drug users, however, may relish the identity that being a recovered drug user gives them and choose to remain in contact with or even become part of the drug treatment system. Hence, for example, a large proportion of the recovered users in the Best, Ghufran, et al., (2008) study were ex-drug using professionals. For all these reasons, drug users who recover from drug use outside of the drug treatment system are an unknown quantity and hard to access.

2010 Drug Strategy

Late in 2010, a new drug strategy was released ‘Reducing Demand, Restricting, Supply Building Recovery’ (HM Government, 2010). This strategy had recovery of individuals at its heart and by instituting recovery reforms, it aimed to offer individuals with drug problems “the best chance of recovery and enable them to make a full contribution to their local communities” (p. 3). It was acknowledged that recovery is “an individual person-centred journey that will mean different things to different people” (p. 18). While it was felt that the ultimate goal was to enable individuals to achieve abstinence, it was acknowledged that there was a

role for substitute prescribing and that medically assisted recovery was an option i.e. still being in receipt of a prescription whilst holding down a job and having positive family lives without the use of illicit drugs. As the title suggests, the strategy had three themes: reducing demand; restricting supply; and building recovery in communities. Criminal justice drug treatments were to continue to be supported under the theme of reducing demand, aiming to consistently enforce effective criminal sanctions to deter drug use and support people to recover. Under the treatment theme ‘building recovery in communities’, the policy does not determine how treatment should be provided but aims for a recovery oriented ‘system’ which has eight best practice outcomes in mind. At the top of this list of outcomes is ‘freedom from dependence on drugs and alcohol’. A reduction in crime and offending is the only outcome not focused on benefits to the individual. The strategy aims to take a whole systems approach to “address the needs of the whole person” (p. 20) involving education, employment, housing, family support services, wider health services and, where required, prison and probation services. They consider embedding the principles of recovery in all of these services to be vital. They want geographical areas to build networks of ‘Recovery Champions’ – both those working in the field at strategic and treatment level and those who themselves are in recovery - who will spread the message that recovery is achievable and worth aspiring to. The policy takes the view of the role of drug treatment further than previous drug strategies, saying that recovery is about enabling people to successfully reintegrate into their communities, not just tackling the symptoms and cause of drug and alcohol dependence.

Recovery capital

The 2010 Drug Strategy refers to the concept of ‘recovery capital’ as the best predictor of recovery being sustained (HM Government, 2010). This is based on the work of Granfield and Cloud (1999) who defined recovery capital as, “the sum total of one’s resources that can be brought to bear in an effort to overcome alcohol and drug dependency” (p. 179). Cloud and Granfield (2008) recently developed their theory further and stated that recovery capital consists of four components: social capital; physical capital; human capital and cultural capital (Cloud & Granfield, 2008). Social capital is the sum of resources, actual or virtual that accrue to an individual or group through possession of a durable network of more or less institutionalised relationships of mutual acquaintance recognition (Bourdieu & Wacquant, 1992). In relation to substance use, those attempting to address their substance use who have access to social capital may be aided in recovery by the expectations and obligations of others. People with social capital are in a much better position to initiate and maintain a successful recovery effort than individuals without social support. In coerced drug treatment, the drug users are particularly chaotic, often with limited family and social support hence will often be entering treatment with low levels of social capital. Physical capital includes income, savings, property, investments and other tangible financial assets that can be converted to money. Substance dependent individuals with physical capital are able to access options for addressing their substance use that are not open to those without these resources e.g. private treatment, residential rehabilitation or the finances needed to move to a different geographical area. In criminal justice drug treatments, drug users often have very limited physical capital hence the

assumption that they are offending to fund their drug use. Human capital includes skills, educational achievements, health, mental health, and other individual human attributes that enable individuals to function effectively in society. Human capital allows an individual to maximise the benefits associated with membership of that society and attain personal goals. When lacking this capital, substance dependent individuals can find themselves immersed in drug subculture where criminal activity can undermine their ability to cultivate prosocial values and patterns of behaviour that could bolster their chances for legitimate success in life. Cultural capital includes values, beliefs, dispositions, perceptions and appreciations that emanate from membership in a particular cultural group (Bourdieu, 1986). It embodies cultural norms and the ability to act in ones own interest within these norms to meet basic needs and optimise opportunities. In relation to drug users in coerced drug treatment the view of drug related crime as an acceptable method of funding drug use, demonstrates a lack of cultural capital and makes re-entry into conventional life particularly challenging (Terry, 2003). The concept of recovery capital is therefore more than just simply getting someone into treatment, it also considers an individuals' investment and ability to operate as part of a community. Coerced drug treatment needs to consider how to address areas of recovery capital that may be lacking in coerced drug users e.g. cultural, social and human capital.

Best and Laudet (2010) discussed recovery capital at a community level and suggest there is evidence of the social transmission of some of the key elements of recovery capital. The growth of recovery capital through groups

and recovery oriented systems of care may provide ready made social supports for individuals starting out on their recovery journey.

The role of treatment in recovery is unclear. Recovery capital includes a range of aspects that would normally fall outside the remit of drug treatment.

Additionally, people are able to recover from drugs naturally without treatment and reports from those who have recovered show that they feel treatment played a minimal role in their recovery. White (in press) argues that treatment is best thought of as an adjunct of the community rather than the community being viewed as an adjunct of treatment (p. 7, in press). Best and Laudet (2010) suggested that treatment services should work to enable their clients to start their recovery journey and support community based, socially grounded recovery activities. This suggests that drug treatment has a limited but important role to play in recovery and establishing recovering drug users in the community where they can continue their recovery.

Reviewing the issues in coerced drug treatments

While the government is continuing to invest in drug treatment within the criminal justice system, it seems timely, given the findings in the current thesis alongside the ever increasing scientific literature, to revisit some of the main issues for coerced drug treatment: the effectiveness of coerced drug treatments, the links between drugs and crime and the role of motivation and coercion. Following this it is important to consider the role of criminal justice drug treatments in the recovery movement.

Effectiveness?

Since DTTOs started, more evidence has begun to appear on the effectiveness of drug treatments, in the UK, both coerced and voluntary. A number of these have already been considered as part of the individual studies that make up the current thesis: Scottish DTTO pilots (McIvor, 2004); Drug Treatment Outcome Research Study (DTORS) (Jones et al., 2007; 2009); Drug Outcome Research in Scotland (DORIS), (McIntosh, Bloor, & Robertson, 2007), and the NTA study into criminal justice treatments (Millar, Jones, Donmal, & Roxborough, 2008).

Generally, the findings have been that drug use and offending are reduced by drug treatments in the Criminal Justice System (Best, et al., 2002; ; Best, Day, et al., 2008; Hough et al., 2003; Jones et al., 2007; 2009; McSweeney., 2007; Millar et al., 2008; Turnbull, McSweeney, Webster, Edmunds, & Hough, 2000; University of Essex, 2002), though these studies have their limitations. The most common criticism of drug treatment research is that there is no control group which can be used to allow a measurement of treatment effectiveness. There are a number of rating scales for rating the evidence from treatment effectiveness or outcome studies, including the Scientific Methods Scale² (SMS – Sherman, Gottfredson, MacKenzie, Eck, Reuter, & Bushway, 1997). The ‘gold standard’ in outcome studies is a Randomised Control Trial (RCT) which is hard to obtain in the drug treatment field, particularly in the criminal justice system (Hollin, 2008) and Tucker and Roth (2006) felt RCTs were not well suited for studying chronic health and behaviour problems such as substance misuse. In terms of the SMS next comes the need for a control group, again, in

² This has been adapted specifically for reconviction studies by Friendship et al., 2005.

this area of treatment it is hard to obtain an appropriate control group. Not even the largest or highest funded studies such as NTORS (Gossop, 2005a; Gossop et al., 1999; 2001; 2002) or DTORs (Jones et al., 2007; 2009) managed to obtain a control group.

The pilot evaluation of DTTOs and evaluations in other areas used a variety of comparison groups including comparing DTTO clients to clients on similar local drug schemes (e.g. Eley, Gallop, McIvor, Morgan, & Yates, 2002; Turnbull et al., 2000;) or recruiting voluntary drug treatment clients from local treatment services (Schaub et al., 2010). Comparison groups consisting of clients on similar local drug schemes, however, are not considered sufficient to ensure research validity under the Maryland Scale (Hough, 2010).

McSweeney et al, (2007), as part of a wider European study into what they call Quasi-Compulsory Treatment (QCT), attempted to address the issues of comparison groups. They used the term QCT to refer to “drug treatment that is motivated, ordered or supervised by the criminal justice system but takes place outside prisons” (p. 471). In England, the QCT client sample were those on a DTTO and the comparison group comprised voluntary treatment entrants attending the same treatment agencies where the QCT clients were being treated. However, only 52% of eligible treatment entrants participated in the study, the remainder either did not present to treatment or dropped out of treatment prior to the first interview. Those who were interviewed were therefore a biased sample and, as the authors acknowledged, those who dropped out before interview may have “represented some of the most

intractable and needy people" (p. 473). Relying on self-report measures across a range of outcomes – offending behaviour, drug use, social integration and mental health, they stated "the message from our research is not that 'coercion works' but that treatment can be an effective alternative to imprisonment" (p. 486). QCT entrants showed considerable and sustained reduction in substance use, injecting and offending behaviours and improvements in mental health. Similar reductions were found in voluntary treatment entrants. The nature of Stevens et al.'s data does not allow direct comparison between their findings and those reported in this thesis but, as in Study 4, their results showed a decrease in drug use (24%) rather than complete abstinence from drugs. Additionally, similar to the findings in Study 5 in the current thesis, the QCT group in Stevens et al.'s study reported that 83% continued offending after starting treatment. The findings from Stevens et al., (2007) supported those from the wider European study examining QCT in the UK, Austria, Italy, Switzerland and Germany (Shaub, et al., 2010). However, the use of self-report measures of drug use are problematic in a study such as theirs where the clients are chaotic (Kilpatrick, Howlett, Sedgwick, & Ghoddse, 2000) as they are likely to be in criminal justice populations. Additionally, self reports on offending behaviour are known to be less reliable in those convicted of property offences (Farell, 2005) which are thought to be the most common offences in drug users.

Research to date suggests that criminal justice drug treatment in England and Wales is effective at getting people into treatment (Skodbo et al., 2007), retaining people in treatment (Keene et al., 2007), reducing offending (Best, Day et al., 2008; Hough et al., 2003; McSweeney et al., 2007; Milllar, et al.,

2008; Study 5) and, based on self-report data, reducing drug use also (McSweeney et al., 2007; Turnbull et al., 2000).

The National Treatment Agency (NTA) estimated that drug users require on average six attempts at drug treatment in order to be drug free (National Treatment Agency, NTA, 2009) and Best, Ghufran, et al., (2008) found that former heroin users had had an average of 3.1 episodes of treatment and 5.4 previous 'quit' attempts before succeeding in becoming drug free. Perhaps one of the positives of drug treatment in the criminal justice system is simply that it gets people back into treatment, albeit repeatedly. Even offenders in the current thesis (Study 2) stated that on breaching an order, they liked being given the opportunity to come back and try again, and offenders interviewed in the DDC pilots also reported that they liked being given another chance by the courts when up on breach proceedings (Matrix Knowledge Group, 2008). Perhaps this is one aspect of what the expansion of drug treatments in the criminal justice system offers – just repeated opportunities to get offenders back into treatment. Hopefully then, at some time, their recovery capital will match their motivation thus enabling them to make the necessary changes and step away from the revolving door of drug treatment.

Consideration however needs to be given to whether community drug treatment in the criminal justice system in England and Wales is suitable for everyone. The data presented in the current thesis showed that offenders who engaged in the treatment on offer and went on to complete an order reduced their drug use and offending. However, a large proportion of offenders whose orders were

revoked for breach of their order and/or further offences (57%) seemingly got limited gains from the treatment in terms of their drug use and offending. It was those with the highest previous reconviction rates and levels of drug use throughout the order who showed the least improvement in their drug use (Study 4). DTTOs were targeted at just these people - high end chaotic drug using offenders – and as an alternative to custody, these are the people for whom it seems least effective.

Other studies have also found groups of offenders who are seemingly resistant to treatment (Best, Day, et al., 2008; Gossop, Marsden, Stewart, & Rolfe, 2000a) and this is not a new finding. About one in four patients treated in methadone programmes have been found not to respond well to treatment (Institute of Medicine, 1990). Best, Day, et al. (2008), in his study on criminal justice drug treatments, suggested that those who were resistant to treatment were primary offenders rather than primary drug users (based on Nurco's classification, 1998). Alternatively, these could be people early on in their drug treatment careers who have not yet been through the revolving door of drug treatment frequently enough to have developed the skills, recovery capital or social support they need to achieve and maintain abstinence. Or these could simply be people who do not wish to change their lifestyles. Evaluations of the new Integrated Drug Treatment System (IDTS) in prisons may help to throw light on this subject. If the IDTS has good results, then maybe for some offenders drug treatment in custody may actually be the better option in terms of reducing their drug use.

Interviews with treatment staff in the current thesis (Study 3) suggested that proper assessment of offenders' suitability for drug treatments was key to the success of the orders. As offenders will get treatment wherever they are in the criminal justice system – arrest, community order, remand, custody, parole - perhaps now efforts could be made to target treatments at the people most suited to each treatment. Proper assessment of motivation, lifestyle, drug using behaviours, offending history, and offending behaviour is needed to enable this to happen. As part of this, social support networks should be assessed as these are key in maintaining abstinence (Best, Ghufran, et al., 2008; Hser, 2007; Flynn et al., 2003). The concept of recovery capital may also be worth consideration here as well. White and Cloud (2008) developed a recovery capital/problem severity matrix and use this to assess appropriate interventions. For individuals with high problem severity/complexity and low recovery capital, high intensity, broad scope (e.g. outreach, assertive case management and sustained recovery), long duration interventions are required (Cloud & Granfield, 2000; 2004). However, they suggested that for such individuals, brief treatments isolated from an individual's natural environment (such as drug treatment whilst in custody) without the use of substantial community based supports is likely to result in failure (White & Cloud, 2008).

Drugs and crime theories

Whilst there is no doubt that drug use and offending are linked, the assumption made that drug use directly causes offending (via Goldstein's economic necessity model, 1985) is problematic in its simplicity. The economic necessity model assumes that drug use directly leads to crime, taking no account of other

factors that are known to be related to drug use (e.g. age, employment status etc, refs) or even the role of the individual, their lifestyle decisions and their social support network support (Copello, Orford, Hodgson, & Tober, 2009).

The evidence for dependence on an economic necessity model seems to be failing. Surely, if all drug related crime can be explained by the economic necessity model, then treating drug use would stop all crime. Whilst studies have found that drug treatment does reduce offending, it does not necessarily stop all crime and in some cases drug treatment has a limited effect on crime (Bennett & Wright, 1986; Jarvis and Parker, 1989; Burr, 1987; Gossop, et al., 2005b; Study 5.). Additionally, in many research studies, crime has been shown to precede drug use (Pudney, 2002) and continue after cessation of drug use (Nurco, 1987). No studies into the relationship between drug use and crime have been able to demonstrate causality, so the relationship is still merely an association between drugs and offending which are also associated with many other variables. For example, Bennett (2000) in the New-ADAM study found that socio-demographic variables may be more important than drug use in predicting some types of offending, while other researchers have argued that drug using and offending behaviours cannot be understood without an examination of them in their social context (Seddon, 2006). McIntosh, et al., (2007) argued that research into drugs and crime is limited by a lack of research into the effect of a reduction in drug use rather than merely abstinence. This is an important aspect to consider given that until recently, drug treatments in the UK have focused on harm reduction rather than complete abstinence.

The current studies found a reduction in offending for some drug users but not for all. Those with lower drug use throughout the order showed lower frequency of offending post DTTO, although no relationship was found between change in drug use and frequency of offending post DTTO³. The current studies however did not set out to test the relationship directly and hence the findings were limited.

Evidence would seem to suggest that there is no one simple model in play and instead, there exists a combination of models and factors to explain the links between drug use and crime (Bean, 2004). Additionally, the relationship between drug use and crime is thought to change within individual drug users over their drug using careers (Simpson, 2003).

Whilst drug treatment generally has benefited from the focus on drug related crime by means of increased funding for treatment services, the focus has been on reducing crime, not drug use. In some cases this has been to the neglect of dealing effectively with individuals' drug problems beyond substitute methadone prescribing and harm reduction measures (Hunt & Stevens, 2004). Drug treatments in the criminal justice system are currently subject to the recovery agenda in the new UK Drug Strategy (2010) and will now need to focus on treatment of drug use as a main aim alongside reducing offending if there is to be equality of treatment provision within and without the criminal justice system.

³ Due to the nature of the data available it was not possible to clarify if those who were reducing their drug use also reduced their offending. The measure of drug use is only available for the duration of an order while offending rates were available two years pre and post order start. The measure of change in drug use therefore was only a measure of change whilst on an order; it takes no account of drug use immediately before the start of an order when it is expected drug use may change in anticipation of an order commencing.

Coercion/motivation

As DTTOs were the first form of coerced drug treatment in England and Wales, there was concern among drug treatment staff that if offenders were coerced into treatment, they would not be motivated and hence would have poor treatment outcomes (Study 3). The literature review in the current thesis included a number of studies that have attempted to look at the interaction between coercion and motivation (Longshore, Prendergast, & Farabee, 2004; Longshore & Teruya, 2006; Ryan, Plant, & O'Malley, 1995; Simpson & Joe, 1993; Wild, Cunningham, & Ryan, 2006;). In the current thesis, the offender interviews (Study 2) found that, despite being on a court order, a large proportion of the offenders actually wanted to be in drug treatment. This supports the idea that simply because someone is coerced into treatment they are not necessarily unmotivated to address their drug use, as found by other researchers (Hiller, Knight, Leukefeld, Simpson, 2002; Stevens et al., 2006).

The staff interviewed as part of the current thesis (Study 3) felt that 'motivation to change' was key to offenders' success on an order. While studies comparing coerced treatment to voluntary treatment have found limited differences in outcome (Schaub et al., 2010), it is well established that motivation to enter drug treatment and readiness to change influence length of stay in treatment (Simpson, 2001) which predicts outcome at follow up (Joe et al., 1998). Motivation at intake is also related to favourable follow up outcomes in drug use (Shen, McLellan, & Merrill, 2000; Simpson, Joe, & Rowan-Szal, 1997) and treatment retention and engagement (DeLeon et al., 1995; Joe et al., 1998;

Ryan et al., 1995; Simpson, Joe, Rowan-Szal, & Greener, 1995). However, these studies comparing voluntary and coerced treatment are flawed. Whether treatment is coerced or voluntary is determined simply by the source of referral to treatment, and not the involvement of court in the treatment decision (Seddon, 2007). Some researchers suggest there is an interaction between external pressure (i.e. coercion from a legal source or friends or family) and internal motivation that can lead to better treatment outcomes (De Leon, Melnick, Kressell, & Jainichill, 1994; Longshore et al., 2004; Simpson & Joe, 1993).

Groshkova (2010) expressed concern that current models of motivation in substance misuse treatment are not sufficiently grounded in the main psychological theories. He suggests that self-determination theory (SDT, Deci, & Ryan, 1985) may improve understanding of the dynamics of motivational factors and their role in change. Wild, et al., (2006) have also looked at SDT in relation to motivation and coercion. SDT proposes that individuals have a genuine tendency to engage in activities that endorse positive health and growth, they term this 'intrinsic motivation'. Intrinsic motivation is associated with increased well-being and health (Ryan & Deci, 2000) but not all behaviours are intrinsically motivated (Deci & Ryan, 1985, 2002). Extrinsic motivation, i.e. motivation from external sources (which could include pressure to enter treatment from court, family or friends) is often required where behaviours are perceived as inconvenient or not enjoyable (e.g. undergoing substance abuse treatment). Motivation is conceptualised along a four point continuum (Ryan & Deci, 2000; 2002) where motivation moves from extrinsic to internal motivation

through two further stages of internalisation or identification of motivation. Extrinsic motivation is at one end of the continuum along with ‘introjected motivation’ which refers to a partial internalisation of a behaviours value though ambivalence remains. In coerced drug treatments this could be individuals who have accepted treatment in order to avoid a custodial sentence and they believe it may be a good idea to address their drug use but feel the high attendance requirements and demands of a court mandated drug treatment are not required to aid them in doing this. On the opposite end of the spectrum with intrinsic or internal motivation is ‘motivated through identification’ where an individual identifies with some external factor perceived to represent individuals own values and beliefs. In coerced drug treatment this could be those who would not have chosen to enter drug treatment voluntarily but are motivated to address their drug use and identify with and accept the coerced treatment and internalise the treatment goals. This supports our finding that despite being coerced into treatment our offenders were not necessarily unmotivated to address their drug use (Study 2) again suggesting that perceived level of coercion is more significant than actual level of coercion. Indeed, key in SDT is that it is not the external event (in the case of coerced drug treatment this is being sentenced to drug treatment) but its functional significance (Ryan & Grolnick, 1986) or meaning that affects motivation.

Under SDT a sense of autonomy, competence and relatedness are critical to the process of internalisation and integration. Autonomy concerns the experience of acting with a sense of choice and self-determination. Competence is the belief that one has the ability to influence important

outcomes and relatedness is the experience of having satisfying and supportive relationships. Addiction treatments that enable clients to feel autonomy and support confidence are likely to enhance intrinsic motivation, and engagement of clients in activities that they find challenging, (.e.g. drug treatments). In coerced drug treatments it may be hard to achieve a sense of autonomy where drug users are required to engage in drug treatment or face the consequences.

In line with SDT Wild et al., (2006) suggest coerced treatment success may not be due to initial reasons for entering treatment but whether individuals are able to internalise the goals of the treatment. Therefore, instead of offenders needing internal motivation at treatment commencement to succeed on orders (as proposed by DTTO staff in Study 3) it may be more important that an individuals' belief in their autonomy and confidence to change once they are in treatment are key to raising their levels of intrinsic or identified motivation. This may be aided by interventions that work to increase internal motivation such as MI or BTEI as suggested by the NTA.

MI is a goal directed person centred counselling style which, when used in drug treatment services explores and resolves an individuals' ambivalence around their drug use in order to elicit behaviour change (Miller & Rollnick, 2002). It has been shown to have excellent effect on motivation in voluntary drug treatment clients (Burke, Arkowitz, & Dunn, 2002), though its efficacy in coerced treatment populations is less clear (Ashton, 2006, Ginsburg, Mann, Rotgers, & Weekes, 2002). Ashton (2006) considered this was due to poor quality research, an incompatibility between the aims of MI and the criminal justice

system, and a lack of the psychological, intellectual, physical, economic, or social resources required in drug treatment clients in order to benefit from MI. Best et al, (2010) found that MI was underutilised in DRRs drug treatment sessions. They suggest this may be due to tensions in the role of workers between developing a therapeutic relationship, demonstrating warmth and empathy, whilst also being involved in proceedings to breach individuals. This is similar to the DTTO staff reported in the current thesis (Study 3) who found tensions between the two roles they were required to perform. The success of MI in coerced drug treatment may be dependent on highly skilled workers who are able to balance the tensions of the two roles. SDT has been noted to contain similar assumptions and principles to those used in MI (Britton, Williams, & Connor, 2008; Groshkova, 2010; Markland, Ryan, Tobin, & Rollnick, 2005). However, the use of SDT in relation to MI and addictions treatment has not yet been sufficiently studied (Groshkova, 2010).

BTEI, or the Birmingham Treatment Effectiveness Initiative, is an example of another motivational treatment intervention recommended by the NTA. It was developed based on a combination of treatments that have been shown to increase motivation. The manuals have been made available by the NTA but as yet there is no published information on efficacy.

The recovery agenda and criminal justice drug treatments

The recovery agenda may raise specific issues for coerced drug treatments. While we have identified that offenders entering coerced drug treatments may be no less motivated to address their drug use than those entering treatment

voluntarily (Study 2), the systems of drug treatments in the criminal justice system may need to undergo some changes in order to maximise effectiveness in reducing drug use.

Focus and content of treatment

In recent years, the focus of drug treatment policy has been on the role of drugs in causing crime, based on the reliance on the drugs-crime model.

Commentators have argued that this has enabled drug users to be coerced into treatment under a guise of reducing harm to the society without consideration for individual drug users (Hunt & Stevens, 2004). The 2010 UK Drug Strategy (HM Government, 2010) addresses this by putting recovery of individuals at the heart of drug treatment instead of benefits to the community.

In the current thesis, Study 2 found that offenders entered coerced drug treatment to address their drug use. Despite this, Study 3 found that treatment staff were focusing on reducing offending and not reducing drug use. While coerced drug treatments are part of the criminal justice system, the treatment they provide needs to match that available to other drug users outside the criminal justice system. Under the new UK Drug Strategy (2010), coerced drug treatments are also required to focus on the recovery of the individual thus working to get offenders free of their dependence on drugs and reintegrated back into society. In order to achieve this, coerced drug treatments that operate solely in the criminal justice system without the involvement of other drug treatment agencies may need to review their treatment approach. While substitute prescribing will continue to be a part of drug treatments, psychosocial

interventions such as MI, BCT, BTEI and ITEP show good evidence of effectiveness on improving treatment outcomes. However, on the DTTOs under examination in this thesis, the majority of treatment staff were generic Probation officers who, while skilled in reducing offending, did not necessarily have the treatment skills required to implement these evidence based drug interventions. Consideration should be given by criminal justice drug treatment managers to once again include some drug treatment specialists in DTTO staff teams or contracting out some aspects of treatment to specially trained workers. Indeed, the high intensity interventions recommended by the NTA require specialist psychological therapists to deliver them. Given that DTTOs were aimed at drug misusing offenders who had a long history of drug use and many previously failed attempts at drug treatment, it could be argued that nearly all offenders on these orders would have benefited from high intensity interventions. Provision for high intensity interventions delivered by trained specialists should be in place in order for effective individualised treatment packages to be developed.

The findings from the Best et al., (2010) study that only an average of 12 minutes of each key worker session is available for evidence based interventions is worrying. Evidence based interventions need to be given priority in order for treatment to work to reduce drug use.

Redefining outcome

The movement toward the recovery of individuals in the 2010 UK Drug Strategy is positive and the acknowledgment that recovery will mean different things to different people is particularly helpful. In order for criminal justice drug

treatment aims to be effective for individuals, they should be something that is of relevance and importance to the drug using offenders rather than having a predetermined set outcome enforced on them and simply focusing on offending. If drug users feel that treatment is meeting their aims and needs, then surely they are more likely to remain engaged with treatment and/or return to treatment following a relapse for further input?

Performance target setting

The 2010 UK Drug Strategy acknowledged that there had been a focus on delivering process targets rather than treatment outcomes. Initially, when the current study commenced, DTTOs' performance targets were related to the number of orders commenced per year. In 2004, DTTO performance was measured on completion rates whereby an offender was required to reach the end of their order without having it revoked. However, this target risked services selecting offenders who were likely to complete an order rather than those whose drug use was at a level so as to require the intensive supervision provided on a DTTO.

Based on evidence that retention in treatment is related to treatment outcome (see Gossop, 2005a for a review), the NTA target for drug treatments required clients to be in contact with services for a minimum of 13 weeks. The only measure of drug use instigated in the study area was the Christo Inventory of Substance Use (CISS – Christo, Spurell, & Alcorn, 2000), a measure that has been highly criticised and was intended only as a screening measure (Christo et al., 2000). More recently, the NTA developed the Treatment Outcome Profile

(TOP, Marsden, Farrell, & Bradbury, 2008), which relies on self report of offending and drug use though it is clinician completed and the client need not be present when it is completed. This measure has also been highly criticised (Boyd, 2009; Easow, Varughese, & Luty, 2009). While self reported drug use has its limitations in this client population, (as discussed at length in Study 5), it still has its uses as a measure that is quick and easy to obtain, however, it should not be used in isolation. More use needs to be made of the drug testing results that are already gathered as part of the orders.

Treatment careers

It is important to acknowledge that with the recent growth in the drug treatment industry, drug treatment services no longer stand in isolation, an individuals' involvement with drug treatment services is rarely limited to one episode. Drug use is acknowledged to be a chronic relapsing condition and drug users in treatment in the criminal justice system may have previously been elsewhere for treatment and may go elsewhere for treatment after leaving the criminal justice system drug treatment. It is also accepted that drug users will undergo a number of treatments throughout their drug using career. McSweeney et al., (2007) found that, when following up a group of drug users six months after starting drug treatment, 54% of the original group were still in treatment, though only 27% still attended the same treatment service as at intake. The findings in this thesis (Study 1) showed that even prior to the introduction of drug treatment in the criminal justice system 43% had been in drug treatment elsewhere at some point previous to commencing a DTTO.

Findings from work with those who do manage to achieve and maintain recovery from drug misuse shows that it takes a number of attempts to achieve this. Best, Ghufrun, et al. (2008) found that former heroin users had had an average of 3.1 episodes of treatment and 5.4 previous 'quit' attempts before succeeding in becoming drug free. Dennis et al., (2005) looked at treatment careers and found that an individual's treatment career involved three to four episodes of care. With these findings in mind, drug treatment needs to take a long term view of treatment careers as part of a recovery 'journey' rather than focusing on individual treatment episodes and their outcomes.

Drug treatment needs to be viewed as a long term process covering the individual from first entering the drug treatment system (either voluntarily or coerced) right up to the point of ceasing to use drugs, whether with or without help from the drug treatment system. It then becomes a case of looking at an individual's drug using career rather than individual treatment episodes for evidence of effectiveness. Rather than each treatment agency dealing in a single episode of treatment, each aiming for abstinence, drug treatment agencies need to view their role more as supporting drug users from the point of entering drug treatment right up to achieving abstinence.

Drug treatment agencies need to encourage social engagement to help build sufficient community resources, employment and social support (i.e. recovery capital) in the individual necessary for them to maintain abstinence. Where this recovery capital is lacking it is highly likely that abstinence will not be maintained necessitating further treatment.

As part of taking a longer view of recovery, relapse from drug use should not necessarily be seen as negative. Barker, Horrocks, Kelly, and Robinson (2002) found that their interviewees viewed relapsing into drug use as 'returning to square one' and some of the interviewees in Study 2 saw DTTOs as their 'last chance' to address their drug use, which suggests that relapse and failure on a DTTO would result in a loss of hope of ever being able to address their drug use. Hope has been shown to be vital in healing (Yahne & Miller, 1999). Irving, Seider, Burling, Pagliarini and Robbins-Sisco (1998) found that higher levels of hope and self-efficacy correlated with longer periods of abstinence from substance abuse. Recent work has also demonstrated the potential usefulness and role that hope may have in understanding and predicting criminal behaviours (Irving et al., 1998; Marshall, Anderson, & Champagne, 1997; Martin & Stermac, 2010). Drug users, especially chaotic entrenched drug users, will take many attempts to achieve and maintain recovery and, throughout each of their relapses, they need to maintain or be able to rebuild hope that they can eventually change. Hope is also a critical aspect of motivation: if someone has no hope that they can change, they will not be motivated to attempt to change (Miller & Rollnick, 2002) and are unlikely to return for further treatment.

Encouraging drug users and drug treatment workers to stop focusing on individual treatment episodes and taking a longer view of recovery, may help drug users to maintain hope that recovery is possible. It is important that individuals feel able to return to treatment, either in the criminal justice system or voluntary drug treatment, following relapse without fear of judgement. Re-

entry into the treatment process should be viewed positively as a chance to take a drug user another step closer to the end of their treatment and drug using career.

The proposed use of recovery champions in the 2010 UK Drug Strategy (HM Government, 2010) is likely to be beneficial in building and maintaining hope in drug users. Community recovery champions, those in recovery themselves, may be particularly important as they will be able to instil a message of hope that recovery is eventually achievable. They will thereby be able to help to rebuild hope in those who have previously failed at drug treatment. Admittedly, this long term view will be hard to maintain in individuals in coerced drug treatments where failure to comply with their treatment order may carry a penalty. This is one of the inherent problems of combining punishment and treatment. Recovery champions in custodial settings would be well placed to target individuals who fail on coerced drug treatments to try and rebuild their hope and belief that recovery is possible counteracting the punishment for failing to succeed in drug treatment and getting them back into the treatment system.

This idea is supported in the literature by Dennis et al., (2005) who suggested that we might be able to improve treatment effectiveness by shifting focus from short term outcomes to looking at the longer term course of substance use, (i.e. multiple treatment episodes, relapse and recovery). Indeed, Hayes (NTA Chief Executive) suggested a shift in policy of treatment agencies (Hayes, 2009).

Taking a whole person view

One of the promising aspects of the original DTTOs was the support that was planned for getting drug users back into education or employment, dealing with housing issues, things known to reduce recidivism (Sampson & Laub, 2003), and to be important in recovery from drug dependence (Klee et al., 2002; Platt, 1998; Room, 1998; Westermeyer, 1989)). Alongside this were the other group activities included such as leisure activities, educational activities, and life skills training. The aim of these was to get offenders interested in activities and learning skills that would help their reintegration into society by giving them interests incompatible with drug use. It is unknown what effect these extra aspects of the orders had on drug users, as no outcome studies have considered them (current thesis included). In the current thesis however, offenders repeatedly reported not having housing as a key reason for failing DTTOs, and few offenders ended the order in gainful employment (Study 2).

Literature on drug use desistance suggests that building new lives and social support networks are important in maintaining abstinence, (i.e. continuing the work done in treatment). The aims of the 2010 UK Drug Strategy (HM Government, 2010) to take a whole systems approach to recovery and the involvement of other agencies to address each person's needs is a positive step. Helping individuals to achieve stable housing, education goals or to get a job will probably build their self esteem and make recovery even more attainable. Of course these are elements included in the concept of recovery capital. It will be especially important in coerced drug treatments where treatment ends on a specific date to ensure that individuals are linked into these

agencies and any local available recovery networks. Another possible method of increasing social support may be the use of Social Behavioural Network Therapy (SBNT: Copello, Orford, Hodgson, & Tober, 2009) in coerced drug treatments.

SBNT was developed for treatment of alcohol problems and has been shown to be effective in this population (Copello et al., 2009). It is based on the premise that social network support for change is central to the resolution of addictive behaviour (Copello, Orford, Hodgson, Tober, & Barrett, 2002). The treatment works by engaging members of an individuals' social network in treatment and uses strategies based on communication skills, education about drugs, coping, increasing social support, and dealing with possible lapse and relapse to develop social network support (Copello et al., 2002). A feasibility study assessing the possibility of using SBNT to treat drug problems showed promising outcomes (Copello, Williamson, Orford, & Day, 2007). Work is currently underway to pilot SBNT for drug users, though there are some issues such as recruitment, engagement, and staff training to be addressed (Williamson, Smith, Orford, Copello, & Day, 2007). SBNT aims to achieve support from existing social networks. In the feasibility study, network members were mainly parents, friends and siblings of drug users. The treatment resulted in reductions in illegal drug use, significant increases in family cohesion, a reduction in open conflict and an overall increase in family satisfaction, all aspects of the social capital component of recovery capital. The use of SBNT may also help to ensure that there will be a positive support network available to the offender once the court order has ended.

Summary

The recovery agenda and the required shift of coerced drug treatment focus back to drug use may necessitate changes for coerced drug treatments.

Introduction of psychosocial interventions such as MI and BTEI will require a different skill mix of coerced drug treatment staff than that observed in the current thesis. Additionally, it is important that staff are freed up from other obligations in order to be able to effectively deliver these interventions. By shifting the focus of treatment from individual episodes to a long term view, combined with the work of recovery champions in criminal justice drug treatment, hope of recovery can be developed and built on in coerced drug treatments. More work needs to be done in coerced drug treatments to aide offenders getting back into education and employment, this could be achieved through linking offenders up with local agencies as part of their treatment. However, attendance requirements on coerced drug treatments will need to be reconsidered to enable individuals to achieve and maintain employment. The use of SBNT could be considered to build social support for drug users outside of that available from the treatment providers though the introduction of SBNT to drug using populations has yet to be fully evaluated and more work needs to be done to assess its efficacy in criminal justice populations.

Future research recommendations

The individual data chapters included in this thesis contain criticisms relevant to each of the individual studies. The main issues will be revisited here, along with

other overarching issues which have a bearing on possible recommendations for future drug treatment research.

Lack of control group

One of the main criticisms of the current studies is the lack of a control group, a problem inherent in many studies of treatment effectiveness in the Criminal Justice System as mentioned previously. Without a control group it is not possible to determine whether any changes in the measured outcome, (in this case drug use and offending behaviour) are due to the intervention (the DTTO). In this study, it could be that the changes in drug use and offending observed in those on a DTTO would have occurred naturally or are due to a factor other than treatment intervention. The use of a control group consisting of individuals with similar drug use and offending histories, who did not participate in a DTTO but underwent treatment as usual (i.e. either a custodial sentence or a referral to the local drug treatment team alongside a probation order) would give a clearer picture of what changes in drug use and offending could have been expected to occur under normal conditions and whether the introduction of DTTOs changed this. Therefore, the results of the studies under examination in this thesis are limited in that they can only demonstrate what changes occurred in individuals drug use and offending whilst on a DTTO but not whether these changes in drug use and offending can be attributed to the DTTO.

The initial research proposal for the evaluation included in this thesis included a control group consisting of offenders assessed as suitable for a DTTO but not sentenced to an order due to lack of funds. DTTO services had a yearly target

for commencements and funds were allocated in line with this target. It was anticipated that more offenders would be assessed as suitable for the orders than the number of places funded. However, with the increase in the funding of DTTOs in the first year of the evaluation, there were no offenders assessed as suitable for a DTTO turned down on funding grounds. Considerations were given to finding another suitable comparison group but this was problematic. Recruiting a comparison group from local drug treatment services would not necessarily include drug users who were offending at the same level as those in the DTTO sample. Recruiting a comparison group of drug users in custody would not necessarily include offenders who were using drugs at the same level as those in the DTTO sample and there were no similar pre-existing schemes similar to DTTOs in the area where the evaluation considered in this thesis was conducted.

Whilst the lack of a control group means that treatment effectiveness cannot be determined from the current studies, it does not mean that the findings of the studies are completely without worth. This is the first study to consider drug testing results and reconviction results together (Study 5), and the offender and staff interviews (studies 2 and 3) have raised interesting points to consider in future drug treatment initiatives. Control groups are notoriously difficult to find in applied research so new methods of drug treatment evaluation need to be considered – methodologies that use a multi-method approach to match the given research questions (Tucker & Roth, 2006).

Commissioned research

The research under examination in the current thesis, studies 1 to 5, were originally commissioned by the Probation Service as a service evaluation of the local DTTOs. As such, it was subject to the needs of the commissioning service. These needs changed over the time of data collection and the research was expected by the commissioners to change along with these. At one point it was suggested that the drug testing results were not of interest to anyone and instead the number of drug tests that were offered should be monitored instead. Skilful negotiation was required between the researcher and the commissioning service to ensure that the research element of the project remained and the project did not simply become a performance management exercise. As such, the measures included in the evaluation were those required and funded by the commissioning service, hence the focus on drug use and offending behaviour as the only outcomes. It is acknowledged that this does limit the current research. An opportunity to look into broader psychosocial change – physical and mental, risk taking behaviour, self-esteem, employability, and relationships would have added greatly to the knowledge about criminal justice drug treatments and their client outcomes.

Interview bias

The offender interviews (Study 2) suffered with a high non-attendance rate for arranged interviews. In particular it was difficult to recruit individuals who had breached their DTTOs or had had their DTTOs revoked since they were no longer in contact with the DTTO team. As a result of this, it is possible that the sample was biased towards those who were positive about and engaged with DTTOs (i.e. turning up for appointments), hence their comments may not be representative of all offenders on an order in the target area during the evaluation period. Targeting individuals who drop out from treatment needs to be built into future evaluation exercises. This could be achieved by getting individuals at assessment to consent to follow up if they drop out of treatment and ensuring that resources are set aside to enable this to happen. Treatment drop outs may be hard to contact and this may be aided by getting information from a third party with permission to contact them should the participant prove difficult to contact. This approach has been successfully used to reduce study attrition (Desland & Bately, 1991). This approach should be treated with caution however with strict guidelines to ensure attempts to achieve contact are appropriate and do not infringe the rights of the individual, or the third party contact, to decline to participate in research.

The staff and agency interviews could also have been affected by potential bias. As the researcher was employed by the NHS drug and alcohol services but seconded to the probation services for the duration of the evaluation, the researcher was often seen by DTTO staff as external to the DTTO team but by NHS staff as 'one of their own'. Despite all efforts made by the researcher to

ensure confidentiality, it is possible that the DTTO team or other agency staff tailored their answers as they felt unable to give open and honest responses.

Limitations of the drug testing data

The drug testing data were subject to a number of limitations. Firstly, there were large amounts of missing data as offenders were not tested by the treatment workers as regularly as expected under the orders. Unfortunately, the exact amount of missing data remained unknown and the reasons for the missing data were unclear. A quantity of the missing data was simply due to staff not testing as frequently as specified in National Standards but also a proportion of the missing data will have been due to offenders not attending for testing appointments. No records were kept of testing appointments offered by the keyworkers so it was unclear what proportion of the missing data this would account for. While some researchers have supposed that a missed drug test appointment equates to a positive drug test result (Barker et al., 2002) this does not seem to be necessarily fair to offenders. Interviews conducted by the researcher with offenders when in breach revealed that there were a number of reasons given for failing to attend appointments in general, not just simply relapsing back into drug use. Should researchers plan to use drug testing data in the future, it would be wise to introduce monitoring systems to examine how often drug tests are actually requested from offenders and what proportion of tests offenders miss versus those not offered to them. From this offenders' reasons for failing to attend testing appointments, as well as reasons for staff failing to offer the opportunity for drug tests could be examined in a systematic way.

Interviews with offenders on the DTTO (Study 2) and DTTO staff (Study 4) revealed that offenders were able to manipulate the tests. By knowing when they were to be tested, offenders were able to manage their drug use around this to ensure that they were producing clean drug test results. To rectify this, a random system of drug testing should be used to ensure that offenders are not aware of when their next test will be. The nature of the current evaluation and the drug treatments meant that the current drug testing data were only available whilst offenders were on an order. It is possible that people entering any drug or alcohol addiction treatment reduce their use in anticipation of an assessment appointment at treatment entry. For those drug users in the criminal justice system, it is entirely possible that the prospect of being sentenced to a DTTO, and the hope of succeeding, may have affected their drug use to the extent that they may have reduced their drug use prior to starting the order. The current drug testing data takes no account of this: it ceases when an offender's contact with the DTTO team ends. It is entirely possible, indeed for many highly likely, that their drug use changes after the end of their time on the order, but within the two year follow up time, which would affect their reconviction rate. Future studies would do well to attempt to follow up clients with further drug tests, but attrition rates from such a study are likely to be high.

Black box of drug treatment

Another flaw of the research presented in the current thesis was that there was no descriptive information available on what the one-to-one treatment with offenders consisted of. The clinicians were not trained in psychosocial

treatments beyond MI so the use of specific psychosocial interventions can only be assumed to be low intensity at best. It was known that substitute prescribing was used for almost all offenders, and the vast majority attended groups addressing issues such as relapse prevention, dealing with cravings, and leisure activities such as going to the gym, playing golf or football. Some educational activities were also made available such as literacy teaching and job skills training.

As found in the recent literature (Best, Day, Morgan, Oza, Copello, & Gossop, 2009; Best et al., 2010), while one assumes that evidence based psychosocial interventions are being carried out in drug treatment sessions, this may not necessarily be the case or they may be being carried for such a small amount of time per session that their worth is limited. Certainly in the study area under consideration in the current thesis, DTTO staff were under pressure with high caseloads and multiple tasks to undertake during each treatment session. Future treatment effectiveness studies would be wise to include a measure of what drug treatment sessions consist of similar to that conducted in the Best et al. studies (2009; 2010). Additionally, in line with Pitling et al., (2009) it would be advisable to consider how well staff meet the training specifications for delivering psychosocial interventions as well as the supervision arrangements and quality ratings for therapists.

The experience of conducting the research

The current research was conducted whilst the researcher was seconded from an NHS drug and alcohol service research team to the newly established DTTO

team and this caused some problems. Staff in the DTTO team were not experienced in research or being part of a research project and were suspicious of the motives of the researcher, feeling that they were under examination, which initially led to a reluctance to participate in the research. Contrary to these suspicions the research was initially designed to include feed back to the DTTO staff and management on offender views, and suggestions for improvements to the orders from both DTTO staff and offenders, with the aim of aiding in the development of DTTOs.

Both the local DTTO team, and by default the evaluation project, were under-resourced. DTTO staff were under pressure to complete required paperwork (including court reports - PSRs and review reports; outcome measures – CISS; probation measures – ACE initially then, AEMS followed by OASys) for an ever increasing number of offenders on orders. This undoubtedly led to long periods of staff sick leave and high staff turnover within the DTTO team during the current evaluation period. As such, the time available from the DTTO team to support the research was limited and a lack of cooperation in completing forms – both those required by the probation service (OASYs) and drug service commissioners (CISS) was an inevitable consequence. This limited the research project as it was anticipated that the OASys would serve as an additional outcome measure for the evaluation although in reality it was so rarely completed at the end of an order that it was not included in the research.

The research project itself suffered from a lack of resources also – the research was originally commissioned to be conducted on a part-time basis, but as the

data monitoring requirements and number of offenders on the orders grew, it became impossible for the researcher to complete all aspects of the research project in half time. Hence, initial plans to interview all offenders starting orders, and to follow up offenders whose orders were revoked had to be put on hold. Also, there were computer hardware and software and office space issues, with four office moves for the researcher within the four year evaluation period. It often seemed that as the research was not part of the core business of the DTTO team, the evaluation research and the researcher conducting it were very low on the priorities of the DTTO team.

Confidential interviewing space was a problem for a significant amount of time during the evaluation. The DTTO team moved bases mid-way through the evaluation period to premises with no provision for confidential interviewing space. While a suite of interview rooms was eventually available, these were not soundproofed and conversations could clearly be heard between rooms. For the offender interviews, this led to problems with ensuring confidentiality and may have meant that offenders chose not to be as open and honest as they would have been had they been sure their responses would not be overheard.

Drug treatment policy changes

The findings of the current thesis were limited by the changes in drug treatment policy during the evaluation. DTTOs were introduced in 2000 but subsumed by DRRs in 2005. Whilst this study still serves to provide new knowledge about the introduction of drug treatment into the criminal justice system, with the more recent changes in drug treatment, its findings are less applicable. This is a

common problem in research in criminal justice settings. Pawson (2002) commented “Evaluation research is tortured by time constraints. The policy cycle revolves quicker than the research cycle, with the results that ‘real time’ evaluations have little influence on policy making” (p.157). Perhaps by designing research which includes an aspect of action research, where findings can be fed back immediately to aid treatment development, this would benefit both workers and offenders and ensure that research is still able to influence treatment.

What should future studies include?

Orford (2008), in a discussion of research methodologies used in the addiction field to assess treatment effectiveness, considers that more studies should involve clients' views on the treatment which suggest a greater use of qualitative methodologies. Orford quotes Sullivan (2003) who goes so far as to say “outcomes research is forcing us to recognise that only the patient [sic] can determine if medical treatment has been successful” (p.1602). Unfortunately, in the current study offenders were not asked for their definition of success, but seeing as there are variations in views of clinicians from different agencies and philosophical backgrounds, this would seem to be an important question to ask. Orford also suggests exploring drug treatment practitioners views on treatment effectiveness.

Interviews conducted with staff and offenders in the current research (Study 2 and 3) revealed information on what they felt was working and how they felt orders could be improved. Interviews with the offenders identified useful

suggestions for improvements which were fed back to the DTTO team and some of the suggestions were acted upon (e.g. bus passes for offenders, and women only groups). Offender or clients views of treatment and success are valuable and worth taking the time to collect.

The move in the 2010 UK drug strategy towards individuals' definitions of success in treatment will raise issues in terms of determining treatment success, particularly for effectiveness research. One approach to addressing this would be just to monitor whether individuals met their treatment aims regardless of what they were. However, a treatment aim of abstinence is much harder to achieve than an aim of repairing an existing relationship so research would also need to examine what individuals consider to be an acceptable goal of drug treatment.

Research drug using careers

If drug use should start to be viewed on a recovery career level rather than on the basis of individual treatment episodes, then research also needs to take a new approach to studying drug treatment careers rather than individual treatment episodes. Indeed, with the plethora of treatments now available the effects of one treatment can no longer be viewed or measured in isolation as individuals are likely to have been in treatment before and enter further treatment after the episode in question (Best, Ghufran, et al., 2008; Dennis et al., 2005; McSweeney, et al., 2007). Perhaps a new approach needs to be taken of following an individuals' treatment path for the whole length of a treatment effectiveness study. Others make similar suggestions – Humphrey

and Tucker (2002) argue that extensity of treatment should be examined as well as intensity of treatment. Orford (2008) suggests long term monitoring arrangements should be considered alongside long term care. Dennis et al., (2005) suggested evaluation of substance use treatment needs to account for “the chronic cycle or relapse, treatment, readmission and recovery over multiple years and episodes of care” (p. 559). Hser et al., (2007) argue that we should go further than a career approach and take a life course approach to drug treatment similar to that used in criminology. Such an approach may aid desistance research, and investigations into the relationship between drugs and crime.

Areas for further research

This thesis has highlighted many flaws in the existing research and areas for further research including further investigation of the interplay between offending and drug use within individuals across drug using careers and further research into motivation in coerced drug treatments, particularly with regard to SDT. One possible future research project would be to conduct a prospective, longitudinal study picking up drug users entering the drug treatment system for the first time, across all treatment agencies, and following their progression through the treatment system. Taking an action research approach interviews could be conducted at points along the way to see what clients are finding helpful and what is not helpful with these findings being fed back into the services. Self-report measures of drug use, offending, physical and mental health could be collected. Alongside this, drug tests and reoffending rates (Offenders Index) could be used to verify self reports. Changes in treatment

provider, periods of abstinence and relapse could be plotted. However, such a study would be costly and time consuming. High numbers of participants would need to be recruited in the initial stages of the study to account for attrition rates.

Conclusion

While the evaluation of criminal justice drug treatments under consideration in the current thesis suggests that DTTOs did work for a number of offenders in terms of reducing drug use and offending, a significant group of offenders showed limited change with continuing drug use and high rates of offending. Perhaps this was due to the highly chaotic nature of the individuals under study. Other aspects of treatment in the criminal justice system in England and Wales have been shown to have promising results at getting offenders into treatment and retaining them in treatment with self reports of reduced drug use and offending (Best et al., 2002; Best, Day et al., 2008; Hough et al., 2003; Matrix, 2008; McSweeney et al., 2007, Millar et al., 2008; Skodbo et al., 2007; Stevens et al., 2007; Turnbull et al., 2000; University of Essex, 2002).

The focus of the treatment under examination in this thesis was on reducing offending rather than drug use. The new government strategy will require the focus of drug treatments within the criminal justice system to be on the recovery of the individual. This will require the use psychosocial interventions to address substance misuse which may not be available where all drug treatment on a court order is provided by probation staff.

The shifting focus to the recovery of drug users (rather than simply reducing crime) means that drug treatments can no longer be considered in isolation. Drug treatment in the criminal justice system is part of a wider treatment system which needs to take a long term view of drug treatment focusing on individuals' drug using careers as they begin and end different episodes of treatment and their development of recovery capital.

Motivation appeared to be key to the success of offenders on the orders and the use of psychosocial interventions such as MI, MET and BETI may be beneficial. For many offenders motivation did not seem to be affected by being on a court order. Many offenders wished to address their drug use reinforcing the idea that perceived levels of coercion are more important in determining motivation and treatment than actual levels of coercion.

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Appendix A – Letter from Leicestershire Research Ethics Committee

LEICESTERSHIRE + RUTLAND

Healthcare

NHS Trust

Community Hospitals Mental Health Community Health Learning Disability

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DC/MC/6222

15 March 2001

Dr. Marilyn Christie
R&D Team Leader
Community Drugs & Alcohol Service
Drury House
50 Leicester Road
Narborough
Leicestershire
LE9 5DF

Dear Marilyn

Re: Evaluation of Drug Treatment & Testing Orders

Please find enclosed a copy of the Ethics Committee's reaction to the above project submission. As is indicated therein, this project is surprisingly not considered as appropriate, or as needing the approval of the Leicestershire Research Ethics Committee, but instead is within the remit of the Probation Service. As the latter organisation is involved in the commissioning of this work, I would imagine they would not object to the study being progressed.

As you can see, the principal issue that would have been raised would be that of fully informed consent, but as we have previously discussed, the evaluative aspects of the study can easily be seen as an adjunct to the compulsory nature of the order itself. The R&D Group is however still concerned that the sponsoring organisation wish to exercise an effective veto on the outcomes of the research, and I am willing to write to the sponsors expressing such concern if you so wish.

However, this letter also serves as confirmation of formal **Trust Approval** to undertake the project, and please accept our best wishes on the success of the study.

Regards,



Dave Clarke
[R&D Manager]

Enc.

Melanie Sursham
Direct Dial 0116 258 8610

5 March 2001

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Dear Dr Christie

An evaluation of the Leicester, Leicestershire and Rutland Drug Treatment and Testing Orders (DTTOs). Our ref. no. 6222.

Further to your application dated 16 February 2001 which was considered by the Leicestershire Research Ethics Committee at its meeting on Friday 2 March 2001.

Thank you for submitting this to the Committee. The Committee felt however that this study falls outwith the remit of this Committee and should be approved through the Probation Service.

For information the Committee felt that if this was in our remit we would ask that informed consent be obtained from all participants.

Yours sincerely



P Rabey
Chairman
Leicestershire Research Ethics Committee

(NB All communications relating to Leicestershire Research Ethics Committee must be sent to Leicestershire Health)

Appendix B – Patient Information Sheet

Project Information Leaflet

An Evaluation of the Leicester, Leicestershire & Rutland Drug Treatment and Testing Orders (DTTOs)

Principal Investigators:

Ms. Charlotte Terris
Dr. Marilyn M. Christie
Ms. Deborah Mundin
Mrs. Tina Arrindell

This study is sponsored by: Leicestershire & Rutland Probation Service.

1. What is the Purpose of the Study?

The overall purpose of the present study is to look at the effectiveness of the Leicestershire & Rutland Drug Treatment and Testing Orders in terms of reducing crime and reducing drug use in those offenders on a DTTO. We are doing this by talking to offenders subject to a DTTO (those who successfully complete the order and those who breach or do not complete the order), as well as DTTO staff, and other agency workers.

2. What will be involved if I take part in the study?

You will be interviewed by one of the Research Workers for approximately 20 minutes. The interview will take place at your convenience. During that time, we will be interested to hear of your opinions, expectations, and experiences of DTTOs as well as any suggestions of how they could be improved to better meet your needs. We will also ask you about your drug use and offending behaviour before the Order started.

3. Will information obtained in the study be confidential?

Some notes will be taken during the interview and they will be coded to enable the Research Worker to follow you up when you complete the Order. We will not be recording any other identifying details such as your name, address, date of birth or anything that could identify your answers to be yours. No notes will be made in your clinical records, and your participation will not affect your treatment plan. No staff or workers apart from the interviewer (even your keyworker or your GP) will have sight of your answers.

4. What if I am harmed by the study?

This is basically a consumer satisfaction interview. You will not be asked to discuss anything that you find distressing or upsetting. Medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

5. Expenses

Interviews will be conducted during the course of your attendance for your DTTO and therefore we do not expect anybody to have to pay extra to take part. If your participation in the interview means that you will incur travelling expenses, then these will be reimbursed by the project at the public transport rate. Receipts (e.g. bus, train tickets) may be required.

6. What happens if I do not wish to participate in this study or wish to withdraw from the study?

Participation in this study is part of your compulsory Drug Treatment and Testing Order. We need you to take part to ensure that the orders are as successful as possible.

Appendix C – Offender interview briefing

"We are conducting an evaluation into DTTOs and as part of this we want to speak to people on the order as you are the only ones who know what it is really like to be on a DTTO.

I am a researcher seconded to the DTTO team simply to conduct this evaluation and I work entirely separate of your case manager. Whatever you tell me remains entirely confidential and will only be fed back to case managers alongside other peoples comments. For example we may say that 12 people said this and 3 people said that. I will only talk to your case manager directly about you if there is an issue that you ask me to discuss with them. It is set up this way so that hopefully you can be completely honest with me. I will make notes during the interview to remind me of what you have said but these notes will be anonymised and are only accessible to me and will be stored in a completely different building. Your case manager will not see them.

You do not have to take part in this interview but as I said we want to know what it is like to be on an Order and the only way to find this out is by talking to people on the orders. The interview should only take 10 – 15 minutes. If you do not want to be interviewed you will still be considered as having attended your appointment with me and your case manager will not be informed that you chose not to participate. You are also free to leave at any time during the interview or refuse to answer any questions that you are not happy with. Are you happy to continue?

Appendix D – Offender Interview Schedule

Starters

- 1 What is it like so far being on a DTTO?

- 2 Why did you agree to the Order?

- 3 How many hours a week are you ordered to attend DTTO services?

- 4 What are your views on this? Do you think it is a reasonable amount?

Why?/ Why not?

- 5 How much did you spend on drugs last week (the week before the Order started)? How much are you spending on drugs now?

- 6 What drugs did you use in the last month before the order started?
(Attached sheet)

- 7 Approximately how may (acquisitive) crimes (eg. Shoplifting, burglary etc.) did you commit in the month before the Order started?

- 8 Have you committed any offences since the order started?

9 Have you had any previous contact with drug and/or alcohol treatment agencies? Which services? When? Outcome?

Breachers

1. Why did you breach / not keep to the conditions of the DTTO?
2. What might have helped you to keep to the conditions of the order?
3. Are there any needs that are not being met? How can we help you better to stay within the conditions of the Order?

Revoked and Resentenced

1. Why did you breach/not keep to the conditions of the DTTO?
2. What might have helped you to keep to the conditions of the order?
3. Would you accept the offer of a further DTTO if this were ever made?
Why?
4. Have you any suggestions for improving the DTTOs?

Follow up/Expired naturally/Terminated early for good progress

1. Now that you have completed your orders (or been on your order for more than six months) , what are your overall opinions of the DTTOs?
2. What did you like about the DTTOs?
3. What are your opinions about:
 - a) urine testing?
 - b) court involvement?
 - c) court interviews?
4. What treatments have you received?
 - a)
 - b)
 - c)
 - d)
 - e)
5. Which were the top three in terms of usefulness for you?
6. Did you get the type of help or treatment you wanted?
7. What else could/should have been done to better meet your needs?

8. What did you not like about the DTTOs? Were there any *specific* problems?

9. How did being on a DTTO affect your:

- a) drug use?
- b) offending behaviour?

10. How much did you spend on drugs last week?

11. What was the range of drugs used?

12. Approximately how many (acquisitive) crimes (e.g. shoplifting, burglary etc) did you commit in the last month?

13. Which aspects of DTTOs helped or hindered you to make changes?

14. Have you got any suggestions to improve the DTTOs for others?

Appendix E – Staff interview Schedule

Starting Interviews

1. a. What were the previous arrangements for offenders who had problems with drug misuse and how did they work?
b. In what ways do the Drug Treatment and Testing Orders improve upon these arrangements?

- 2 a. What do you feel are the benefits of the DTTOs?
b. Can you identify any potential / existing problems with the DTTOs? How could these be overcome?

3. What are your overall opinions about:

The sentences?

The review hearings?

The drug testing

The outcomes?

Why some offenders succeed?

Why some offenders breach?

4.
 - a. What key agencies have the DTTO Team set up relationships with?
 - b. What are those relationships like between the DTTO Team and other agencies?
 - c. What are the positive aspects of the relationships?
 - d. How could they be improved?
5.
 - a. What's good about (what are the benefits) of the current working practices that you have experienced identified?
 - b. Have there been any problems? How could these be improved?
6. What do you perceive the outcomes of this project to be in respect of:
 - a. A reduction in offending of those subject to orders?
 - b. A reduction in drug use of those subject to orders>
7. To what extent has the project succeeded in being accessible to minority groups (e.g. ethnic minorities, women, employed, those with young children, etc.)
- 8 To what extent do you think the project has provided value for money so far?

Repeat staff interview

1. How do you think current DTTO arrangements have improved upon the way in which drug misusing offenders were dealt with prior to DTTOs?
2. a) What do you feel are the benefits of DTTOs?
b) Can you identify any potential/existing problems with the DTTOs? How could these be overcome?
3. What are your overall opinions about:
the sentences?

the review hearings?

Drug testing?

The outcomes?

Why some offenders succeed?

Why some offenders breach?
4. a. What key agencies have the DTTO Team set up relationships with?
b. What are those relationships like between the DTTO Team and other agencies?

c. What are the positive aspects of the relationships?

d. How could they be improved?

5. What agencies should we have previously set up relationships with but didn't, what happened?

6. a. What's good about the (what are the benefits) of the current working practices that you have experienced /identified?

b. Have there been any problems? How could these be improved?

5. At this moment in time, from your experience, what are the outcomes of this project in respect of

a) a reduction in offending of those subject to orders?

b) A reduction in drug use of those subject to the orders?

6. To what extent has the project succeeded in being accessible to minority groups (e.g. ethnic minorities, women, employed, those with young children, etc.)

Why are there not many women or ethnic minorities?

7. To what extent do you think the project has provided value for money so far?

Leaving staff

- 1 a) What do you think of DTTOs now that you can be honest?!
 - b) Can you identify any potential/existing problems with DTTOs? How could these be overcome?
 - c) Do you think DTTOs need to be changed, if so how?
-
2. What are your overall opinions about:
 - the sentences?
 - the review hearings?
 - drug testing?
 - The outcomes?
 - Why some offenders succeed?
 - Why some offenders breach?
-
- 3) a. What are the benefits of the current working practices that you have experienced in
the team?

- b. Have there been any problems? How could these be improved?
- 4. What has it been like for you working in the DTTO Team?
- 5. At this moment in time, from your experience, what are the outcomes of this project in respect of:
 - a. a reduction in offending for those subject to orders?
 - b. a reduction in drug use for those subject to orders?
- 6. Do you still agree with the philosophy of coercing people into treatment?
- 7. To what extent do you think the project has provided value for money so far?
- 8. Do you think the government should still invest in this scheme?

Appendix F – Agency Staff Interview Schedule

Agency Staff

1. a. What are your overall opinions of DTTOs as a concept?
b. What are your overall opinions of the DTTOs locally?
2. What do you feel are/were the benefits of the DTTOs?
3. What problems have you experienced with the DTTOs? How could these have been resolved/avoided?
4. What was/is your relationship like with the DTTO Team? What were the positive aspects of the relationship? How could it have been improved?
5. What impact has the DTTO had upon the services you provide?
6. How well do you think the DTTO project has
 - a. reduced offending
 - b. reduced drug use?
7. To what extent do you think the DTTO project has provided value for money?

Interviews with DAAT Commissioners

1. What are your overall opinions of DTTOs?
2. What do you feel were the benefits of the local DTTO model?
3. To what extent do you think the DTTO project has provided value for money?

Interview with Crown Court Judge and Magistrates

1. What are your overall opinions of DTTOs as a concept?

What are your overall opinions of DTTOs in Leicestershire?
2. What do you feel are the benefits of the DTTOs?
3. We have been interviewing DTTO offenders throughout the evaluation project and among other things we have been asking them their opinions and experience of the review hearings. Can you give us your opinions on review hearings?
4. How well do you think the DTTO project has
 - a. reduced offending
 - b. reduced drug use?

5. A huge amount of money has been invested in DTTOs as an alternative to a custodial sentence and it looks like this is likely to continue. Bearing this in mind, do you think that DTTOs provide value for money?

Appendix G - Staff Interview Analysis Template

1. Benefits of DTTOs

- a. Access to treatment
- b. Intensity
- c. Coercion
- d. Alternative sentence

2. Problems of DTTOs

- a. Resource issues
- b. National Standards
- c. Activities and group work
- d. Required attendance hours
- e. Clients with dual diagnosis
- f. Employment issues
- g. GP issues
- h. Training needs
- i. Problems with establishing a new order

3. New aspects of DTTOs

- a. Review hearings
 - i. Positive aspects
 - ii. Negative aspects
- b. Drug testing
 - i. Positive aspects
 - ii. Negative aspects

4. The definition of success on a DTTO

5. Outcomes from DTTOs

- g. Overall
- h. Reduction in offending
 - i. Reduction in drug use
 - j. Why offenders succeed
 - k. Why offenders breach
 - l. value for money
- 6. Inter-agency relationships
 - c. Problems
 - d. Solutions
- 7. Equality of service
- 8. Working practices
 - a. Positive aspects
 - i. Multi-disciplinary team
 - ii. Supportive team
 - iii. Relationships with offenders
 - iv. All treatment provided in house
 - v. Team ethos
 - vi. Team working
 - b. Negative aspects
 - i. Maintaining consistency in treatment
 - ii. Clarity of roles
 - iii. Administration tasks
 - iv. Training needs
 - v. High workloads
 - vi. Lack of supervision

- vii. Conducting treatment in the CJS
- viii. Communication
- ix. other

Appendix H - Agency Interview Template

1. Overall opinions of DTTOs
 - a. Positive
 - b. Negative
2. Benefits of DTTOs
3. Problems with DTTOs
 - a. Theory behind DTTOs
 - b. DTTO staff
 - c. Limited access to DTTOs
 - d. Treatment issues
 - e. Practical issues
 - f. Court issues
4. The definition of success on a DTTO
5. Outcomes from DTTOs
 - a. Reduction in offending
 - b. Reduction in drug use
6. Value for money
 - a. Treatment effectiveness
 - b. Comparison to other options
7. Relationships
 - a. Positive aspects
 - b. Negative aspects
 - c. Possible improvements
8. Impact of DTTOs on other agencies