Coercing change: balancing rights, justice and health

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Britain is undergoing its biggest change in drug policy and practice ever – and most of it without a shred of evidence to back it up. Despite mountains of evidence that community treatment works, criminal interventions, such as DTTOs, are still being extended, expanded and re-invented across the UK – at huge cost to the UK taxpayer and at the expense of other forms of treatment. Neil Hunt is part of a pan-European research study looking at coercive treatment within the criminal justice system. We reveal what the government is not telling us about their crime agenda.

People sometimes get muddled when they talk about 'need' and confuse it with notions of 'want' and 'supply'. Within the healthcare sector, one of the clearest and most widely used discussions of need is provided within what is known as the 'epidemiological approach to needs assessment' (Stevens & Raftery, 1994). This regards the concept of 'need' as a 'population's ability to benefit from health care'.

Need is distinguished from 'demand' ie, want: as people may want treatments that do not work or have not yet been invented. So, while it is meaningful to talk about need for a vaccination against hepatitis B among injecting drug users (IDUs) it is not meaningful to talk about a vaccination for hepatitis C, as no such vaccination exists.

Need is also distinct from 'supply'; as people will sometimes provide services even though evidence would suggest that they are ineffective or detrimental. For example the earliest use of heroin or cocaine for treating opium or morphine dependence frequently compounded problems rather than alleviating them. Even though people were acting in good faith and trying to address drug problems.

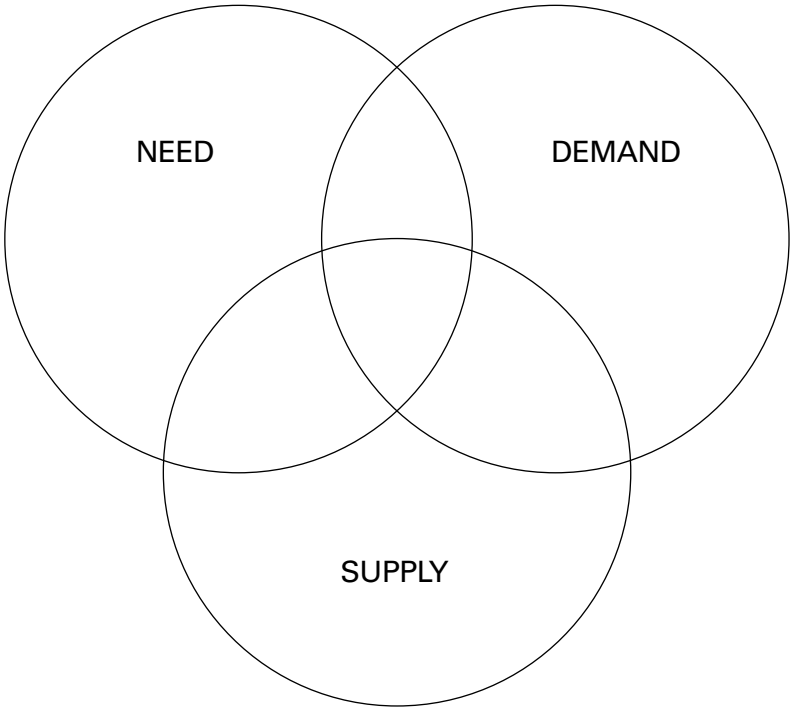
The overarching aim within an epidemiological approach to needs assessment is therefore to distinguish need, want and supply such that services which work are provided and used by the population with capacity to benefit from them: in other words we maximise the overlap between these elements.

Needs cannot be said to exist simply because governments roll out services nationally. Nor does need exist just because drug users elect to receive interventions. We need to ask searching questions about what works.

So, when we are considering relatively new quasi-compulsory treatment (QCT) programmes to encourage drug-using offenders into treatment – drug treatment and testing orders/drug rehabilitation requirements (DTTOs/DRRs) – our first question should be, what is the evidence that they work?

Of course, we know something about the effectiveness of treatment within community settings through studies such as NTORS (National Treatment Outcome Research Study). It's well-known that *'for every extra £1 spent on drug misuse there is a return of £3 in the cost savings associated with lower levels of victim costs of crime and reduced demands on the criminal justice system. These cost savings are only one part of the benefit from treatment, and also only indicate*

Figure 1 The relationship between need, demand and supply (Stevens & Raftery, 1994)



immediate rather than longer-term benefits….As may be expected, the ratio of costs to benefits is likely to change. For example, treatment could be expected to reduce the number of premature deaths among drug users. Only a few averted deaths would add substantially to the calculated social cost savings' (Gossop *et al.*, 2001).

Does crime pay?

How does QCT compare with this? There are different ways of answering the question 'does QCT work?' Conventionally, this can be understood with reference to a hierarchy of evidence. Because, remember, without evidence that QCT works we cannot reasonably say that need exists.

The most basic process question is: can DTTOs be made to operate? Will the various stakeholders cooperate and will people accept and be retained on them, rather than going to prison? There are also fairly crude questions about effectiveness: most obviously does people's drug use decrease or stop while they are receiving a DTTO?

In England, DTTOs were rolled out on the basis of somewhat limited evidence that they could be made to work and rather equivocal evidence of their outcomes based on pilots in three areas. At this point it could not reasonably be claimed that there was a need for them. The evidence was not sufficiently robust. However, their roll-out enables further investigation that can in time better answer this question.

Slightly better questions about whether QCT works might ask: is people's drug use more likely to decrease or stop while they are receiving a DTTO than if they receive no treatment? After all, anecdotally we know that some people use imprisonment and reduced access to drugs as an opportunity to clean up.

Understanding whether there is a need for DTTOs partly rests on understanding whether people who are eligible for them do better in treatment or with the disposal they would otherwise have received. Qualitative data from within a European study of DTTOs and similar quasi-compulsory treatments – QCT-Europe – reveals many instances where clients clearly value the opportunity to address their drug problems through a DTTO. This should not be in dispute as it is not hard to find clients who talk positively about the opportunities a DTTO can provide and some people do progress through DTTOs in the way that ministers hope.

However, these services can prove difficult – with a high risk of relapse among day programme participants due to the difficulty of controlling their drug use. In this respect, I have interviewed people in

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prison who describe the revocation of their order as a welcome and necessary event that has allowed them to achieve a sustained drug-free period that seemed unachievable while they were on a DTTO.

This is not necessarily any criticism of the various people involved in the considerable challenge of rolling out DTTOs. But it does underline the point that we should not uncritically accept that just because something is heavily invested in, for laudable purposes, it will work as we hope.

Then there are also questions about how the magnitude of any outcomes for people on DTTOs compared with people who receive similar treatment 'voluntarily' ie, outside of the criminal justice system? This is one of the questions being addressed within QCT-Europe: an ongoing study across six European countries that compares outcomes for samples of drug users receiving quasi-compulsory treatment (QCT) with others receiving 'voluntary' community-based treatment (see www.kent.ac.uk/eiss/qct/index.htm for interim findings).

Abstinence is not the only goal

This is a good point to address a myth that I think is still held by some harm reductionists: that DTTO workers and other treatment staff in the CJ system only work towards abstinence.

The emphasis on achieving abstinence that runs though ministerial speeches, legislation and performance monitoring for DTTOs is – rightly I believe – a source of criticism. Emphasising abstinence is fine, where this coincides with what the drug user aspires to. And it often is what people want when they first enter treatment. But requiring abstinence (pre-determining what the outcome of treatment should be) flies in the face of widely-accepted conventional understandings of how the treatment process should unfold and the therapeutic alliance on which it is based.

What has become clear to me through QCT-Europe is that despite the emphasis on abstinence, many staff have a client-centred view of treatment that involves a far wider range of outcomes. In fact, it is common for people to express frustration that systems poorly capture and reflect important progress that clients make in reducing risks and moving towards reintegration. Within the study, DTTO workers have regularly voiced concern that court decisions are sometimes blind to important gains that clients have made.

Returning to the question of how QCT works, the last questions to get asked tend to be about cost effectiveness. You have to know something about effectiveness before you can really begin to answer this sensibly. Once you know with some confidence how effective DTTOs (or their successors, DRRs) are, then you can begin to evaluate how much it costs to achieve a given outcome. You can also make some judgements about what economists call 'opportunity cost' ie, the value of the alternatives that you have foregone in order to implement your preferred option. As any decision to do one thing is also an implicit decision to forego something else.

Managing the balances between the need for treatment of offenders (through QCT) and others' need for treatment, we need to remain aware that our considerable investment in DTTOs is money that is not being spent on treatment for which the need is more clearly established.

If the demand for community treatment is being met and waiting lists in community settings are negligible we may not need to be too troubled. However, if access to community treatment is constrained through unacceptably long waiting times, then we should question whether we are getting the balance right when meeting drug users' needs.

Zero tolerance – on waiting times

Staying with the question of waiting times for a moment, I want to mention something of an 'AHA!' experience that arose within the QCT-Europe study.

As we were discussing this issue with a research colleague in Switzerland, we were asked 'but why do you have waiting times anyway?' Whereas we had been working from a deeply embedded assumption that waiting times are an inescapable part of treatment systems – we had, after all, never known anything else – she worked from an

assumption – similarly embedded in her experience – that people wanting treatment would receive it immediately. Quite reasonably, she pointed out that any delay is likely to be detrimental to engaging people and struggled to understand why we would tolerate this.

Of course, problems with treatment engagement are well known here. The Department of Health is currently funding research to better understand the reasons why so many people fail to engage in or drop out of treatment. Clearly we shouldn't prejudge the findings of this research. But enough is already known about what drug users want when they ask for treatment for the hypothesis that being able to start treatment at the point when it is wanted – when your motivation is high enough to propel you through a treatment service's door – is a highly plausible determinant of good engagement.

This is also consistent with the experience of a number of English participants in the QCT-Europe study, and accounts of their perceptions and experience of 'voluntary' treatment. Expectations that access to voluntary treatment could reasonably be obtained were often low and in several cases the offending that led to a DTTO arose while people were on a waiting list for treatment.

So when we think about access to treatment for which need has been reasonably well established ie, 'voluntary' community drug treatment, I think this means that we should be critical of assumptions that a three week waiting time is in any way reasonable.

In terms of effectiveness, this suggests to me that when we think about where resources should flow, it may imply a priority of greatly improving access to community treatment of better-known efficacy before investing so extensively in other interventions.

Should we enhance health or reduce crime?

A central strand within disputes about UK drug policy concerns the question of whether the emphasis should be on enhancing health or reducing crime. Each of these is a perfectly valid objective and sometimes we will be able to do things that achieve both simultaneously. Where we can, this scenario is relatively uncontroversial. NTORs shows that, for people who seek treatment, alongside the gains in health and well-being there are substantial crime reduction benefits. Such collateral gains are very much to be welcomed.

More controversial are situations in which treatment is redirected from one thing that is more likely to enhance health (but may have little effect on crime) towards others that are thought more likely to reduce crime (but have less impact on the health and well-being of drug users).

There seem to be some obvious principles here that relate to where you crop up in the system – in community settings or in the criminal justice system.

It is generally accepted that within voluntary health and social care systems the client's needs are paramount, even where their behaviour incurs costs to others. This principle recurs within various problems associated with excessive consumption, notably smoking, drinking or over-eating. Although each of these generates costs and harms to others, interventions primarily focus on the needs of the client and not these wider impacts. If you are seeking voluntary treatment, any crime prevention benefits are only important to the extent that they arise because committing less crime is embraced as an aim of the client – and it often is an implicit objective – or where they arise collaterally.

Conversely, it is generally accepted that part of our proper response to people who have offended is to provide effective rehabilitation that reduces offending – crime prevention. On this basis, the aims of QCT seem an entirely reasonable and proper enterprise for society. Sidestepping important, wider questions about the criminalisation of drug use and the ways that drugs are regulated and made available are obviously germane to this debate: under a system of drug prohibition, if DTTOs and their like can be made to work and reduce crime, we should embrace them. Obviously this brings us back to the basic question of their efficacy and therefore need, but I think we have to accept that this is a question that is gradually being answered through studies such as QCT-Europe. Eventually, we should be in a position to make an informed judgement about the extent to which DTTOs and their successors work.

Healthcare and 'human rights'

Besides questions of need, the issue of human rights is also pivotal to the provision of treatment and care. In the UK it is

axiomatic that people in prison should have the same right to treatment as other members of society. Offending should not disqualify you from healthcare you would otherwise receive. Treatment exclusion is not intended to be a component of anyone's punishment and this principal is espoused in government departments and services, for example where the Department of Health and Prison Service who say that:

> *'Healthcare in prisons should promote the health of prisoners; identify prisoners with health problems; assess their needs and deliver treatment or refer to other specialist services as appropriate. It should also continue any care started in the community contributing to a seamless service and facilitating throughcare on release.'* (Joint Prison Service and National Health Service Executive Working Group, 1999)

In this context, I want to conclude by drawing attention to current discrepancies between care that is available in the community and that which is available in prisons and the way that this highlights an unacceptable two tier approach to people's rights. I am particularly talking about opioid substation treatment and needle exchange.

There is an extensive body of literature on the effectiveness of methadone and a smaller but similarly encouraging body of literature on the use of buprenorphine. Furthermore, we know from the work of people such as Kate Dolan and colleagues (1998a; 1998b; 1999) that methadone programmes can operate within prisons and provide the continuity of treatment that we are expected to provide. In fact, the evidence of their effectiveness is so strong that methadone and buprenorphine have now just been designated 'essential medicines' by the World Health Organisation.

The stark failure to provide optimised substitution therapy in prisons in a way that gives continuity with community settings amounts to the withholding of essential medicines from a population we know to be vulnerable on multiple indices. This seems to me to be a major affront to prisoners' rights.

At a time when the international public health community is rightly critical of countries in central and eastern Europe and south east Asia that fail to provide such effective treatments in the face of epidemic heroin use and injecting, we are guilty of reproducing such inequities with one of our own most vulnerable populations. And I can't help wondering whether this is an opportunity cost of our focus in other areas?

Finally, I want to draw attention to the other obvious inequality in the way that prisoners' rights to healthcare are discriminated against.

Needle exchange is one of the UK's largely unsung successes. Our low HIV rate among IDUs is the envy of most other countries in which injecting occurs.

We know that imprisonment is strongly associated with acquiring hepatitis C. From an anonymised independent study we also know that around 6% of adult males in prison who inject report that they begin injecting in that environment.

Table 5 **Adapted from Weild *et al.* (2000)**

	Ever injected n (%)	**HIV (injectors) n (%)**	**HBV (injectors) n (%)**	**HCV (injectors) n (%)**	**First injected while in prison (injectors) n (%)**	**Ever injected in prison (injectors) n (%)**	**Shared in prison (prison injectors) n (%)**
Adult male n = 2769	660 (24)	3 (0.5)	131 (20)	200 (30)	36 (6)	195 (31)	147 (75)
Female n = 407	117 (29)	1 (0.9)	27 (23)	40 (34)	3 (3)	29 (26)	20 (69)
Young offender n = 714	30 (4)	0 (0)	2 (6.7)	0 (0)	1 (3)	6 (20)	3 (50)

Prison remains a critical risk environment for the acquisition of blood-borne infections in which accepted effective community treatments are denied to the population.

To underline this point I just want to highlight the conclusions of a recent review of the evidence concerning treatment in prisons jointly undertaken by the WHO, UNAIDS and UNODC (2004), which concluded:

> *The evidence shows that such programmes should include all the measures against HIV transmission which*

are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment. All these interventions have proved effective in reducing the risk of HIV trans-mission in prisons. They have also been shown to have no unintended negative consequences.'

With the inclusion of the United Nations Office on Drugs and Crime we should conclude that this is hardly a bunch of fly-by-night radicals.

A call for better treatment for all

So, in summary, it seems reasonable to me that we should be evaluating alternatives to prison for drug dependent offenders. However, the need for quasi-compulsory treatment – in terms of capacity of the population to benefit – remains to be clearly demonstrated. In this light, and from an evidence-based policy perspective, the failure to invest adequately in treatment for which the efficacy is better known seems like an error of judgment.

A much greater emphasis on improving the accessibility of community-based treatment beyond our current aspirational – but still seriously inadequate – waiting times seems a priority.

Finally, our failure to provide crucial interventions, of known efficacy: substitution treatment and needle exchange, to a highly vulnerable population: prisoners, in a way that provides continuity of treatment with the wider community is a shameful affront to prisoners' human rights. I question whether it is the politically driven desire to be seen to do something that prevents crime that has distracted from the provision of such services that seem more likely to enhance health?

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