Reducing alcohol and other drug problems in New Zealand's criminal justice system

New Zealand Drug Foundation Policy Position
August 2007

Introduction

This paper presents the New Zealand Drug Foundation's policy position on reducing alcohol and other drugs (AOD) problems in New Zealand's criminal justice system. It is aimed at identifying priorities for action which are supported by evidence. A more detailed review of current evidence on effective interventions, and of policy and practice in some relevant countries, supports this paper.

New Zealand Drug Foundation policy

- Problems with the use of alcohol and other drugs make a significant contribution to crime in New Zealand, including property crimes and violent offending.

- Research shows that addressing AOD problems can be cost-effective in reducing both offending and the harms resulting from AOD problems, when coordinated and timely services are available throughout the criminal justice system.

- We support recent significant moves by New Zealand's criminal justice and health agencies to reduce these problems, including expanding prison AOD treatment services, improving coordination between responsible agencies, and developing strong relationships with service providers. The *Effective Interventions* interdepartmental initiative provides a sound basis for such action.

- We support the Department of Corrections in taking a harm minimisation approach to AOD problems, and we support the expansion of harm reduction programmes.

- At present there is no coordinated AOD plan across the criminal justice system. The result is that AOD services are available in some parts of the system but not others; there are major gaps in service provision including court-based services and aftercare; and service provision is not always based on best practice.

- We urge government to develop a "whole of government" plan to address AOD problems for people in the criminal justice system. The plan should include both treatment and public health measures. Urgent attention should be given to:

    - Extending court-based assessment, and matching referrals to service provision
    - Developing national justice system alternatives to imprisonment which include appropriate treatment for people with AOD problems
    - Improving treatment access for people on remand, probation and home detention

- Improving prisoners' access to AOD treatment when needed, including reviewing policies on timing of access to treatment and access for short sentence prisoners
- Giving prisoners access to opioid substitution treatment (OST) and other addiction treatment pharmacotherapy on the same basis as the general population
- Increasing harm reduction initiatives in prisons, such as needle exchange
- Ensuring coordinated support and pre-release planning for prisoners, linked to well resourced and managed aftercare
- Ensuring that independent, adequately funded evaluations of treatment and other rehabilitation programmes are carried out and made publicly available.

- Services must be resourced to succeed, and to meet needs. Available data indicates that only around a quarter of prisoners who need AOD treatment are receiving it. Current plans to increase treatment places are a positive move, but must be expanded if real gains are to be realised.

Guiding principles

- Prisoners are entitled to receive health services equal in level and quality to those available in the community, including harm reduction and treatment

- Harm minimisation strategies (supply reduction, demand reduction, and harm reduction) are effective in reducing the harms from AOD problems

- While prisons are primarily places of punishment, they can also provide opportunities for people to address their AOD problems; an effective corrections system would be designed to make the most of such opportunities

- AOD interventions for Māori should be developed and delivered in partnership with Māori, including iwi and hapū, and Māori providers

- Service consumers, including prisoners, should be involved in policy and service development, as their experience makes an important contribution to effective interventions

- Families/whānau and communities need to be resourced to support people who are dealing with their AOD problems, both in prison and on release.

Background to the policy

There is strong evidence that alcohol and other drugs (AOD) problems contribute to criminal activity.[1] People with substance use problems have much higher rates of criminal activity than the general population,[2] and as many as 80 percent of New Zealand prisoners are or have been dependent on alcohol and/or other drugs.[3] Between 30-50 percent of inmates report having been under the influence of a drug at the time their offence was committed.[4]

AOD use makes a significant contribution to prison numbers. A 2006 report found that 6 percent of all convictions were for drug offences – 75 percent of those for offences involving cannabis (although it is not clear how many of those were for possession).[5] While some police districts operate diversion schemes for simple possession, especially first offences, some do not. The Drug Foundation has strongly recommended that the Misuse of Drug Act be reviewed to address issues of fair sentencing.

Imprisonment by itself has little effect in reducing continued criminal behaviour.[6] However, there is a body of evidence that reducing AOD problems through harm minimisation (including demand reduction such as brief intervention and treatment; harm reduction; and supply reduction) makes a moderate but significant contribution to reducing criminal activity (see our *Evidence Review* paper for detailed discussion of the evidence base). This is in addition to the value to society of reducing the harms that AOD problems cause to individuals, their family/whānau, and their communities.

New Zealand has a high rate of imprisonment by OECD standards. At May 2007, there were 8076 prisoners - about half of those Māori, and about 5 percent women - as well as over 8000 people on community sentences and 28,400 doing "community work".[7] Imprisonment is forecast to continue increasing unless there are major changes to New Zealand's criminal justice system. It costs around $68,879 a year to keep a person in a New Zealand prison.[8]

For all these reasons, reducing AOD problems in the criminal justice system, particularly among those going through the prison system, is a priority for New Zealand.

In July 2005 the New Zealand Drug Foundation held a workshop on *Reducing crime through 'best practice' on alcohol and other drugs in prison settings*. Experts spoke on harm reduction initiatives, current services and treatment options inside prisons and in the community; and public health approaches. Workshop participants supported a number of actions to improve services, including significantly improving collaboration between justice/corrections and health agencies; developing "best practice" guidelines for groups with specific needs, particularly Māori; destigmatising addiction; and increasing community understanding that effective criminal justice AOD services can in the long term make New Zealand safer. Many of their proposals are reflected in this policy. The workshop and the Drug Foundation's continuing policy work on these issues was timely, as government had also begun to focus on how to improve rehabilitation, including AOD treatment.

Prisoners' rights to receive health services are set out in the Correction Act 2004, which states that "(1) A prisoner is entitled to receive medical treatment that is reasonably necessary; (2) The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public."[9] Specific standards of care are detailed in the *Memorandum of Understanding* between the Ministry of Health and the Department of Corrections, and in Corrections' Policy and Procedures Manual. The Code of Health and Disability Rights also applies to prisoners.

The Office of the Ombudsmen released a report in 2005 stating that "…a major factor in criminal offending, namely unlawful drug use, is not being satisfactorily addressed in prisons."[10] The report made strong recommendations on health services for prisoners, among them that the Department of Corrections:

a) while assessing each case on its own merits, removes the absolute requirement that a prisoner be drug free before entering drug and alcohol abuse programmes;
b) substantially extends the provision of drug and alcohol education and criminogenic programmes;
c) upgrades its record-keeping system in order that it may identify statistically the numbers of prisoners who would likely benefit from drug and alcohol education and criminogenic programmes as against those who actually receive them.[11]

In early 2006, a group of Ministers, senior officials and NGO leaders travelled overseas to study other corrections models. In August 2006, the government launched the *Effective Interventions* policy initiative "to improve the criminal justice system and make New Zealand a safer and fairer society".[12] The New Zealand Prison Fellowship and the Salvation Army, both of whom have long experience of providing services to people in the criminal justice system, launched a national project on *Rethinking Crime and Punishment* in October 2006. The results of New Zealand's first national Prisoner Health Survey, released in November 2006, also provided more evidence on the need for AOD services.

Effective interventions

Our review of research indicates that AOD services for people in the criminal justice system are most effective when access is available when needed throughout the system. This starts from screening after arrest, includes screening and diversion where appropriate in the court system, treatment in prison or while on a community sentence, and "aftercare" in the community, to reinforce the gains made by treatment and help a person reintegrate.

We also found that population groups such as women, indigenous peoples and young people have distinctive needs for treatment and support.[13]

Arrest

Arrest has been identified as a potential turning point, and made a focus in the United Kingdom.[14] Evaluations of the UK arrest screening and referral pilots for drug users with multiple arrests have shown reductions in drug use and crime, with a cost-benefit ratio of around 7:1.[15] Best practice guides for such services have been developed. Arrest or cell-based screening is carried out in other countries, but seems to be at a local level (counties or states). We have not found any long-term studies of effectiveness.

Remand prisoners have been identified as a group with high needs for AOD services, including continued access to OST and other medications.[16]

Court-based services

Courts can also be a location to promote or support change. Dedicated drug courts (not covered in this evidence review) may be the best known intervention; they are becoming common, especially in the US, and have been piloted in Australia, Canada and the UK. Other services, such as screening/assessment, and referral to treatment as part of sentencing, are widespread, but relatively little evidence was available on their success.

Court-based diversion to treatment is used in many jurisdictions. The consensus of long-term reviews is that when linked to continuing supervision and support, diversion is successful in reducing both AOD dependence and criminal behaviour.[17]

Diversion to treatment can be voluntary or coercive. Despite concerns about coercive treatment, there is a considerable body of evidence on its effectiveness, both short and long-term.[18]

Services in prisons

There is growing evidence that appropriate treatment can have long-term effects. A 2006 critical review estimated that people treated had around 20 percent less recidivism than those not treated.[19] Some treatment models were much more effective than others: therapeutic communities were considered very effective, and there was some evidence of effectiveness for 2-step programmes and drug-free units. Other models - in particular "boot camp" style programmes - were ineffective in reducing AOD problems or recidivism. Counselling had some effectiveness in reducing recidivism, but little in reducing AOD use.[20]

A 2001 review concluded that while treatment by itself was effective over the first one to three years, coordinated aftercare was necessary if positive outcomes were not to fade by the end of three years after release.[21] Other reviews support this conclusion.

Harm reduction services are provided in many prisons, including opioid substitution treatment (OST) and needle exchange programmes (NEPs). OST is considered very cost-effective in reducing re-incarceration, reducing Hepatitis C infection rates, and reducing deaths.[22] Reviews of NEPs have found evidence of their effectiveness in reducing transmission of blood-borne viruses such as HIV/AIDS and Hepatitis C.[23]

Aftercare

Research has found that well-planned long-term aftercare is effective, and is likely to be essential in supporting people released from prison to both maintain reduction or abstinence from substances, and reduce their chances of recidivism.[24] Homelessness and lack of support are associated with high rates of morbidity and mortality soon after release,[25] and with early return to offending.[26]

There is considerable evidence of the value of maintaining or improving connection to family/whānau and other community supports in supporting behaviour change from treatment, both while the prisoner is still inside and on release.[27]

Policy issues in reducing AOD problems in New Zealand's criminal justice system

This section presents some key data on New Zealand prison population, and outlines some policy issues underpinning AOD policy and services.

AOD problems in the New Zealand criminal justice system

At May 2007, 8076 New Zealanders were imprisoned. About half of all prisoners are Māori. About 5 percent of prisoners are women, although the rate of female imprisonment is rising. Māori women make up over half of women in prisons.[28] A 2001 report found that 83 percent of inmates had abused or been dependent on alcohol or other drugs,[29] which is similar to findings from other developed countries.[30] At present numbers, as many as 4000 sentenced inmates could benefit from treatment. However, no records are kept on numbers of those identified as needing AOD treatment.

We have not been able to find any data on AOD problems among people on community sentences (probation, home detention). Given the numbers (1,293 on home detention; 1,244 on parole; 5,500 people on supervision and 28,400 doing "community work" in 2005/6),[31] this could be a significant group with unmet needs. The Ombudsmen's recommendation that Corrections identify "… the numbers of prisoners who would likely benefit from drug and alcohol education and criminogenic programmes as against those who actually receive them"[32] could well be extended to this group.

Current AOD services

As noted earlier, New Zealand has no strategy to address AOD problems in the criminal justice system as a whole. The key strategic document is Corrections' *Strategy to reduce drug and alcohol use by offenders 2005-2008*. The strategy explicitly takes a harm minimisation approach, and recognises that while supply reduction is effective, demand reduction and harm reduction are also essential. It covers alcohol as well as illicit drugs, and recognises the harms caused by tobacco. While the strategy mentions people on community-based sentences, the focus is largely on prisons.

At present New Zealand has no formal arrest screening/referral scheme, although a few DHBs provide such services. New Zealand actively uses police diversion, but its use and application differs between police districts, leaving room for inequity of treatment. We are not aware of any system to monitor AOD screening and referral as part of diversion, nor of any data on numbers and outcomes. Similarly, while court-based services are available in some areas, as pilots or DHB services, there is no national system.

With the exception of some AOD programmes funded by Corrections to address "criminogenic needs", funding and providing AOD services is the responsibility of the health sector. The *Memorandum of Understanding* (MoU) between the Ministry of Health and the Department of Corrections includes the principle that services should be provided to inmates "commensurate to the general population of New Zealand (section 4.1.1) and to

same standard (4.1.2).[33] In 2006, 174 "intensive" AOD treatment places were funded, and it is intended to increase those over the next two years so that around 500 people a year can access treatment. There were also a number of places on "100 hour programmes" (criminogenic programmes).

Under current policies, treatment for prisoners with drug problems is offered towards the end of their sentence. This policy does not seem to fit with best practice guidelines for AOD treatment. Similar policies mean that prisoners on short sentences do not have access to AOD services, the rationale being that substantial AOD treatment is in the form of 24-week programmes. This means that people who present with frequent minor offences can be excluded from services that could reduce or eliminate repeat imprisonment. Treatment programmes which begin in prisons and commit the person to continue after release, as used in other countries, could eliminate the current service gap.

Government policies have been to target resources and interventions only at those deemed to be at highest risk of re-offending. It should be noted that the New Zealand approach contrasts with other jurisdictions (such as the UK) which have increased the focus on early interventions to prevent and reduce crime. As noted in the Ombudsmen's report, prisoners in New Zealand have been expected to be "drug free" before entering any treatment programme. We understand that this policy has been reviewed.

Harm reduction in prisons has included a pilot educating prisoners on how to reduce blood-borne diseases, and providing access to bleach (for cleaning needles) and condoms. Opioid substitution treatment (OST) is now available to all people who were on OST before entering prison. However, prisoners are not yet able to start OST in prison. This policy is inconsistent with the "equal access to health services" commitment in the Corrections Act 2004 and the Health-Corrections MoU, and we understand it may be under review. There have also been problems for prisoners continuing OST on release from prison.[34]

Aftercare services in New Zealand are provided by a mix of providers including the Community Probation service; national NGOs such as PARS, the Salvation Army and the New Zealand Prison Fellowship; and local providers. Despite Corrections policy that all people should leave prison with a care plan and aftercare services (including accommodation) in place, providers and advocates have described many cases where this has not happened. The Department of Corrections has recently started to employ "reintegration caseworkers", and to work with other agencies to form reintegration teams.[35]

Meeting the needs of Māori in the criminal justice system

The New Zealand Drug Foundation is committed to operating in a way that reflects the principles of the Treaty of Waitangi. This leads the Foundation to focus on how AOD policies and services contribute to improving Māori health and wellbeing. The contribution that AOD problems make to the extremely high rates of Māori arrest, conviction, and imprisonment, and how those problems could be reduced, are a critical policy issue for the Drug Foundation as well as for government.

The Department of Corrections has a strategy to reduce Māori offending,[36] and it supports a number of initiatives, such as tikanga Māori programmes. It also supports the involvement of Māori elders, and people with expertise such as tohunga, in supporting and working with Māori inside the criminal justice system. The department's *Strategy to reduce drug and alcohol use by offenders 2005-2008* makes reducing alcohol and other drug use by Māori a priority. However, we have not been able to locate any evaluations of existing programmes or services, and we have not been able to find any Māori-led AOD programmes.

Research, monitoring and evaluating interventions

Participants in the Drug Foundation's 2005 workshop strongly supported the need for "systematic research to create evidence showing what works in New Zealand". They noted that there has been very little research on appropriate AOD interventions for New Zealand. While pilot initiatives have been carried out in different parts of the criminal justice system (such as court assessments) often these are not fully evaluated, or evaluations are not made public.[37]

As noted above, the Ombudsmen's 2005 report recommended that Corrections establish a system to record the numbers needing AOD services and the number receiving them. Such a database could also be linked to the studies of long-term outcomes which would establish the effectiveness of AOD treatment in general for New Zealand, and be able to compare the effectiveness of different programmes. Similarly, case studies (such as targeting one prison for changes, researching the outcomes, and comparing outcomes between sites) could help determine long-term policies and service strategies.

Much of the valuable research data reviewed for the policy has come from long-term cohort studies, following people through and after prison for several years. Critical findings have included the high risk of illness and death soon after release; the effectiveness of mandatory treatment under certain conditions; and the "added benefit" of aftercare in reinforcing behaviour change.[38] Such studies could support the development and improvement of services for New Zealand.

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