
ARREST REFERRAL
Emerging lessons from research

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FOREWORD

Since 1990 the Home Office Drugs Prevention Initiative has been piloting a community-based approach to drugs prevention. In the first phase, 1990-95, 20 small teams were set up to work with local communities. Their aim was to inform, encourage and support communities in their resistance to drug misuse. In all, they supported more than 2,000 drugs prevention projects. These projects drew help and support from local business people, voluntary workers and a wide range of statutory and non-statutory organisations.

As part of the strategy Tackling Drugs Together which was launched on 1 April 1995, the Drugs Prevention Initiative began its second phase which is to run until March 1999. Twelve larger teams covering a much larger geographical area in England are delivering local action within the framework of a published national programme of work, designed to demonstrate clearly what communities can do to reduce drugs misuse. The teams support drugs prevention projects within their local areas, working with a range of local partners, to find out whether and how different approaches, targets and settings can have a positive effect on young peoples' knowledge, attitudes and behaviour in relation to drugs misuse. A programme of learning is in place, supported by 17 independent research studies, to help identify and capture good practice about effective community-based drugs prevention approaches. A key aim of the DPI is to spread these good practice messages to policy makers and practitioners nation-wide, to influence future policy and practice.

This report gives interim findings from the continuing evaluation of the DPI criminal justice projects being conducted by the Criminal Policy Research Unit at South Bank University. The report focuses on the arrest referral components of the DPI criminal justice drugs intervention demonstration projects in South London and Derby, and on the Get it While You Can arrest referral project in Brighton. Later reports will cover other elements of the demonstration projects.

If you would like more information about the Drugs Prevention Initiative or about the work described in this report, please contact the Central Drugs Prevention Unit, Room 354, Horseferry House, Dean Ryle Street, London SW1P 2AW (0171) 217 8631, fax: (0171) 217 8230.

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SUMMARY

This paper reports on evaluations of arrest referral schemes in Brighton, Derby and Southwark. The schemes were all demonstration projects under the Home Office Drugs Prevention Initiative. The Brighton study was financed through DAT Challenge funds and the other two formed part of a larger evaluation for the Home Office which is assessing a series of demonstration projects in Derby, Salford and South London. In the course of the two studies, we have assembled a large amount of information about:

- the size of the problem drug using population
- the costs associated with problem drug use
- types of referral scheme
- and the impact of these schemes.

The size of the problem drug using population

Problem drug use can be defined as that which involves dependency, regular excessive use, or use which creates serious health risks. It is hard to make firm estimates of the number of people who are engaging in behaviour which is both illegal and socially stigmatised. Most attempts have taken as their starting point the workloads of agencies which deal with problem drug users, and have made allowances for the hidden population. Epidemiologists have argued that the number of notifications to the Home Office Addicts Index needs to be multiplied by a factor of between 2 and 5 to take account of the number of problematic drug users who are not in touch with agencies.

As 43,000 people were notified in 1996, this would yield a total figure for England and Wales of between 85,000 and 215,000. As the British Crime Survey suggests that around 4 million people use illicit drugs each year, this implies that around 3% of the drug using population could be defined as problematic users. Using the same approach for our three sites, but fine-tuning the estimates in the light of information about the number of problem drug users passing through police stations, our best guess at the problem user population in each site is:

Southwark	2,000
Brighton	1,800
Derby	1,000

The costs associated with problem drug use

For the 97% or so of illicit drug users who have not (or not yet) encountered any serious problems associated with drug use, there is no convincing evidence of causal links between drug use and acquisitive crime. For problem users, by contrast, the evidence is overwhelming of clear but complex links. The users we interviewed in Brighton and Derby were

spending £400 per week on average on drugs, and those in Southwark were spending £350. If one assumed an average spend across the country of £200 per week and a national estimate of 130,000 problem users, there would be a weekly aggregate drugs spend of £26 million, or an annual spend of around £1.3 billion. If the problem using population is closer to 200,000, the annual spend would exceed £2 billion.

Only a small proportion of this money is raised legally. According both to findings from our follow-up surveys and from data collected from police records, users raise money in a variety of ways, including shoplifting, burglary, dealing, fraud and sex work. Problem drug users may raise between £650-£850 million through acquisitive crime. The cost to victims will be much higher, as stolen goods are fenced at less than their market value. The figure could be between £2-2.5 billion or even higher.

The complexity of the causal links need stressing. Most of those whom we interviewed had long criminal histories, with an average of 21 previous convictions. Criminal and drug using careers seem to develop in parallel: acquisitive crime provides people with enough surplus cash to develop a drug habit, and the drug habit locks them into acquisitive crime.

The costs of problem drug use falling on public services is also high. Expenditure on specialist drug services by Health Authorities and social services departments is probably in the region of £100 million. The benefits bill may be in the region of £600 million per year, though it is unrealistic to attribute all this expenditure to problematic drug use: some people may have developed drug habits precisely because of the limited life opportunities open to them, including those for employment. The costs to criminal justice could well be in excess of £500 million per year.

Types of referral scheme

Arrest referral schemes are premised on the fact that treatment services for problem drug users can have a significant impact in reducing drug misuse and related crime. We have identified three approaches to arrest referral: the information model; the proactive model; and the incentive model. Early schemes exemplified the information model. They involved the provision of information about local drug and other relevant services by the police to those who they had arrested. The information in these sorts of scheme is usually offered to all arrestees on a “take it or leave it” basis. Take up rates have been found to be low.

The proactive model involves drug workers working in close co-operation with the police, often with direct access to prisoners in custody suites. They may approach arrestees in the police station themselves, providing assessment either on site or at a subsequent meeting. Whilst police officers may screen or target arrestees for the drug worker, information about drug services and encouragement to seek advice is always provided by the drug workers. The three schemes which we evaluated were proactive ones.

Finally, there is the incentive model, which exploits the fact that the criminal justice system is a coercive one, through which incentives can be held out to encourage problem users to seek assistance in tackling their drug problems. Typically, the schemes are targeted at people arrested for possession of controlled drugs. The “caution plus” variant of such schemes involves cautioning coupled with the opportunity - or requirement - to seek advice and help from a drug worker. The “bail scheme” variant involves deferring a decision about cautioning, providing the offender with a window of opportunity to seek help. To operate legally, these schemes have to avoid offering the possibility of dropping charges as an inducement to seek treatment.

The impact of arrest referral schemes

We have assessed the impact of the three proactive arrest referral schemes in Southwark, Derby and Brighton, by carrying out follow-up interviews with samples of people who have passed through each scheme. The full interview sample consisted of 128 respondents, or around one in five of the clientele of the relevant drug workers. 90 of the 128 had had involvement with drug workers at the point of arrest; the remainder were referred by probation or court staff¹. We have used the full sample to provide a profile of problem drug use in the three sites. When describing the work of the arrest referral workers we have focused on the 90 contacted at the point of arrest. When examining outcomes in terms of drug use and offending, we have omitted a further 10 respondents who were given prison sentences and thus had only limited opportunities for drug use and other crime.

The full sample was overwhelmingly male (86%). Most used illicit opiates (82%), and stimulants (72%). The majority were in their mid to late twenties or early thirties. Almost half the sample said that this was their first contact with any drug agency, though most had long criminal histories, with an average of 21 previous convictions.

Of the 90 respondents who were seen by an arrest referral worker, 66 were referred in total, the large majority to drug agencies. The remaining 24 were simply given advice and information. 53 of the 66 made contact with the relevant drug agency, and were offered various forms of assistance. 41 actually accessed help or treatment of some sort.

Respondents were interviewed six to eight months after first contact with the drug workers. Comparing the month before arrest with the month immediately before interview, self-reported drug use fell steeply amongst the 80 respondents who had contact with the arrest referral scheme and avoided a prison sentence. 21 of the 80 said that they were no longer using any form of illicit drug. 35 said that they were no longer using illicit opiates or stimulants. Most of the remaining 45 reported some reductions in their drug use. 59 respondents reported intravenous drug use before contact with the scheme, a figure which fell to 33 for the month before interview. The average number of days per month on which the injecting users actually injected fell from 29 to 19. There were sharp reductions in drug

¹ The outcome of these contacts will be presented in later reports.

expenditure, with a decline in the median (mid point) expenditure from £400 per week to £70 per week. There were steep corresponding falls in the number of crimes committed.

Interpreting the findings

These findings suggest very substantial reductions in both drug use and crime following contact with arrest referral schemes, but they need to be interpreted carefully. Account must be taken both of response bias amongst those we interviewed, and of selection bias in assembling the sample. Some response bias occurred, in that some users clearly presented an exaggerated account of their drug use before contact with the scheme, and/or an optimistic account of their drug use in the month before interview. We have no doubt, however, that the improvements claimed by the majority have some basis in reality.

We also think that the process by which our sample was selected means that it is biased towards successes. As mentioned above, we were able to interview around a fifth of offenders who had had contact with the relevant drug workers in the year before fieldwork. Despite the fact that workers put us in touch with our sample, we do not believe that they “cherry picked” their successes for us to interview. However, our sample is very probably biased towards the *contactable*; those who proved impossible to contact are likely to include a disproportionate number of “failures”.

Assuming that reductions in drug use and in acquisitive crime did occur for a significant proportion of those in contact with the schemes, there remains the problem of causality. Was it contact with the scheme which triggered these reductions, or was it the process of arrest? Do our findings simply reflect the natural cycles of chaotic drug use, with peaks which create very high risks of arrest, and troughs which follow them? Would the users have found their way to treatment services in any case? We cannot provide definitive answers to these questions. We think nevertheless that the weight of evidence is that arrest referral schemes can be successful in drawing forward in time the point at which problem users access help from drug agencies, and start to address their drug use.

Whilst we cannot be sure of the extent of benefits flowing from arrest referral schemes, it is fairly certain that they are cost effective. We estimate the cost per contacted client at £140, and the cost per successful referral at about £400. The clientele of arrest referral schemes are imposing such high costs on public services that only very modest reductions in drug use and in related offending are needed to ensure that the schemes pay for themselves.

Conclusions

This study provides good evidence that arrest referral schemes can be effective in reducing drug use and drug-related crime. The schemes are designed to put problem drug users in touch with treatment agencies following arrest. When they are successful, they draw forward in time the reduction and cessation of drug use which inevitably will occur at some

stage in drug users' careers. On the basis of our experience in evaluating these three schemes and others which have achieved less success, we regard the essential ingredients of referral schemes as:

- a proactive mode of work
- a working style which wins the respect and trust of users
- adequate resourcing
- a capacity to provide ongoing support
- appropriate treatment services to which to refer
- adequately resourced treatment services to which to refer.

CONTENTS

	page
SUMMARY	iii
1. INTRODUCTION	1
2. THE PROBLEM DRUG-USING POPULATION	5
3. COSTS ASSOCIATED WITH PROBLEM DRUG USE	9
4. TYPES OF REFERRAL SCHEME	15
5. IMPACT OF REFERRAL SCHEMES	19
6. CONCLUSIONS	32
REFERENCES	41
APPENDICES	
A. INTERVIEW SCHEDULE	45
B. ARRESTING OFFICER PROFORMA	59

1: INTRODUCTION

Of all the agencies dealing with drug misuse, the police and the courts probably come into contact with problem drug users to the greatest extent. Whilst they can catch this population, however, there is little evidence that conviction and punishment does anything to reduce their drug use. By contrast there is quite good evidence that properly resourced and appropriately tailored intervention by drug agencies can substantially reduce drug use and drug-related crime (see Hough, 1996 for a review). Increasingly, therefore, referral schemes are being set up to serve as a bridge between the criminal justice system and treatment services.

This paper reports on evaluations of arrest referral schemes in Brighton, Derby and Southwark. The Brighton study was financed through Drug Action Team Challenge funds², and the other two formed part of a larger ongoing evaluation for the Home Office Central Drugs Prevention Unit of Drugs Prevention Initiative demonstration projects. (This is also assessing sites in Salford and in other parts of South London.)

The goal of the demonstration projects is to build integrated referral systems which identify problem drug users at several points as they pass through the criminal process, and refer them to treatment. The various components of a comprehensive system would be:

- assessment at arrest
- arrest referral
- probation assessment
- court referral to treatment programmes
- prison assessment and treatment
- referral on release from custody.

Arrest referral is the best developed component of the schemes under evaluation, and to date, our research has concentrated largely on arrest referral. We expect later reports to cover other elements of the demonstration projects, and to consider in more detail the inter-relationships between interventions at different stages in the criminal process.

Arrest referral schemes are mechanisms designed to increase the chances that criminally involved problem users will access treatment for their drug problems at or shortly after the point of arrest and thus reduce their offending. For the schemes to be worthwhile, several conditions must be met:

- there must a pool of problem users who are not in touch with services
- they must fund their use through crime
- it must be possible to draw this group into treatment, and retain them in treatment
- and the treatment must be effective.

² Results are presented more fully in Edmunds et al. (1997).

This report presents the evidence which we have accumulated about the extent to which these conditions can be successfully met. Chapter 2 presents estimates of the number of problem drug users in the three sites who might benefit from treatment services. Chapter 3 examines how this group funds drug use, and offers estimates of the costs they impose on public services and on victims of crime. Chapter 4 discusses types of arrest referral scheme, and Chapter 5 present the results of our evaluation. Chapter 6 offers some concluding thoughts, and some recommendations to those planning to establish arrest referral schemes.

Definitions

This report often refers to ‘problem drug users’. Whilst hard and fast definitions are impossible, it is useful to differentiate between casual - or controlled - drug use and problematic use. We take problematic drug use to be that which involves dependency, regular excessive use, or use which creates serious health risks. Those users whom we regard 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. Problem drug users are those who could benefit from the services of drug agencies offering medical or other forms of treatment³.

In referring to ‘problem drug use’, we are not implying that some categories of illegal drug use are problem-free, or that so-called ‘recreational’ drug misuse is unproblematic. In the first place, the illegality of drugs covered by the 1971 Misuse of Drugs Act cannot simply be brushed aside, even by those in favour of amending the legislation, so long as it remains on the statute book. No less important, casual drug users expose themselves to a variety of health risks, some more firmly established than others. Nevertheless, just as it is useful to distinguish between problem drinkers and others, a term is needed to differentiate between those with serious drug problems and others who use drugs. Rather than invent a new term, this report follows current usage amongst drug workers.

The research sites

The three research sites share some features in common, and have some important differences. All are urban areas; all have populations under a quarter of a million; all have higher than average drug problems. However, the nature of these problems differs.

Brighton is a largely white and middle-class seaside resort, with a seasonally fluctuating population of around 150,000. Though it is an affluent and attractive town, it has a high transient population, homelessness, poverty, some problem housing estates, seasonal unemployment, drug use, an off-street sex industry, and a high incidence of HIV/AIDS. Brighton has higher than average drug problems for a town of its size. There is a plentiful supply of cheap heroin, though stimulant use is less obvious than in many parts of the country.

³ This definition is slightly narrower than that offered by the Advisory Council on the Misuse of Drugs (ACMD, 1988), which would embrace users who were encountering only legal problems and thus would not stand to benefit from treatment.

Southwark is a large inner London borough, with a population of 230,000. Although there are wealthy areas in the south of the borough, the middle and north is dominated by large swathes of poor housing estates. The borough has high levels of unemployment and scores badly on many indices of deprivation. Recorded crime rates are amongst the highest in London - though they have fallen more rapidly than elsewhere. There are several semi-open drug markets in the borough, with good availability of crack, heroin and other drugs.

Derby is a county town city of 220,000 in the East Midlands. Its traditional economic base has been in engineering and manufacturing industries, which have fared poorly over the last two decades. The population is predominantly white, with an unemployment rate comparable to Brighton's and lower than Southwark's. Burglary and vehicle crime are significant crime problems, though numerically shoplifting was the single most common offence in 1996. Derby has had a well established population of amphetamine users - reputedly with reliable local supply; heroin use appears to be growing though crack has not yet appeared on the streets in significant amounts.

Research methods

Problem drug users are a hard group to research. Their drug use is both illicit and socially stigmatised. It is covert. If drug agencies - who have something to offer them - find them hard to reach, the task facing researchers is that much more difficult. We are unapologetic, therefore, about the fact that our research fails to achieve the rigour of a randomised controlled trial. A moment's thought will show that mounting an evaluation of this sort would be both technically and ethically problematic, and would certainly fall beyond the budget of our project.

We have followed a 'multi-enumeration' strategy (c.f. Howes *et al.* 1995) and assembled a variety of types of information for the three sites:

- workload statistics from police stations and drug agencies
- statistics from Regional Health Authority Drug Misuse Databases (RHADMDs)
- survey and interview data from police officers
- interviews with drug workers
- information on assessment forms completed on problem users by arrest referral workers
- personal interviews with sub-samples of users in touch with arrest referral workers.

The statistics collected from police and drug agencies, together with RHADMD data, provided us with the raw material from which to estimate the size of the problem user populations, and the extent of unmet need, in each site. We have used several different approaches for making these estimates (a process of triangulation, in research jargon). We regard them as informed best-guesses, rather than precise point-estimates.

The interviews provided us with information about the impact of the schemes. Three of us carried out fieldwork in the first half of 1997. We interviewed 128 problem drug users who had been in contact with the schemes in 1996. Interviews were face-to-face, using a structured questionnaire (which also allowed for semi-structured data collection). Key issues covered were:

- drug use, and its financing, prior to and since contact with the scheme
- the nature of the intervention offered
- opinions about the value of the scheme
- views on how users might best be assisted in tackling drug problems.

Responsibility for locating respondents fell to drug workers in each scheme. This was partly to overcome issues of confidentiality, and partly for practical reasons. (The implications of this are discussed in Chapter 5.) A £10 payment was offered on completion of the questionnaire (reproduced in Appendix A.). We have no information on response rates encountered by drug workers, but believe that the problems in assembling the sample lay in *locating* respondents rather than in securing their *consent*. Interviews were conducted on a named basis rather than anonymously, as we propose to mount a criminal record check on respondents using the Home Office Offenders Index at a later stage in the project.

2: THE PROBLEM DRUG-USING POPULATION

Whether someone's drug use is problematic is a subjective matter, and a question of degree. At one end of the spectrum, there is a broad consensus that heavy dependence on illicit drugs creates problems for the users and others around them. At the other end, a significant proportion of the population uses drugs, the vast majority with few discernible short-term ill-effects. Extrapolating from the British Crime Survey, at least a quarter of those aged between 16 and 30 take illicit drugs each year; the figure for those between the ages of 16 and 60 is at least one in ten. This means that some four million people use illicit drugs each year⁴. The vast majority of these will simply use cannabis; a minority will use Class A drugs, usually ecstasy, and a much smaller minority will use cocaine and opiates.

Problematic use: the national picture

It is hard to estimate the proportion of drug users whose use is problematic. Epidemiologists have tried various approaches such as 'capture-recapture' methods and households surveys with only limited success (see Howes et al., 1995, for a discussion). Most estimates rely on extrapolation from treatment agency statistics, informed by ethnographic research. There are two related sets of statistics on people receiving treatment for drug problems. Until 1996, medical services were under an obligation to make returns to the Home Office Addicts Index; and a parallel set of databases are maintained by Regional Health Authorities. These statistics fail to 'capture' the full population of problem users for two reasons:

- many are not in touch with agencies
- many are in touch, but are not notified.

Epidemiologists have argued that the number of notifications to the Home Office Addicts Index needs to be multiplied by a factor between 2 and 5, to take account of the number of problematic users who are either in touch with agencies but not notified, or out of touch with agencies altogether (Hartnoll and Lewis, 1985). Our own work is consistent with this. For example, we have data on 193 problem users who have been referred by arrest referral workers in South London⁵. A quarter (25%) were in touch with drug services of some sort at the time of contact; 41% were not presently in touch, but had had contact in the past. The remaining 35% had never been in touch. We do not know what proportion of those currently in touch were notified to RHADMDs, or to the Addicts Index, but the figure is very probably under a third of the total sample⁶.

⁴ If the population aged 16-59 is 37 million, and the BCS figure of 10% using in the last year is accurate, this would yield a total of 3.7 million. However, the BCS estimate is likely to be an undercount, because of under-reporting, and under-representation of high-risk groups in the sample.

⁵ These users come not only from Southwark, but from the other four boroughs covered by the demonstration project mounted by the South London Drugs Prevention Team.

⁶ Our figures imply that the total number of problem users is three to five times the number of notifications, *provided that* notified users have the same probability of arrest as other problem users, and the same probability of being identified and referred by arrest referral workers. Notified users are probably somewhat *less* at risk of arrest, but those who are arrested are probably *more* willing to disclose that they are problem users than others.

The most recent (and final) figures from the Addicts Index refer to 1996. These show 43,000 notifications. Factoring up to account for non-notified users, this suggests a total figure for the country of between 85,000 and 215,000. Applying a multiplier of three to the Addicts Index figure would yield our best estimate of 130,000. Assuming that there are 4 million illicit users in the year, around 3% of the illicit drug-using population annually may be regarded as problem drug users. This could be an underestimate, bearing in mind that stimulant users are thought to be under-represented in treatment agencies' caseloads and thus on the Addicts Index.

The Regional Drug Misuse databases would yield estimates of a similar order, though these record 'treatment episodes' rather than people, and as the data are anonymised, converting episodes to people involves making assumptions.

These figures are broadly consistent with estimates which have been made of the number of injecting drug users in the country. The ACMD (1988) suggested a total of 125,000, whilst Sutton and Maynard's (1992) estimate was 100,000.

Problematic use: the three sites

For our three sites, we used RHADMD figures as our starting point, but we collected additional information:

- the numbers of arrestees passing through each police station in the last year
- a survey of arresting officers about the prevalence of problem use
- the proportion of arrestees who received attention from police surgeons over this period, or who were identified by custody staff as problem users.

The survey of arresting officers built on the work of Chatterton et al. (1995). This involved the completion of a proforma on recent arrests, comprising a series of 10 questions designed to identify regular users of Class A drugs. The proforma is reproduced at Appendix B. We also trawled custody records and records of police surgeons' attendance to give us - fairly firm - baseline estimates of the number of people who were identified as problem users whilst under arrest. For the most part, withdrawal symptoms or the request to see a police surgeon formed the basis of the identification. Table 1 pulls all these statistics together into a single summary chart. It should be noted that statistics for Southwark are extrapolated from those of the Peckham Division (a third of the borough) and those for two divisions (Lewisham and Streatham) on Southwark's borders, abutting the other two divisions.

We asked professionals in each area - including police, probation officers and police surgeons - to estimate what proportion of offenders passing through the local police station were problem drug users. As Table 1 shows, they offered figures of around a half. We think

that this is high. Our surveys of arresting officers in Derby and South London suggested a figure of 15-25%.

The figures for arrestees who saw police surgeons in the police station, or who were unequivocally identified as problem users by custody staff, varied widely. It was lowest in Derby, at 2%, and surprisingly high in Brighton, at 12%. There is a small amount of double-counting here, in that some of those identified as users in this way will have been seen by police surgeons on two or more occasions. But there is obviously extensive under-counting as well, as the majority of problem users will probably avoid disclosing their status to the police.

In deriving estimates from police statistics, we are obviously failing to take account of those problem users who fund illicit drug use legally or who do so through crime but manage to avoid detection.

These various statistics set upper and lower limits to the size of the problem user population in each site. In Southwark, it is obviously well in excess of 600 - the average annual number of notifications and, coincidentally, the number of problem users identified as such in custody suites. We think a figure around 2,000 is a sensible estimate. For Brighton, tripling the RHADMD figures would yield 1,200; however the proportion of arrestees identified by police surgeons and custody staff stands at almost 900, and we think that a figure around 1,800 may be more realistic. The Derby figures suggest a somewhat lower population, closer to 1,000.

Table 1: Estimates of problem drug using population

	SOUTHWARK	BRIGHTON	DERBY
Total population	232,000	150,000	230,000
Total number of arrests (12 months)	15,000	7,500	7,500
Professionals' best guess at proportion who are problem users	7,500 (50%)	3,250 (50%)	3,399 (45%)
Proportion Class A/amphetamine users (from Arresting Officer questionnaire)	3,750 (25%)	n.a.	1,133 (15%)
Proportion identified by police surgeons/ custody records as problem users	600 (4%)	876 (12%)	117 (2%)
RHA notifications uplifted by a factor of three	1,800	1,200	456 ⁷
Our best guess at the problem user population	2,000	1,800	1,000

⁷ There were 152 notifications for Derby in 1997. We believe that this figure may reflect disproportionate under-notification in Derby.

The prevalence estimates for Southwark are broadly consistent with the results of the study by Howes *et al.* (1995) which used the 'capture-recapture' method in Lambeth, Southwark and Lewisham. Using a definition of problem user which may be slightly broader than ours, their best estimate of prevalence in 1992 implies a Southwark total of around 5,000 problem users, of whom half were opiate users and some 1,300 were injectors.

A more recent survey of 200 arrests in one Southwark division carried out by the Metropolitan Police Service (Stout and Monaghan, 1998) also came up with consistent figures: 19% of arrestees carried a Police National Computer marker for drugs; 14% were identified by the MPS Drugs Intelligence Unit as drug misusers; in 3% of cases custody record data indicate drug misuse. In total, 35% of the 200 arrestees had one or more drug identified, including arrests for possession of cannabis.

Unmet need

These estimates imply considerable unmet need. Obviously it is a circular argument to suggest that the uplifted RHADMD figures point to unmet need. However, our alternative estimates derived from police statistics give us some confidence in the uplifted figures, as does the fact that two in three problem users identified by arrest referral workers are not currently in touch with drug services.

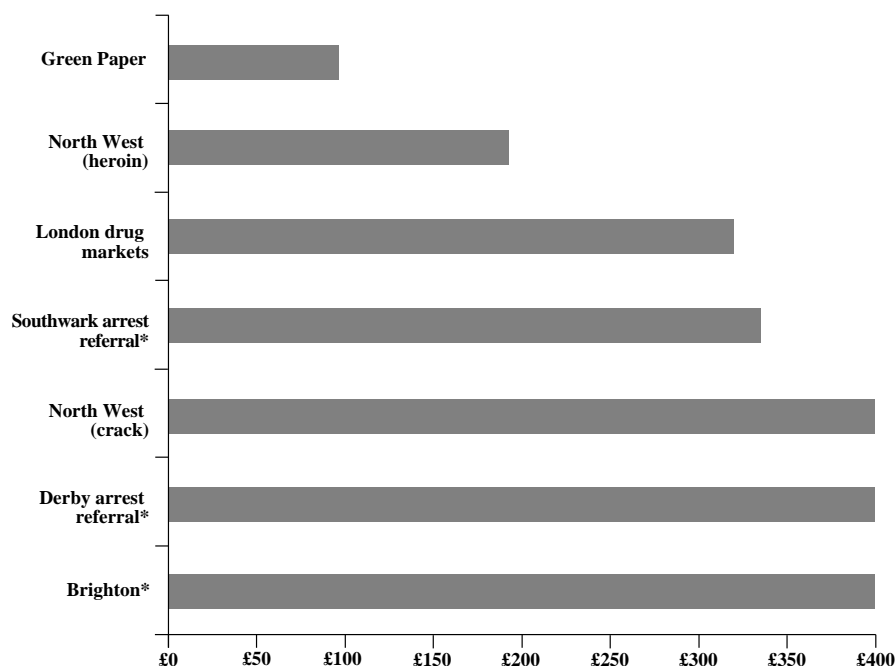
3: COSTS ASSOCIATED WITH PROBLEM DRUG USE

For the 97% or so of illicit drug users who have not (or not yet) encountered any serious problems associated with drug use, there is no convincing evidence of causal links between drug use and acquisitive crime. Certainly people may commit various forms of property crime, and use the proceeds to buy - amongst other things - drugs. However, they will also use this money to buy alcohol, clothes, CDs etc. One might perhaps point the finger at a consumerist life style as a causal factor behind the offending (*c.f.* Parker *et al.*, in press) but there is no reason to single out any particular item on which money is spent as the “cause” of the offending.

For problematic users, by contrast, the evidence is overwhelming of clear but complex links between drug misuse and crime. A growing number of studies have documented beyond doubt that problem users are now spending very large sums on drugs, and that few are able to support their use through entirely legal means.

Figure 1 shows estimates from various studies of the weekly spend of problem drug users. Where possible, we have presented the mid-point value (the median) rather than the average (the mean). In our own work, we have found that the averages tend to be skewed by a

Figure 1: Weekly spends



Sources: Edmunds *et al.*, (1997); Parker and Bottomley, (1996). Estimates for asterisked sites are medians, not means.

very small number of very heavy spenders who report weekly spends in excess of £1,500 per week. The table suggests that the figures set out in the Green Paper 'Tackling Drugs Together' (Home Office, 1995) were rather conservative. An average spend across the country of at least £200 per week amongst problem drug users may be more realistic⁸. If this is so, and if the national estimate of 130,000 problem drug users is tenable, it implies a weekly aggregate drug spend of £26m, or an annual spend of around £1.3b. If the population is closer to 200,000, the annual spend could exceed £2bn.

According both to findings from our follow-up surveys (see Chapter 5) and from data we collected from police records, users raise money in a variety of different ways, including theft, fraud, dealing, sex work, and the use of legitimate income such as benefits and earnings. Shoplifting, dealing and burglary are probably the most widespread methods used by problem users to raise money, with fraud being significant, and robbery rare. Many of those we have interviewed reported dealing at least intermittently to raise cash, though only a minority raised their money primarily through dealing⁹. Following the methodology set out in the Green Paper 'Tackling Drugs Together' (Home Office, 1995), one can make estimates of the costs of this drug use to crime victims. Assuming that between a half and two-thirds of the £1.3b is raised through acquisitive crime, some £650 million - £850 million has to be generated in this way. The costs to victims are much higher than this, because stolen goods are fenced at less than their market value. A factor of 3 was used in the estimates of costs to victims made in the Green Paper; this would yield a figure of around £2bn-£2.5bn. Whether users do manage to sell stolen goods for as much as a third of their market value is questionable; the fraction could be much lower, and the total costs to victims could thus be much higher. If a factor of five is nearer the mark than one of three, the total would be around £3bn-£4bn. The majority of these costs are, of course, borne by organisations rather than individuals and very often passed on to consumers. We have made no attempt to assess the non-financial costs to victims, which can obviously be considerable.

The complexity of the causal links needs stressing. As will be seen in Chapter 5, the majority of those whom we interviewed had long criminal histories, with an average of 21 previous convictions. 92% of the sample had been arrested long before they recognised that their drug use was problematic. Whilst we cannot offer definitive evidence, it makes sense to conceptualise the causal links as dynamic or interactive. Criminal and drug-using careers often develop in parallel; stated simply, acquisitive crime provides people with enough surplus cash to develop a drug habit, and the drug habit locks them into acquisitive crime¹⁰.

⁸ This sort of expenditure could easily be incurred with a relatively light habit. For example, someone using 2.5 grammes of heroin a week at a price of £80 a gramme would hit this target; someone paying £50 a gramme could afford 4 grammes, or just over a half a gramme a day. Our respondents included people who were spending almost £2,000 a week on a mix of heroin and crack.

⁹ Assuming that the market would not allow one to skim more than 15 or 20% profit from street level dealing, a maximum of 1 in 5 users could finance their use exclusively through dealing.

¹⁰ Similarly sex work may facilitate regular drug purchase, and dependency may lock people into sex work - with the added complication that drug use may make sex work more palatable.

Costs to Public Services

In addition to costs to victims, there are those falling to public services, which are straightforward, if hard to measure. They include the costs to the health service of dealing with problem use and related ill-health, the costs to social security systems in providing unemployment or sickness benefit and housing benefit, and the costs to the criminal justice system in responding to drug-related crime. These costs are real, in that they create a demand on a finite public purse, and preclude other spending possibilities.

Costs to health and social services are hard to estimate. Expenditure on specialist drug services by health authorities and social services departments is probably in the region of £100m¹¹ (substantially in excess of the £41.3m notionally allocated for England by the Department of Health in 1997/98). Figures for generic health care are an unknown, but could be very high indeed. For example, a quarter of our sample of 128 had overdosed at least once in the month before contact with criminal justice drugs worker; 39% recognised that their use had become problematic because of physical health problems. Problem users present the health service with a wide range of emergency and non-emergency demands. Then there are the costs of viral infection - notably HIV/AIDS and hepatitis. HIV/AIDS will impose high costs for a relatively small number of patients. Costs arising from the treatment of Hepatitis B and C are likely to be substantially higher in the long term, given the greater prevalence - but it remains to be seen precisely how burdensome Hepatitis C turns out to be¹². We have no basis on which to estimate generic social services costs (eg in providing care facilities for the children of problem users), except to say that these are significant.

The vast majority of problem users are unemployed and claiming benefit. Regional Drug Misuse Databases suggest a figure of around 80%. The majority will be claiming unemployment or sickness benefit and many will be claiming housing benefit. If one assumes an average weekly benefit payment of £100 for 90% of 130,000 problem users, the weekly bill is £12m (or £600m a year). It is unrealistic to attribute all this expenditure to problematic drug use. Indeed some people may have developed drug habits precisely because of the limited life opportunities open to them, including those for employment. Nevertheless, any interventions which enable a problem user to return to the workforce will yield a saving of some £5,000 a year.

Costs to the criminal justice system

Costs to the criminal justice system can be estimated either by apportioning expenditure to offenders who are problem users or by estimating how many offences result in formal legal action, and apportioning costs to these crimes. The first approach involves estimating the number of problem users who pass through the criminal justice system annually, expressing

¹¹ Extrapolated from expenditure in three large health authorities:- East Sussex, Brighton and Hove; Lambeth, Southwark and Lewisham; and Leicestershire.

¹² Some 70% of problem users are estimated to have Hepatitis C (Strang and Farrell, 1996); if only a small proportion develops severe liver problems, treatment costs will still be very significant. The likely costs of Interferon/combination treatment could in time be very high.

this estimate as a proportion of offenders proceeded against, and applying this proportion to total criminal justice costs. For example:

- 130,000 problem users
- assume that 100,000 of them are criminally involved
- assume that 50,000 are arrested and prosecuted annually
- these would represent 10% of all offenders prosecuted for notifiable offences
- thus accounting for around 10% of the £11bn spent annually on the criminal justice system

The resultant figure of just over £1bn per year (or £10,000 per criminally involved user) would need trimming down to take account of the proportion of police resources spent on non-criminal matters. One might assume, for example, that only a third of policing costs are directly absorbed by crime; if policing costs account for 75% of the criminal justice spend, this would reduce the figure to around £500m, or £5,000 per criminally involved user. It is also worth bearing in mind that at least 15% of the prison population are drug dependent on admission, suggesting that around £200m of the prison budget is absorbed by this group¹³.

Whether a figure somewhere between £500m and £1bn is plausible can be assessed by following the second approach, and looking at the costs of the criminal process in specific cases. Examples of average costs, updated from figures published by the Home Office (1992) to correct for inflation, are:

- recording a crime: £100
- a pre-sentence report: £200;
- a month remanded in custody: £2,000;
- a contested trial in the Crown Court: £12,000;
- a guilty plea in a magistrates court: £220 +;
- a six-month prison sentence (with three months served): £6,000;
- a one-year probation order without conditions: £1,200;
- average system cost per recorded burglary: £600.¹⁴

The majority of criminally involved problem users will be raising money through shoplifting, other theft and fraud. Take the case of a shoplifter who gets caught and prosecuted twice a year¹⁵. Let us assume that in each case there is a guilty plea, with a probation order in the first case and a two month prison sentence in the second. Costs might be as follows:

¹³ Extrapolating from estimates made in the late 1980s by Maden et al, 1991.

¹⁴ This figure represents the total system costs of dealing with all recorded burglaries, averaged across the total number of recorded burglaries.

¹⁵ The 60 users we interviewed when evaluating the Brighton 'Get It While You Can' arrest referral scheme had an average of 1.6 convictions per year.

£200	police costs for initial response to the two crimes
£800	for police costs in preparing two cases for the CPS
£400	for CPS costs in prosecuting two uncontested cases
£400	magistrates' court costs in dealing with two uncontested cases
£400	for two pre-sentence reports
£1,200	for one 12-month probation order
£2,000	for a 2-month prison sentence
<u>£5,400</u>	TOTAL

Some problem users may stay out of contact with the criminal justice system for long periods. On the other hand, some pass rapidly through the 'revolving door' time and time again, and others, though less frequently prosecuted, incur high costs. Take the case of drug dependent burglars. Someone who burgles to fund a habit may commit well over 50 burglaries a year. If 50 of them are reported to, and recorded by, the police, the costs of initial police response and recording will be £5,000. There will be rather larger detective costs for the cases which are investigated but not solved. The minority of cases resulting in detection and conviction will be very expensive: a *single* prosecution resulting in a year's prison sentence may involve a combined bill from the police, Crown Prosecution Service, Crown Court and prison services in excess of £15,000. The two approaches to criminal justice costs yield convergent estimates, which suggest that a total figure between £500m and £1bn is of the right order of magnitude.

Estimates for the three sites

Table 3 applies the same methods and assumptions as we have used for national estimates, to yield local estimates in the three research sites. We have slightly uplifted the average weekly spend, however, given that levels of expenditure in our three sites is higher than reported in other studies. The table poses the obvious questions whether the absolute level of investment in health care and criminal justice is right, and if the balance of expenditure between services is sensible.

Table 3: Costs associated with problem drug use

	SOUTHWARK	BRIGHTON	DERBY
Best guess at number of problem users	2,000	1,800	1,000
Average weekly spend	£250	£250	£250
Total weekly spend	£500,000	£450,000	£250,000
Total annual spend	£26m	£23m	£13m
Between ½ and ¾ raised through acquisitive crime	£13m-£17m	£11m-£15m	£6m-£9m
Cost to victims (3 x cash raised through acquisitive crime)	£39m-£51m	£33m-£45m	£18m-£27m
Cost to criminal justice system £2,000-£5,000 per user	£4m-£10m	£3.6m-£9m	£2m-£5m
Expenditure on specific drug services (estimates)	£2m	£1.5m	£1m

4: TYPES OF REFERRAL SCHEME

There is growing evidence that treatment services for problem drug users have a significant impact in reducing drug misuse and related crime. The National Treatment Outcome Research Study is beginning to replicate findings from America (Department of Health, 1997). There is also evidence from largely North American research that the criminal justice system can be used effectively to encourage or coerce problem users into treatment (see Hough, 1996, for a review). This body of research clearly suggests the potential of referral systems to provide bridges between the criminal justice system and treatment services.

The most widespread form of arrest referral scheme exemplifies the *information model*. Its defining feature is the provision of information by the police to people passing through custody. The information is usually offered to all arrestees on a “take it or leave it” basis; however, some police officers in some schemes target the information on people judged to be in need or even act as broker between arrestee and drug worker. Dorn (1994) has offered a description and critique of these schemes, including very limited take-up rates.

The *pro-active model* involves drug workers working in close co-operation with the police, often with direct access to detainees in custody suites. They may approach arrestees in the police station themselves, providing assessment either on site or at a subsequent meeting. Whilst police officers may screen or target arrestees for the drug worker, information about drug services and encouragement to seek advice is always provided by the drug worker.

Finally, there is the *incentive model*, which exploits the fact that the criminal justice system is a coercive one, through which incentives can be held out to encourage problem users to seek assistance in tackling their drug problems. There are obvious legal sensitivities to be considered in offering any pre-trial incentives, though there are examples of bail support schemes and caution-plus schemes in which arrestees are given incentives to seek help. One of the better known is the Kirklees Drug Arrest Referral Scheme (Formby, 1997). Court-based referral in the form of a probation order with treatment conditions, is a much more overt form of incentive model than bail and caution-plus schemes. There are other options at the court stage. The most obvious is to require treatment as a condition of a probation order, an approach which is being developed in the Treatment and Testing Order. But there are other options: deferring sentence and adjourning cases - though again, these raise issues about due process which need to be given careful thought. It may be possible to reduce the legal problems surrounding coercive models of referral by involving defence solicitors in their operation.

The ‘Get It While You Can’ scheme in Brighton

This was one of the first schemes to exemplify the proactive model. GIWYC is a rapidly expanding network of referral systems, but we focused on the original scheme, based in

Brighton, which started in the early 1990s. The GIWYC scheme has been evaluated twice before, first by the Brighton & Hove Drugs Prevention Team (Theobald and Vale, 1993), and then by Turnbull et al. (1995) for the Home Office Central Drugs Prevention Unit, but neither evaluation focused substantially on outcomes.

The project is based at Brighton and Hove magistrates' court. Referral workers located potential clients in the police cells and the courts, and had open access to the police cells. At the time of the research, there were four staff: a project leader¹⁶, two arrest referral workers based at the police station and one court worker. Police workers are contactable by a pager when they are away from the station. They see arrestees in their cells unsupervised. Relationships between workers and police struck us as good. The court work is similar in nature, though the court worker is reliant either upon court staff phoning the office, or upon recognising a familiar name on the court lists.

GIWYC's database can provide some statistics about the scheme's workload. Clients seen with alcohol but not drug issues (26% of caseload) have been included, because at the time of writing the database could not readily separate alcohol and drug clients. Figures cover the 12 months from 1 May 1996, over which period GIWYC saw 664 individuals at least once. The majority of clients (535 or 81%) are first contacted in the police cells. 88% were male, and 93% were white. As with other arrest referral schemes, the average age of contact is late-twenties; 30% were under the age of 26, and very few were under 17. Opiate use predominates amongst drug users. Acquisitive crime accounts for just over half of all offences disclosed to the GIWYC team.

The Southwark scheme

The origins of the Southwark scheme are to be found in a pilot project developed in the late 1980s. This involved the appointment of a Home Office-funded drugs worker located in the local Community Drug Team; the worker was on call to respond to referrals prompted by information given by police to arrestees. The project was developed in the early 1990s with co-funding from the Inner London Probation Service (ILPS) to provide an on-call service to all three police divisions in the borough, as well as satellite clinics in probation offices.

This scheme provided the starting point for the South London Drugs Prevention Team's (SLDPT) demonstration project. This involved the development of referral structures at different stages in the criminal process in the five boroughs covered by the SLDPT. For arrest referral, all arrestees passing through custody suites were to receive a referral card showing a central freephone number (at SLDPT) and the numbers of the drug agencies forming part of the scheme. At the start of the project, SLDPT negotiated an agreement with local drug agencies that they would find staff time, from within existing resources, to respond to the extra referrals expected to flow from referral systems built around arrest (and at other points of the criminal process). In practice staff earmarked for the delivery of the service found it

¹⁶ At the time of fieldwork, the project leader was largely involved in developing new dimensions to the scheme, and in setting up similar projects elsewhere.

very hard to find the time to develop the arrest referral component of their work. In the early stages of the scheme, therefore, the arrest referral schemes operated to all intents and purposes according to the information model.

The exception to this was Southwark, where the SLDPT and the Inner London Probation Service continued to fund a dedicated drugs worker to carry out arrest referral work and work with probationers. This worker became well known in all three police divisions in the borough, and her referral rate built up rapidly because of her direct and personal contacts within the stations. The Southwark scheme thus operated according to the proactive model. For reasons which will become apparent below, the Southwark approach of employing a drugs worker with explicit responsibility for arrest referral work was adopted by the other four boroughs covered by the SLDPT demonstration project. At the time of field work, however, the Southwark scheme was alone in pursuing this approach¹⁷.

The Derby scheme

The Derby scheme had independently settled on a similar proactive approach. The scheme had its origins in a partnership between the probation service and health authority which predated the establishment of the East Midlands Drug Prevention Team (EMDPT). Probation and health had jointly financed a criminal justice drugs worker to handle referrals from the probation service. The EMDPT provided finance for a second criminal justice drugs worker to carry out arrest referral work. The two workers were managed by **apa** (now renamed Addaction). The arrest referral worker was based at the main Derby police station. She provided a service both for arrestees and remand prisoners, offering advice, information and referral to other services. She also offered a limited follow-up service, providing ongoing support in some cases. The probation worker was based in Derby's statutory drugs and alcohol agency, The Elms. She received referrals from probation officers and provided assessment reports for courts; she also supervised offenders serving probation orders with conditions of treatment (1A6 Treatment Orders). After our evaluation started, a Youth Justice drugs worker joined the team. She was based at the Youth Justice Unit in Derby, to work with young offenders¹⁸.

The Derby scheme had moved further than the other two in the direction of an *integrated* criminal justice referral system, with linked workers each focusing their effort on different parts of the criminal process. The arrest referral component of the scheme was less heavily resourced than that in Brighton, and more heavily than the Southwark scheme.

Referral rates

The referral rates per arrest referral worker for the Brighton, Derby and Southwark schemes are compared in Table 4 to the three information schemes which were active as part of the

¹⁷ Once other boroughs had adopted this approach, referral rates increased markedly. The results will be presented in a later report.

¹⁸ This element of the EMDPT project is being evaluated separately, under the aegis of a study on youth justice interventions.

SLDPT demonstration project at the end of 1996. Table 4 demonstrates that pro-active schemes are much more productive than ones which simply offer information. In two of the pro-active schemes, the referral rate per month has substantially increased since December 1996; if anything, therefore, the table understates the differences in productivity between the two approaches. It is striking that the referral rates per worker in the three schemes are all comparable, although referral levels are substantially different, reflecting resourcing levels. This suggests that the more heavily resourced schemes were at no risk of saturating their market.

Table 4: Referral levels and rates per month in different sites

	Referral numbers per month	Referral rates per worker per month
Pro-active Schemes		
Southwark	5.5	11.0
Derby	13.5	13.5
Brighton	28.0	14.0
Information Schemes		
London Borough B	1	n.a.
London Borough C	0	n.a.
London Borough D	0	n.a.

Note: Figures cover 6 months in Southwark, 8 months in Derby and a year in Brighton. The Brighton figures exclude referrals of problems drinkers and referrals dealt with by the court worker. Figures in Southwark cover a six month period once the scheme was properly established; the early months of the scheme made heavy demands on the worker's time in terms of delivering training and making presentations about the scheme.

5: IMPACT OF REFERRAL SCHEMES

This chapter presents the results of our follow up surveys in the three sites. We set targets of 40 face-to-face interviews in Southwark and Derby and 60 in Brighton. We asked drug workers in each site to contact as many of their clientele as they could. They were to approach them in the order in which they were first seen until the target sample was reached. It proved a struggle to meet these targets, and there are obvious limitations to the use of opportunity samples assembled in this way, as discussed below.

The full interview sample consisted of 128 respondents (32 from the Southwark scheme, 36 from Derby and 60 from Brighton). The Southwark sample constitutes almost 30% of the 110 drug clients referred via the Southwark scheme from June 1996 until the time of research in July 1997. The Derby sample represents roughly 25% of the drug clientele, having 146 initial referrals in the period between August 1996 and July 1997. The GIWYC sample represents around 15% of the problem drug users seen by drug workers in the previous year. There was an average timelag of 7.5 months between clients' initial contact and interview¹⁹.

We interviewed respondents in drug agencies, probation offices, police stations, rehabilitation units or prison. Nineteen of those whom we interviewed in Derby and Southwark had been contacted by a drug worker not as part of the arrest referral scheme but as part of the probation side of the scheme; there were also ten self-referrals, and 9 which had been made from courts or prisons. Only one of our Southwark sample had made use of the freephone helpline. Our analysis makes use of differing sub-samples:

- findings providing a *profile* of problem drug users draw on the full sample of 128²⁰
- findings covering the referral *process* draw only on the 90 arrested before contact²¹
- findings about the *outcomes* of those in contact with arrest referral schemes generally draw on the 80 who were arrested but not subsequently imprisoned.

Several possible types of bias exist in our sample, which need to be taken into account when interpreting the results:

Biases in sample selection

- clients who found the schemes helpful were more likely to have remained in

¹⁹ The timelag was designed to provide a sufficient period between initial contact and access to services to allow an assessment of medium term outcomes.

²⁰ Including respondents who were interviewed in connection with other aspects of the evaluation (to be reported later), findings on which are relevant to profiling drug use in the three sites.

²¹ These include six cases who were self-referrals following arrest.

touch with the arrest referral worker, and therefore to be contactable, than those who found them unhelpful.

- those whose drug use became more chaotic after contact with the scheme would have been harder than others to contact.
- offenders in prison were, literally, a captive audience who were particularly easy to contact. The same was true to a lesser extent for those engaged in treatment programmes.

Response biases within the selected sample

- some respondents had difficulty remembering in precise detail their drug use prior to contact with the arrest referral worker. In some instances the period of time that elapsed between initial contact and research interview was a year.
- those who were more chaotic in their drug use may have been more anxious than others about receiving payment, and may have been readier to say whatever they thought we wanted to hear.
- those who were not totally convinced of confidentiality may have spoken more openly and in greater detail of drug use and offending behaviour prior to contact with the arrest referral worker compared to current levels, especially those on treatment orders or in prison.
- some respondents may have been influenced by some sense of ‘macho pride’ exaggerating their prior drug use.
- some of those we interviewed had established a good relationship with the arrest referral worker and were highly motivated to give a good account of them.

We can offer no conclusive test of validity and reliability. A minority of respondents gave less than credible accounts of past and current drug use - reporting exaggerations of both increased and reduced use²². The motivation for such misrepresentation is complex, with some respondents having numerous reasons for doing so. The time of the most recent conviction served as a ‘cut-off’ point for the disclosure of particular offences. All respondents talked freely of drug possession but some were more reluctant to discuss selling drugs. A similar distinction was made by respondents between non-confrontational, so-called ‘victimless’ crimes e.g. shoplifting, and more serious crimes such as street robbery - with burglary occupying a more ambiguous position.

²² We tried to quantify this in the GIWYC sample. We reckoned that 10 of the 60 had given responses about current drug use which were implausible (See Edmunds et al., 1997.)

The interview focused on two main “outcome domains” - drug use and offending. We have only limited information on other domains of health and social functioning. Overall we feel more confident about the accuracy of responses than about the representativeness of our sample. We have done some limited checking of reliability of responses, in that for 25 users we were able to compare self-reported drug use in the month before contact with the scheme with the record of drug use for the same period made during client assessment by drug workers. Levels of drug use disclosed by respondents to arrest referral workers at the point of contact with the schemes was broadly similar with that reported during our interviews.

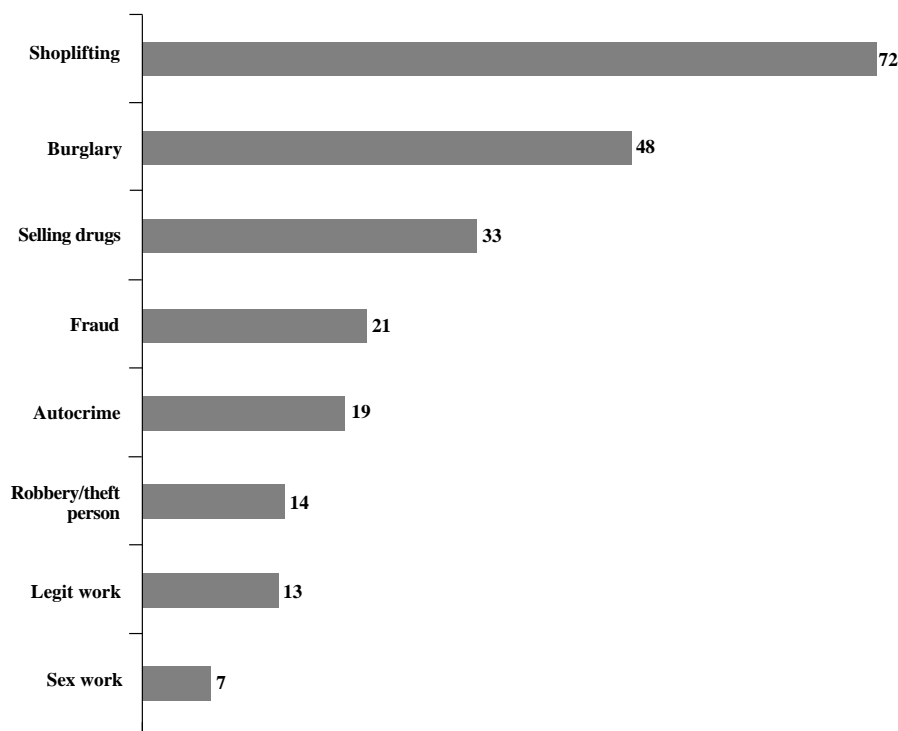
Profile of respondents

Of the 128 respondents, 110 (86%) were male. Ages ranged from 16 to 56, with an average age of 29 years. 122 described themselves as white, two as Asian, and four as black. There were slight age differences between the sites: the average age in Derby was 27; in Brighton it was 29; and in Southwark 31.

The sample were largely polydrug users at the time of contact with the schemes. 82% used illicit opiates; a quarter of these also had prescribed methadone. 72% used stimulants²³. Two thirds used cannabis (or at least thought it significant enough to mention). More than half (58%) used both opiates and stimulants. A quarter used opiates but not stimulants. Eighteen (or 14%) reported using stimulants but not opiates; and four said that they used neither stimulants nor opiates. Most (105) had current experience of injecting drug use, and 94 had injected in the month before contact. Expenditure on drugs was high. The mean weekly expenditure was £563, and the median was £400. (The median is probably a better measure of central tendency as the mean is skewed upwards by a small number of very big spenders.) The 47 cases for whom this was the first contact with any drug agency spent slightly more (£602 per week) than the others (£542 per week). Most reported a mix of strategies for financing their use, as shown in Figure 2.

²³ In our sample, stimulant use was largely confined to amphetamine, crack cocaine and, to a lesser extent, powdered cocaine.

Figure 2: Ways of financing drug use



Note: the chart shows numbers reporting each strategy, based on a sample of 128 users.

Looking at our sample's demographic and drug profiles in the round, we have located a group of opiate users who are predominantly white, male and in their late twenties. What distinguishes our sample from many earlier studies is the extent to which this opiate use occurs in combination with other drugs. The limited representation of users who are young, female or black reflects the caseloads of the schemes. Whether the schemes are sufficiently geared up to reach such groups is discussed in the final chapter.

Almost half (43%) of the sample stated this was their first contact with any drugs agency. However most had had previous contact with the criminal justice system. The majority of those whom we interviewed had long criminal histories, with an average of 21 previous convictions. 92% of the sample had experienced arrest long before they recognised that their drug use was problematic. Table 5 presents landmarks in their drug and criminal careers.

Table 5: Respondents' drug use and conviction histories by scheme

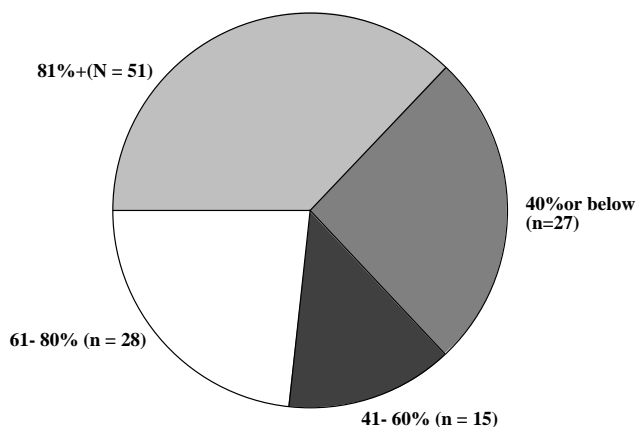
	Scheme			
	Southwark	Derby	Brighton	Total
Average age of first illicit drug use	15	15	15	15
Av. age of first criminal conviction	19	17	16	17
Av. age of first use of drug of choice	21	21	20	21
Av. age of first injection (n=105)	23	22	22	22
Av. age when use became problematic	25	23	24	24
Av. age at research interview	31	27	30	29
No. using drugs before 1 st conviction	20	19	36	75
No. using drug of choice before 1 st conviction	9	9	9	27
No. injecting before 1 st conviction	4	5	3	12
Average number of convictions	18	20	24	21

The average age for respondents' first use of illicit drugs was 15. The average age of first conviction comes two years after first illicit use, but seven years before the age at which use became problematic. 75 respondents used drugs before first conviction, 27 of whom had used their current drug of choice before first conviction. The average age for first use of current drug of choice was twenty-one years, followed a year later by first injection. The average time between first injection and self-identified onset of problematic drug use was two years.

The Home Office 'Offender Group Reconviction Scale' enables calculation of expected reconviction rates over a two year period, on the basis of offenders' age, offence and criminal history. This provides a measure of any sample's involvement in crime - although it is a relatively crude instrument for our purposes, making no distinction between offenders whose crime is drug related and others. The average reconviction rate nationally is between 53% and 57%. The respondents in our sample had an average expected reconviction rate of 67% (excluding 7 cases with missing data). The respondents from Derby and Brighton had significantly higher expected reconviction rates than those from Southwark: 70% and 72% compared to 54%. We suspect that the differences may reflect lower detection and prosecution rates in London, rather than differences in offending rates (i.e. offenders in Derby and Brighton are more likely to have been convicted for *previous* offences, and thus score highly on the reconviction score, than those in London). (In an ideal world, we would calibrate

the scale to take account of local variations in each site's detection rates.) Figure 3 shows the distribution of scores.

Figure 3: Expected reconviction rates of respondents (n=121)



Referral and take-up rates

Figure 4 summarises referral and take-up rates. Of the 90 respondents who were seen by criminal justice drugs workers at or shortly after the time of arrest, three quarters (66) were referred in total, the vast majority to drug agencies, nine to housing agencies and one to a hospital psychiatric unit. The remaining 24 were simply given advice and information. Fifty-three of the 66 made contact with the relevant drug agency, and were offered various forms of help, as shown in Figure 5. 41 actually accessed help or treatment of some sort.

Figure 4: Referral outcomes (n = 90)

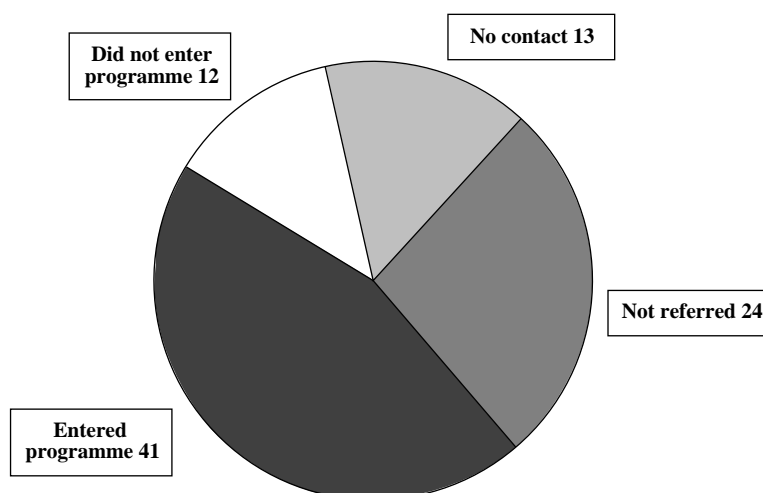
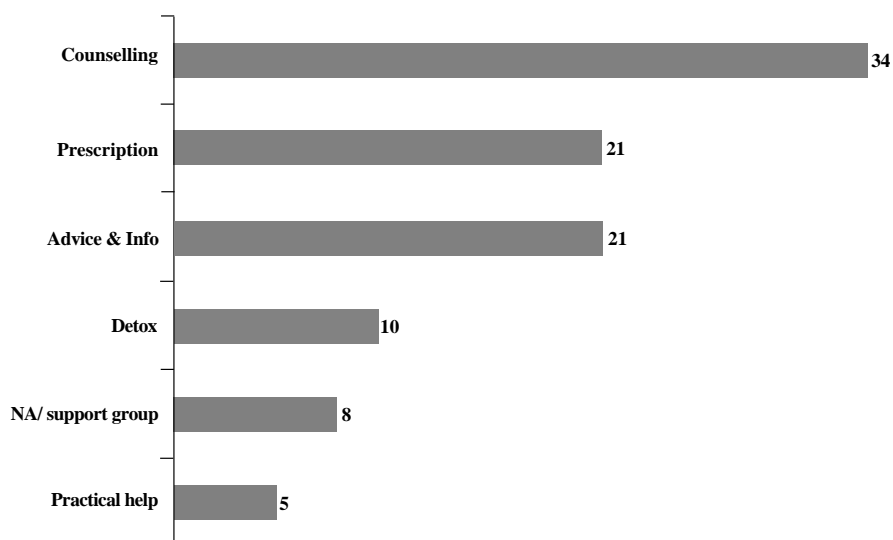


Figure 5: Main services/assistance offered to those acting on referrals



At the time of fieldwork, 11 respondents had completed their programme of treatment, 20 were still in treatment programmes, and 5 had left or had been asked to leave. Twenty three of the 41 who accessed treatment considered it ‘a great help’; 14 said that it ‘helped somewhat’ and four that it had ‘made no difference’.

The arrest referral workers in all three schemes offered support over a period of time. The average number of contacts per client was five, and 75 out of the sample of 90 had seen the worker more than once. This help took the form of support and reassurance (43 cases), advice and information (42 cases), practical or other help (26 cases), and a drop-in service (23 cases). In 12 cases the worker had provided an introduction to an NA group. 39 respondents said that this ongoing support had ‘helped a great deal’, and 15 said it had ‘helped somewhat’.

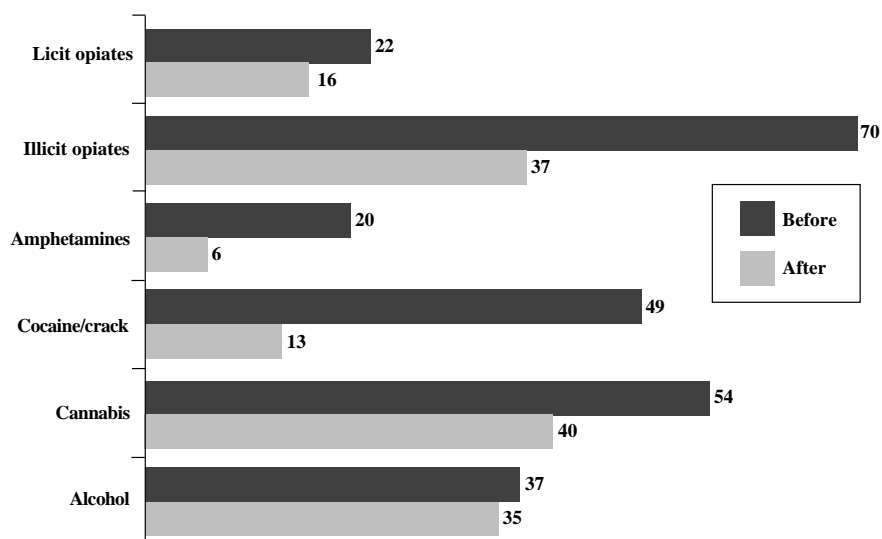
Reductions in drug use

In examining changes in drug use we have looked only at those 80 respondents who saw an arrest referral worker following arrest and who were not in prison at the time of interview. As with the total sample, most (71) were using opiates before their arrest. 50 of the 71 also used stimulants; and there were a further seven who used stimulants but not opiates. Two used benzodiazepines but neither opiates nor stimulants.

We asked respondents about their drug use in the 30 days before arrest and the thirty days before interview, enabling direct comparisons to be made between the two time periods. In the month preceding interview, self-reported drug use had fallen steeply amongst the 80. Half the sample continued to use cannabis, and there was little change in alcohol use (see Figure 6), but other changes were large:

- 13 said that they were completely drug-free, including alcohol
- 21 said that they were free of any form of illicit drug
- 31 said that they were no longer using opiates or stimulants
- 35 said that they were no longer using illicit opiates or stimulants

Figure 6: Changes in drug use



Note: The 'before' period covers the 30 days preceding arrest and contact with drug workers. The 'after' period covers the 30 days before interview.

Table 6 presents the same information in a slightly different way, summarising the interrelationships between use of different drugs before and after contact. It shows a very large fall in the number of people using both opiates and stimulants; there were compensating increases in the number of those using opiates only, and in those using neither opiates or stimulants.

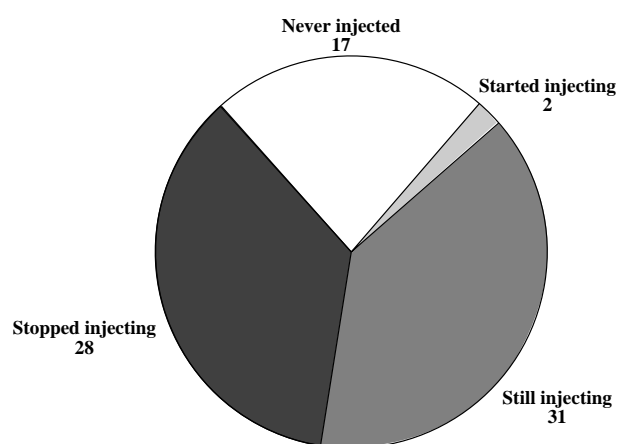
Table 6: Typology of respondents' drug use before and after contact

	Opiates only	Opiates & stimulants	Stimulants only	Not stimulants or opiates
Before contact	21	50	7	2
After contact	31	11	7	31

Reductions in injecting

Fifty-nine of the 80 respondents reported intravenous drug use in the 30 days before contact with the schemes. This fell to 33 in the month before interview. Twenty-eight said they had stopped injecting, and two said that they had started; thirty-one continued to inject (Figure 7). The average number of days per month on which the intravenous users injected fell from 29 to 19.

Figure 7: Injecting behaviour before and after contact (n = 78)



Reductions in drug expenditure

Reported reductions in money spent on drugs were large. The mean and the median weekly expenditure on drugs prior to contact with the scheme was £569 and £400 respectively. The figures in the month before interview were £171 and £70. Figure 8 shows median figures before and after for the three schemes.

Figure 8: Median weekly spend on drugs before and after contact

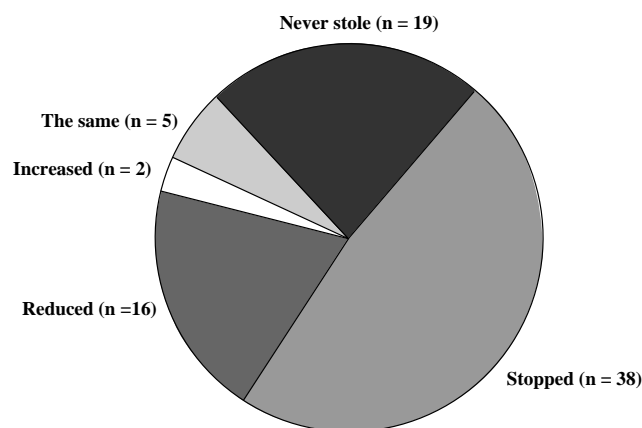


Reductions in crimes committed

There were two separate ways in which we calculated crime reduction. The first measure is “acquisitive crime days” (the average number of days per month on which acquisitive crimes were committed). The second is an estimate of acquisitive crimes committed: we asked respondents not only about their ‘crime days’ but also about the average number of crimes committed per crime day, and so we can calculate the product of the two²⁴.

The average number of acquisitive crime days before contact with the scheme was 30; this fell to 7 in the month before interview. (It was possible to score more than 30 crime days a month, eg by shoplifting on a daily basis and committing frauds every other day.) Figure 9 shows changes in involvement in acquisitive crime.

Figure 9: Changes in acquisitive crime (n = 80)



²⁴We also asked about other categories of crime, but have not reported the results here.

The average number of acquisitive crimes committed in the 30 days before contact with the schemes was 125. The corresponding figure for the month before interview was 28. Table 7 gives the total number of crimes disclosed in the month prior to initial CJDW contact and those in the month before research interview.

Table 7: Total number of offences committed per month

	Month before scheme contact	Month before research interview
CRIME		
Burglary	660	50
Fraud	1,100	140
Shoplifting	6,500	1,740
Theft from person	320	40
Vehicle crime	2,220	230
TOTAL	10,800	2,200

(Note: figures are rounded)

In the month prior to contact the total number of acquisitive crimes committed by the 80 respondents approached 11,000. Whether it is plausible for problem users to offend at the rate of over four a day must be for the reader to judge. Our rate is seven times higher than that reported in the NTORS study of 21 crimes per month per respondent (Department of Health, 1996). The nature of our sample is obviously skewed towards the criminally active. Although we suspect that there may be some exaggeration - for example in reporting *maximum* rates of offending per day as *average* rates, the estimates are not beyond the bounds of credibility. For example, fifty-one of our eighty respondents shoplifted, thirty on a daily basis. The average number of shoplifting offences per day for the 51 active shoplifters was just over four. This is not a demanding target for experienced shoplifters to hit.

Users' views

In addition to structured information about drug use and offending, we asked respondents a series of open-ended questions about addressing drug problems, arrest referral schemes, drug agencies, the police and the criminal justice system.

Respondents were asked to say what had had a significant impact in helping them to address their drug misuse. A large majority said that the intervention provided by the arrest referral scheme had enabled them to contact a suitable agency, thus facilitating harm reduction or

abstinence. Almost a quarter said that the counselling offered by workers had helped, especially regarding their confidence and positive self-image. Receiving information and advice was also regarded as significant. Other interviewees stated that obtaining a prescription, a referral to a specialist agency and attending NA meetings had helped them to address their drug problems.

Emotional relationships also seemed to play a significant role for those we interviewed when attempting to stop or reduce drug use. Many said that family support, child-care issues and friends dying from drug misuse had focused their minds. As one respondent said: 'It is the realisation that I want other things out of life, like good sex, and love without drugs.'

Existing services that many of our respondents welcomed included needle exchanges, referrals to specialist agencies and prison visits. Negative experiences mainly centred around the frustration with waiting lists for prescriptions. The majority of our respondents, however, seemed to appreciate that most agency staff tried their best for their clients and that staff were as frustrated with waiting lists and scarce resources as they themselves.

Respondents were generally positive about the arrest referral scheme itself. Reaching those users who were out of touch with services was seen as very positive. Many believed that agencies need to work with young people more, believing that they might be effective in providing advice and information to younger users who were still in the 'honeymoon' period of drug use. Some said that having an independent worker at the police station was helpful: "It is quite a good idea to have someone in the station giving advice rather than the Old Bill." A minority thought that there was a risk of workers getting too close to the police.

Respondents were generally positive about the arrest referral workers themselves. They described workers variously as good at their job, helpful, approachable, informative, efficient, relaxed and good listeners. One respondent went as far as saying that the worker had "saved my life and stopped me from killing myself." A very small minority were negative: for example, one told a researcher that 'it's not what I wanted, I don't want a script', whilst another thought that 'services do not exist to treat people like me.'

Not surprisingly, there was plenty of scepticism expressed about the police. Many thought that the police did not treat users fairly - though they admitted variation between officers. A majority thought that the police were poorly informed about drug use, often with little or no knowledge about physical addiction or withdrawal. Many felt that they were stereotyped by the police simply as junkies.

Though most of our respondents had long criminal records, a significant minority mentioned prison, and the fear of returning to prison as important motivating factors. "Being arrested

made me focus on my drug problem, it was my first real arrest for Class As; if I continued I thought I would (continually) end up in prison and alone”. The low availability and high price of illegal drugs in prison seemed to encourage some users to take stock of their use. Many thought that drug services in most prisons were woefully inadequate.

6: CONCLUSIONS

This study provides good evidence that arrest referral schemes can be effective in reducing drug use and drug-related crime. This final chapter has three aims. First it provides a framework within which the reader can assess how much weight to attribute to the findings. Secondly it examines issues of cost-effectiveness. Finally it identifies the features which seem to contribute to the success of the schemes we examined, and draws out recommendations for those involved in setting up similar projects elsewhere.

Interpreting the findings

The findings suggest very substantial reductions in both drug use and crime, but these need to be interpreted carefully. Account must be taken both of selection bias in assembling the sample and of response bias amongst those we interviewed.

We are only slightly better placed than the reader to assess the extent to which the benefits we have identified should be discounted to take account of response bias. Whilst we doubt the reliability of a minority of the sample, we have no doubt that the improvements claimed by the majority had some basis in reality. The improvements may have been overstated, not least as a result of the difficulty of reporting accurately on a period of chaotic drug use and offending which had occurred some months before the interview.

The next thing to consider is the extent to which our sample is biased towards successes. We do not believe that workers in the schemes “cherry-picked” their successes for us to interview. Nevertheless, our sample is very probably biased towards the contactable. We cannot divide non-respondents into *non-contacts* and *refusals*. There is no reason to think that people whose drug use is unchanged will be over-represented amongst non-contacts; indeed, a proportion of non-contacts are likely to be those who have become drug-free and moved away from the area to avoid the drug scene. Refusals, by contrast, are more likely to include those whose drug use has continued unchanged. The most cautious assessment would be that nobody except those we interviewed showed improvements. Few would argue this position.

The final thing to consider is whether the reductions in drug use and offending can be attributed to the arrest referral schemes themselves. Several competing explanations need to be considered:

- the deterrent effects of arrest and punishment are the real source of reduction
- the users would have got to grips with their drug problems by themselves
- the reductions reflect the natural peaks and troughs of chaotic drug use
- the users would in any case have found their way to treatment services.

We cannot say definitively whether any of these arguments carry any force. To do so, one would ideally need to carry out evaluative research with an experimental design. This would entail randomly allocating arrestees to see, or not to see, arrest referral workers. The administrative and ethical issues in doing so would probably be insurmountable. Alternatively, one could apply a quasi-experimental design in which experimental and comparison groups were contrasted - but again, the practical problems in assembling and keeping track of a comparison group are overwhelming. Without the prospect of any hard empirical data, therefore, one has to bring more circumstantial evidence to bear in assessing these arguments.

Deterrent effects of arrest and punishment

This argument can be readily despatched. As noted in Chapter 5, almost all our respondents had lengthy criminal histories, and had proved themselves hardened to the deterrent effects of punishment. It is implausible that the reductions in crime and drug use are a consequence specifically of being arrested and punished.

The users would have got to grips with their drug problems by themselves

This argument is that spontaneous remission has taken place (to use clinicians' terminology). There may be a proportion of clients who would have shown improvements regardless of contact with the scheme and agencies to which they were referred. We doubt that this can account for all the improvements - especially in the light of the qualitative findings which illustrate clients' enthusiasm for the schemes. Certainly some of our respondents had reached that point in their drug-using careers where they were "sick and tired of being sick and tired", but this does not rule out the possibility that the arrest referral workers had brought forward in time their contact with agencies which helped them address their drug use.

Natural peaks and troughs of chaotic drug use

This argument is that our findings reflect the natural cycles of chaotic drug use, rather than the effects of referral and treatment. The argument is that many users' drug careers progress not in straight lines but in peaks of chaotic use and troughs of relative abstinence; the peaks will create very high risks of arrest, both because of the level of offending and because of the chaotic state of the user when offending. This is consistent with our data - the very high levels of drug use and offending which were reported for the month before initial contact with arrest referral workers, and relatively low levels of drug use immediately before our interviews. We find the argument plausible to an extent, but doubt that, by itself, it can explain the changes in drug use which were reported to us. We plan to follow up and re-interview as many of the Southwark and Derby samples as possible, to assess their progress six to twelve months after our first interview.

The users would have in any case found their way to treatment services

The final argument is that the treatment services accessed by the users were effective in reducing drug use and crime, but that arrest referral played no part in brokering this treatment. Again, there may be *some* truth to the argument, but between a quarter and a third of those contacted by each scheme had had no previous contact with any drug agency, and a further third or more had lost contact with drug agencies. Whilst these two groups might have established or re-established contact with drug agencies at some stage, there is an overwhelming probability that the arrest referral workers *accelerated* this process.

Cost-effectiveness

In assessing the viability of arrest referral schemes, the key issue for funders is about cost-effectiveness. Few of the evaluative studies in this field have attempted to translate effectiveness into cost-effectiveness, reflecting the complexity of cost-benefit analysis in this field. Here we offer the beginnings of an analysis for the three schemes. What we have done is to estimate the unit cost of a referral, and then to assess what sorts of benefits would have to accrue to render the scheme cost-effective. We have shied away from any attempt to estimate the number of crimes prevented annually by each scheme²⁵. We plan to do this in later reports, when we have firmer data about the throughput of the Derby and Southwark schemes, and when we have carried out more follow-up interviews.

In calculating unit costs, we have taken a broad definition of referral, equating this with all the work which workers do with clients. This makes it quite simple to calculate a crude unit cost per case and cost per referral:

total annual cost of an arrest referral worker ²⁶ :	£33,000	
number of clients contacted:	240	
<i>cost per contacted client</i>	<i>£140</i>	
number of clients referred	160	(66% of total, 13 per month)
clients taking up referrals in 1996/97	80	(33% of total)
<i>cost per successful referral</i>	<i>£400</i>	<i>approx.</i>

One could refine costs to take into account differences in the demands made by different categories of client, but we have no information on which to do so. It is important to note that the cost per successful referral - where success means contact with the agency to which referral was made - allocates all costs onto the referral process. However, the schemes have a broader function than referral, including support to clients on waiting lists.

²⁵ We made an attempt to do so in our first report of the GIWYC evaluation (see Edmunds et al. 1997), but the smaller number of interviews per site in Derby and Southwark have deterred us from repeating the analysis here.

²⁶ This includes salary costs, on-costs, a management overhead and accommodation.

In assessing what benefits result from this expenditure, there are obvious problems of attribution. If a referred client has become drug-free, how are the benefits to be allocated between referral and treatment costs? It makes sense to think of the scheme as drawing forward in time reductions in drug use and crime which would inevitably have occurred at some stage - through treatment, maturation or death. In examining arrest referral's cost-effectiveness, costs have to be balanced against the benefits achieved by prompting "early retirement" from a drug-using career.

However, some of those passing through referral schemes to treatment agencies might *never* have reached treatment if they had not been referred. In these cases, it would make sense to include the costs of treatment in the cost/benefit equation.

If one takes the former position, and assumes that the majority of the schemes' clientele would have absorbed treatment costs at a later stage in their career, the schemes are almost certainly highly cost-effective. With the unit cost of a successful referral (i.e. resulting in contact with treatment agencies) standing at £400, a referral would pay for itself if any of the following occurs:

- the period of time spent by the client on income support or sickness benefit is reduced by a month
- there are 4 fewer crimes recorded by the police (at a recording cost of £100 per crime)
- there is one less burglary recorded and investigated by the police.

The savings to the health system are very hard to estimate, though the scheme has to prevent only one client contracting HIV to save the health service £75,000. It seems probable that the savings to the criminal justice system achieved with our 80 respondents are sufficient to make the schemes cost-effective. For example, some three-quarters of the 600 prevented burglaries (in Brighton) would have been reported to the police, had they been committed²⁷. At a cost to the system of £600 per burglary, the savings would be £270,000.

Features contributing to successful arrest referral

Arrest referral schemes are designed to put problem drug users in touch with treatment agencies following arrest. When they are successful, they draw forward in time the reduction and cessation of drug use which inevitably will occur at some stage in drug users' careers. They do so either by putting people in touch with treatment services earlier than would have otherwise occurred, or by putting them in touch when this would not have otherwise occurred at all.

On the basis of our experience in evaluating these three schemes and others which have achieved less success, we would identify the essential ingredients of referral/street agencies as:

²⁷ This is an average monthly figure derived from the 60 respondents interviewed, who self-disclosed an average of 10 burglaries per month (Edmunds et al (1997)).

-
- a proactive mode of work
 - a working style which wins the respect and trust of users
 - adequate resourcing
 - a capacity to provide ongoing support
 - appropriate treatment services to which to refer
 - adequately resourced treatment services to which to refer.

By a *proactive mode of work*, we mean a style of operation in which drug workers actively seek out problem users as they pass through the criminal justice system, and offer them information and the option of referral. Many arrest referral schemes have relied on the provision of information to arrestees by police officers. These information-based schemes may well be cost-effective because they are very cheap. However as discussed in Chapter 4, the number of referrals which translate into treatment is very small even when schemes are championed by particular officers (c.f. Dorn, 1994; Hough, 1996). To get any volume of referrals, it is essential to have drug workers who have access to offenders as they pass through police stations, courts or prisons.

The *working style* of staff in a referral scheme is obviously a critical factor. The arrest referral workers in each of the schemes all had the ability to strike a rapport with offenders quickly, put them at their ease and establish a degree of trust. The Brighton scheme has placed some emphasis on the value of workers who are themselves ex-users (see, e.g., GIWYC, 1996). We agree that being an ex-user can help establish credibility and rapport; the research literature also stresses the value of workers who are ex-users. However, the workers on the other two schemes achieved comparable success without personal experience of problematic drug use. The point we would emphasise is that the personal qualities of the workers are all-important. To be effective, they need to establish rapport and trust, and to having a non-judgmental style of work which will engage the clients. Ex-users are well placed to work in this way, but others can also work effectively.

Adequate resourcing is obviously important. All three schemes were relatively well-resourced, with ring-fenced funding for arrest referral work. This provided consistency of coverage, which is important both in keeping up the flow of referrals and in maintaining the support of police officers, court staff and workers in drug agencies. Schemes also need to be resourced sufficiently to provide at least a degree of *ongoing support* to clients. Workers in all three referral schemes found themselves drawn into a casework role. To an extent, they were not simply brokering treatment services, but were providing services themselves. In setting up schemes, the probability of this happening needs to be anticipated and properly managed.

That there should be *appropriate treatment services* to which to refer is equally obvious - but a condition which is often met only partially. Treatment services must be appropriate to

the nature of local drug problems. Whilst heroin dependency will present itself in most urban settings at least, patterns of stimulant use vary widely across areas; patterns of service provision do not. Treatment services must also be appropriately tailored to the criminal involvement of the clientele of a referral scheme. In an important sense drug agencies are competing with the 'street scene' for the attention of problem users. Respondents' criticisms of drug dependency units included:

- punitive
- controlling
- cold
- unfriendly
- unsympathetic
- offering little choice
- inflexible
- unresponsive

It is not for us to comment on clinical judgements about prescribing. However, if drug agencies are to yield the crime prevention dividend of which they are capable, they may need to adjust their working style to retain the engagement of this - often difficult - client group.

Finally, there need to be *properly resourced treatment services* to which to refer. Effective referral mechanisms will succeed in bringing a large number of new users into contact with drug agencies. There is little point in building elaborate and costly referral structures which serve as a bridge to under-resourced services which are unable to cope with extra pressures.

If existing agencies are already fully stretched and lack capacity to absorb extra clients, setting up criminal justice referral mechanisms will simply reallocate available treatment amongst problem users. Arguably this may yield community safety gains - if resources are transferred from a client group which is less criminally involved to one which is heavily into crime. Equally, it may have no benefits at all - if those who are displaced from the treatment queue have as serious health and legal problems as those who displace them.

There are obviously a variety of different approaches to extending the range of services for problem drug users. We see advantages in developing a more integrated and comprehensive prescribing strategy which provides a more significant role to G.P.s in prescribing. The role of pharmacy needle exchanges could also be extended.

The problem of funding raises issues well beyond the scope of this research. Resolving them either requires new money or else a reallocation of existing resources. There are ethical as well as utilitarian questions surrounding such allocation decisions - particularly when fast-track access to social goods is given to people as a result of their offending.

Providing treatment services for criminally involved problem drug users promises to be highly cost-effective. The difficulty is that under the current funding structure, costs fall largely on health and social services and the savings accrue largely to the criminal justice system. The solution may lie in ring-fenced criminal justice funds for extra treatment services; or it may be possible to put in place effective joint commissioning arrangements which recognise that referral systems and treatment services have a legitimate call on both health and justice services.

Developing referral systems

This study has provided good - but not conclusive - evidence that proactive arrest referral schemes can result in reduced drug use and acquisitive crime. By way of conclusion, it is worth speculating about ways in which referral systems could be developed.

The three schemes which we have described here had no coercive or diversionary element to them. Schemes elsewhere have exploited the coercive potential of arrest to confront problem users with “an offer they cannot refuse”. Typically, they are targeted at people arrested for possession of controlled drugs. The “caution plus” variant of such schemes involves cautioning coupled with the opportunity - or requirement - to seek advice and help from a drug worker. The “bail scheme” variant involves deferring a decision about cautioning, providing the offender with a window of opportunity to seek advice and help from a drug worker in advance of the final decision about charging.

Such schemes are dependent on the arrestee being prepared to admit the offence without any inducement. Subject to that, it is open to the police to take account of the arrestee’s willingness to address his or her drugs misuse before deciding on the appropriate course of action, making use of police bail if it seems legitimate to defer the decision, for example pending the taking up of an appropriate referral. It is however the case that the prospect of diversion upon which coercive schemes are premised can only apply to the small proportion of problem users who are arrested for relatively minor offences. Those who are heavily engaged in acquisitive crime face almost certain prosecution. And putting scarce referral resources at the service of those arrested for possession of cannabis may in most - but not all - cases be a waste of time and money.

The need for referral schemes to “capture” those persistent offenders who are heavily engaged in shoplifting or burglary may suggest a need to focus referral resources not at arrest but at the pre-sentence stage, when sentencers may ask probation officers to carry out a pre-sentence report. Whilst PSRs make an important contribution to the sentencing process, we think that there is also a strong case for investing in arrest referral schemes. Firstly, many problem drug users will find themselves in court for offences which will attract a fine. The possibility of a PSR will never arise in these cases. Secondly, the window of motivation to seek help may be open wide at the time of arrest, and swing shut again once the shock of arrest has passed.

One issue which has struck us forcibly is the average age of arrest referral clients. Our respondents had long careers of problem drug use, and some had made previous attempts to address their problems. Whilst referral is better late than never, effective early intervention will be that much more cost-effective. In developing referral structures it is thus essential not to focus solely on those with well-established dependency. We cannot offer any recommendations, however, on precisely how to address the needs of younger problem users and of those whose use is likely to become problematic. There is a pressing need to develop and evaluate strategies for doing so.

There are other groups who are as underrepresented in referral schemes as they are in treatment agencies, notably women users and those from minority ethnic groups. Though we cannot offer any evidence, we suspect that this reflects partly a reluctance to seek help on the part of these groups and partly a tendency of police and drug workers not to see them as potential users of drug services. We can only echo the many previous studies which have observed this under-representation and stressed the importance of redressing the balance.

Perhaps the most difficult decision about arrest referral - or any other referral system - is whether available resources should be spent on referral or treatment systems. Against the yardstick of waiting lists, many if not most treatment services are under-resourced. Building new bridges from the criminal justice system to these health services will add to the pressure. In a world of rational planning, one would build up the funding of the treatment services first, and then build referral systems. A practitioner of *realpolitik* might rely on the additional pressure of demand brought about by referral systems to generate the resources for additional treatment services.

Recommendations to those setting up referral systems

1. Ensure that drug workers have access to offenders as they pass through police stations, courts or prisons. A referral system in which police officers or court workers simply provide information about drug agencies will have low take-up rates.
2. Ensure that referral workers have the capacity to establish credibility and win the trust of clients quickly. Ex-users provide an important source of such workers, but not the only source.
3. Don't plan on setting up a referral system 'on the cheap'.
4. Recognise the pressures on workers to expand their role to provide support for clients amounting to casework. This will bring benefits, but also costs which need to be managed.
5. A referral system must have a range of treatment services to which to refer. These must be appropriately tailored to the nature of local drug problems, and to the criminal involvement of the clientele.
6. A referral system must have properly resourced treatment services to which to refer. Otherwise, it will simply displace existing clients.

REFERENCES

ACMD (1988) **Aids and Drug Misuse Part I**. London: HMSO.

Chatterton, M., Gibson, G., Gilman, M., Godfrey, C., Sutton, M. and Wright A. (1995) **Performance Indicators for Local Anti-drugs Strategies: a preliminary analysis**. London: HMSO

Department of Health (1996) **The Task Force to Review Services for Drug Misusers**. Report of an Independent Review of Drug Treatment Services in England. London: Department of Health.

Department of Health (1997) **NTORS: The National Treatment Outcome Research Study**. 2nd Bulletin. London: Department of Health.

Dorn, N. (1994) 'Three faces of police referral: Welfare, justice and business perspectives on multi-agency work with drug arrestees'. **Policing and Society**, **4**, 13-34.

Edmunds, M., Urquia, N. and Hough, M. (1997) **Tackling Local Drug Markets**. Crime Prevention and Detection Paper No. 80. London: Home Office Police Research Group.

Edmunds, M., May, T., Hough, M., Hearnden, I. and Van Rozeboom, R. (1997) **Get It While You Can: an evaluation**. A Report to Sussex Association for the Rehabilitation of Offenders. Sussex: SARO.

Formby, W. A. (1997) **Kirklees Drug Arrest Referral Scheme: interim report, March-September 1997**. West Yorkshire Probation Service.

GIWYC (1996) **Get It While You Can Replication Reference Manual**. Brighton: St Thomas Fund.

Hartnoll, R. and Lewis, R. (1985) 'The Illicit Heroin Market in Britain: towards a preliminary estimate of national demand.' Quoted in Wagstaff, A. and Maynard, A. (1998) **Economic Aspects of the Illicit Drug Market Enforcement Policies in the United Kingdom**, Home Office Research Study 95/1988. London: Home Office.

Home Office (1992) **The Costs of the Criminal Justice System**. London: Home Office.

Home Office (1995): **Tackling Drugs Together: a consultation document on a strategy for England 1995-1998**. London: HMSO.

Home Office (1997) **Statistics of Drug Addicts Notified to the Home Office**. Statistical Bulletin 10/97. London: Home Office.

Hough, M. (1996) **Problem Drug Use and Criminal Justice: a review of the literature** Drug Prevention Initiative Paper No. 15. London: Home Office Central Drugs Prevention Unit.

Howes, S., Farrell, M., Taylor, C., Griffiths, P. and Lewis, G. (1995) **Estimating Local Prevalence of Drug Use: a feasibility study of the complementary roles of capture recapture and household survey techniques**. London: National Addiction Centre.

Maden, A., Swinton, M. and Gunn, J. (1991) **'Drug Dependence in Prisoners'**, British Medical Journal, 302-880

Parker, H. and Bottomley, T. (1996) **Crack Cocaine and Drugs-crime Careers**. Research Findings No. 34. London: Home Office.

Parker, H., Aldridge, J. and Measham, F. (in press) **Illegal Leisure: the normalisation of adolescent recreational drug use**. London: Routledge.

Ramsay, M. and Spiller, J. (1997) **Drug Misuse Declared: findings from the 1996 British Crime Survey**. Home Office Research Study No. 172. London: Home Office.

Southwark DPT (1994) **Southwark Arrest Referral Pilot Project, Phase 2: Initial report of findings after two years, February 1992 - January 1994**. London: Southwark Drugs Prevention Team.

Stout, D. and Monaghan, G. (1998) Unpublished paper, Metropolitan Police Service.

Strang, J. and Farrell, M. (1996) **Hepatitis**. London: ISDD.

Sutton, M. and Maynard, A. (1992) **What is the Size and Nature of the 'Drug' Problem in the U.K?** Yartic Occasional Paper. 3. Centre for Health Economics, University of York, York.

Theobald, P. and Vale, C. (1993). **Get It While You Can - Evaluation Report**. Brighton: Brighton and Hove Drugs Prevention Team.

Turnbull, P. J., Webster, R. & Stillwell, G. (1995) **Get it While You Can: an evaluation of an early intervention project for arrestees with alcohol and drug problems**. Drugs Prevention Initiative Paper No. 9. London: Home Office.

Wagstaff, A. and Maynard, A. (1988) **Economic Aspects of the Illicit Drug Market Enforcement Policies in the United Kingdom**. Home Office Research Study No. 95. London: HMSO.

APPENDIX A: INTERVIEW SCHEDULE

SOUTH BANK UNIVERSITY CRIMINAL JUSTICE INITIATIVE FOLLOW-UP INTERVIEW

INTRODUCTION TO INTERVIEW

Thank you very much for agreeing to be interviewed. We have been contracted to see how successful the scheme is in helping people tackle their drug problems. Everything you tell us will be treated in total **confidence**. It is the scheme which we are assessing, and not the people who have contact with it.

What I'd like to do is spend roughly forty minutes on this questionnaire, which is designed to get a better understanding of the services that can help people tackle their drug problems.

A payment of **£10** will be given on completion of this questionnaire.

INTERVIEW DETAILS

Interviewer 1. 2. 3.

Date

Time interview started

CLIENTS PERSONAL DETAILS

First, a few personal details to help us analyse the results.

Last name

Initials

Sex

1. Female

2. Male

Age

would you describe your ethnic group?

Postcode (first part only)

CONTACT WITH CRIMINAL JUSTICE DRUGS WORKER (CJDW)

How did the CJDW get in contact with you?

Prison / Police/ Probation / Court / Self-referred/Other

Was this first contact with any drug agency?

YES / NO

How many times have you seen the CJDW

(write the number)

Did they offer support over a period of time?

YES / NO

A: Drug use in the month before contact with CJDW

Drug Type	Used in last month?	Days used in that month	Amount consumed on an average day in that month Weight	Cost	Main route(s)* (number)	Age of first use	Duration of episode
Alcohol							
Heroin							
Methadone (presc.)							
Methadone (non-presc.)							
Other opiates							
Benzodiazepines (presc.)							
Type:							
Type:							
Type:							
Benzodiazepines (non-presc.)							
Type:							
Type:							
Type:							
Cocaine-crack							
Cocaine-powder							
Amphetamines							
Cannabis							
Ecstasy							
Other Drugs							

* **Main Routes** (1) Oral (2) Snort/sniff (3) Smoke/chase (4) Inject

A14 'In that month did you have a drugs overdose on any of these drugs?'

No Yes (State drug)

If yes, how many times? _____

A15. 'Can I just check, at any time in the month before contact with the CJDW, did you inject drugs?'

Yes If yes, 'On how many days did you inject?' _____

No

FINANCING DRUG USE BEFORE

A16 How much were you spending on drugs at that time per week? £.....

A17 What were the main ways you raised the cash? (write in three *main* ways, in priority order)

1..... 2. 3.

A18 OFFENCES COMMITTED IN THAT MONTH

		Committed? (tick yes)	Number of days per month committed	Typical number of times committed per day PUT IN RANGE
1	Possession			
2	Selling Drugs			
3	Fraud/forgery			
4	Shoplifting			
5	Burglary/other theft from property			
6	Theft from a person			
7	Theft from a vehicle			
8	Theft of a vehicle			
9	Other theft (specify)			
10	Criminal damage			
11	Public order offence			
12	Soliciting			

A19 What had you been arrested for when you came into contact with CJDW?.....

A20 Were you convicted? Yes/No

A21 What sentence did you get?

B: CURRENT DRUG USE - IN THE LAST MONTH
(try to remember as best you can. If it helps give averages)

	Drug Type	Days used in that month (out of 30)	Amount consumed on an average day in that month Weight	Cost	Main route(s)* (number)
1.	Alcohol				
2.	Heroin				
3.	Metadone (prescribed)				
	Form:				
4.	Metadone (non-presc.)				
	Form:				
5.	Other opiates				
6.	Benzodiazepines (presc.)				
	Type:				
	Type:				
	Type:				
7.	Benzodiazepines (non-presc.)				
	Type:				
	Type:				
	Type:				
8.	Cocaine-crack				
9.	Cocaine-powder				
10.	Amphetamines				
11.	Cannabis				
12.	Ecstasy				
13.	Other				

*Main Routes (1) Oral (2) Snort/sniff (3) Smoke/chase (4) Inject

B14 'In that month did you have a drugs overdose on any of these drugs?' No Yes
 (state drug)
 If yes, how many times?

INJECTING

B15 'Can I just check, at any time in the past month, have you injected drugs?'

Yes If yes, 'On how many days did you inject?'

No _____

FINANCING DRUG USE NOW

B16 How much are you spending on drugs now? (per day/week) £.....

B17 What are your main ways of raising cash? (write in three *main* ways, in priority order)

1. 2. 3.

B18 CRIMINAL ACTIVITY IN THE LAST MONTH

		Committed? (tick yes)	Number of days per month committed	Typical number of times committed per day
1	Possession			
2	Selling Drugs			
3	Fraud/forgery			
4	Shoplifting			
5	Burglary/other theft from property			
6	Theft from a person			
7	Theft from a vehicle			
8	Theft of a vehicle			
9	Other theft (specify)			
10	Criminal damage			
11	Public order offence			
12	Soliciting			

B19 Have you been arrested since your **first** contact with the CJDW? Yes/No

B20 If yes: what for

SECTION 3: C. TREATMENT

C1. Did the CJDW refer you to any drug agency? YES/NO

C2 Which one

C3 Did you get in touch with the agency? YES/NO

C4 What help did the agency offer?

1. prescription
2. detox
3. counselling
4. NA/support group
5. advice & information
6. practical help (housing/accommodation)
7. other

C5 Did you take up the offer? YES/NO

C6 What happened?

1. completed
2. still in programme
3. left
4. asked to leave
5. other

.....

C7 Overall, how helpful would you say your treatment was?

Helped a great deal (1) Helped somewhat (2) Made no difference (3)

Made things a little worse (4) Made things a lot worse (5)

C8 Why do you feel this way?

Only answer this question if you have had **more than one** contact with the CJDW

Outline what has happened after each contact with the CJDW

.....
.....
.....
.....

C9 Did the CJDW offer any assistance *apart from referral*? YES / NO

C10 What was this?

1. support
2. drop in
3. introduce to NA
4. advice & information
5. practical help (housing/accommodation)
6. other

C11 Overall, how helpful would you say this was?

Helped a great deal (1) Helped somewhat (2) Made no difference (3)

Made things a little worse (4) Made things a lot worse (5)

SECTION 4:

D. DRUG HISTORY

D1 How old were you when you first used illegal drugs?

D2 How old were you when you first used your [recent] drug of choice?

D3 How old were you when you first injected?

D4 How old were you when your drug use became problematic?

1. Social
 2. Psychological
 3. Legal
 4. Physical Health
 5. Other (specify)
-

SECTION 5:

E. OTHER OUTCOMES

The next few questions are about other aspects of your life, like employment, housing and relationships.

For each topic, I want to ask first about the month **before** you were in contact with the CJDW.

EMPLOYMENT

E1 In the month before you were in contact with CJDW, were you employed?

Paid Unpaid

E2 Have you worked in the last month? YES/NO

E3 How many days did you have a job: Before CJDW contact

Last Month

RELATIONSHIPS

E4 In the month before you were in contact with the CJDW, were you in a relationship with a partner? Yes/No

E5 And in the last month? Yes/No

ACCOMMODATION

E6 In the month before you were in contact with the CJDW, what was your *main* form of accommodation? [main = spent more than 15 nights there.]

E7 And now?

	Month before CJDW contact	Last month
Own home/rented home		
Relatives'/friends'/partners'/others' home		
Hostel/temporary accommodation		
On the streets (homeless)		
Prison/other detention/police station		
Hospital/residential treatment		
Other (specify)		

SECTION 6:

PREVIOUS CONTACT WITH COURTS

F. This section is about contact you may have had in the past with the courts.

F1 How many times have you been convicted by a court for a criminal offence?
(NB exclude motoring offences)

F2 How old were you when you were first convicted by a court?

F3 Have you ever been sentenced to youth custody (i.e. a Young Offender Institution or detention centre - any custodial sentence passed when you were under 21)?

Yes/ No

If yes, how many times?

That is the end of the question-and-answer part of the interview. I now want to ask you more **general questions** about the best ways of helping people tackle their drug problems.

G1 What is the best sort of thing that drug agencies can do to assist people in tackling their drug problems?

Possible prompts: What has helped you most?
 What's the best drug agency you have had contact with? Why?
 What do you like about it?

.....

.....

.....

.....

G2 What has been your worst experience of a drug agency?

With what agency?

.....

.....

.....

.....

G3 What would improve the Police's relationships with dependent users?

Possible prompts: Do they treat problem users fairly?
 Are they aware of problems of dependent users?
 Knowledge of drugs used.
 Do you think they are able to identify users?

.....

.....

.....

.....

.....

G4 What things have helped you the most in tackling your drug problems?

.....

.....

.....

.....

.....



.....

.....

.....

.....

G5 How do you see your drug career developing from now?

Have you identified 'triggers' that cause you to use?

Are there situations which you avoid?

.....

.....

.....

.....

.....



G6. What do you think of the Arrest Referral Scheme ?

Possible prompts-

1. best things
2. worst things
3. staff
4. style of approach
5. help

1.

.....

2.

.....

3.

.....

4.

.....

5.

.....

.....

H. Criminal record check

Finally, we plan to follow up all the people we interview in a year's time to see if they have had any trouble with the law. To do this we shall check names against a national database of court records. To match names accurately, we need full names and dates of birth.

Will you let us do this? Yes/No

Signature.....

The **only** information which we shall pass to the central records office will be your name and date of birth. Everything which you have told me so far will be stored anonymously.

Full name DoB.....

Thank you for your help in taking part in our research.

Payment Received..... Finish Time
