



## 20th Meeting of the Legal and Policy Correspondents of the European Legal Database on Drugs

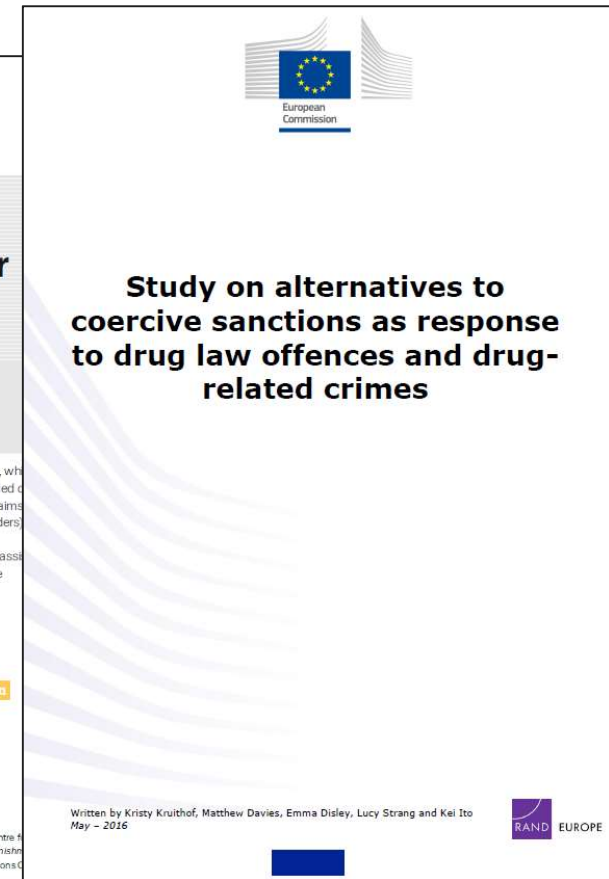
*Alternatives to coercive sanctions (ACS) for drug-using offenders: Barriers and facilitators*

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# What we'll cover...

- Context of current work
- Findings from recent EMCDDA and other research
- Some thoughts on how to facilitate greater use of ACS
- Input from Legal & Policy Correspondents



# Definitions of ACS

*“...rehabilitative measures of treating, educating or reintegrating drug users as alternatives or additions to conviction or punishment...” (EMCDDA, 2015: 1).*

*“...measures that had some rehabilitative element or that constituted a non-intervention (for example, deciding not to charge or prosecute), as well as those used instead of prison or other punishment (for example, a suspended sentence with drug treatment)” (Kruithof et al., 2016: iii).*

# Context (1)

- Prisons across Europe are typically operating at or near capacity. One in four countries experienced overcrowding within their prison systems in 2014. Convictions for drugs offences were a significant driver of these populations (Council of Europe, 2015).
- Similar trends have been observed in a number of regions across the globe (Walmsley, 2016).
- Pressures persist despite legislation and policy existing in many jurisdictions which enables the diversion of drug-using detainees, defendants and convicted offenders, at different stages of the criminal justice process, to various forms of education and treatment.

# Context (2)

- There are European and international **targets to increase the use of alternatives to punishment or coercive sanctions (ACS)** for drug-using offenders, where appropriate.
- Recent studies have confirmed that, while it helps to have such alternatives available in the law, a range of factors, such as limitations within the law, the way they are set up, or the attitudes of key groups, can be **barriers to their use**.
- This session will discuss the content of an upcoming **EMCDDA short report for policymakers on these barriers and corresponding facilitators** and how this information might be used by countries seeking to **increase the use of these measures**.
- Particular focus on mapping the **domains of a diagnostic tool** to help better identify and address existing barriers to ACS use.

# The use of ACS by EU Member States

RAND Europe's (2016) study found that:

- All 28 MS reported having ***at least one ACS available***, and most had more than one. The most commonly occurring ACS was a drug treatment order (17 MS).
- While there were considerable ***differences between MS in their use of ACS***, most forms were ***under utilised*** across the CJS.
- ACS appeared to be mainly offered at the end (court and sentencing) stages of the CJS. There is ***considerable scope to expand availability*** through diversion from arrest, prosecution or investigation.
- Though ***limited in scale*** and ***quality***, there is a ***developing body of evidence*** about features that might make ACS more effective (though limited to drugs courts and US evidence).

# Barriers to/facilitators of ACS use by EU Member States (1)

The research **identified common themes** regarding why ACS were/were not used in practice:

- Use strongly influenced by the **individual beliefs** of those responsible for imposing ACS, such as prosecutors and judges:
  - benefits of treatment over incarceration;
  - a perceived lack of clarity around intervention objectives (What does success look like?)
  - the relapsing nature of drug use and motivations of drug users;
  - awareness about what ACS options are available (and their relative effectiveness)
- Use of ACS shaped by factors that can be changed by policy makers:
  - **Legislative measures** both increased (in the case of laws mandating use in certain circumstances) and decreased (where legislation imposed restrictive conditions) the use of ACS.

# Barriers to/facilitators of ACS use by EU Member States (2)

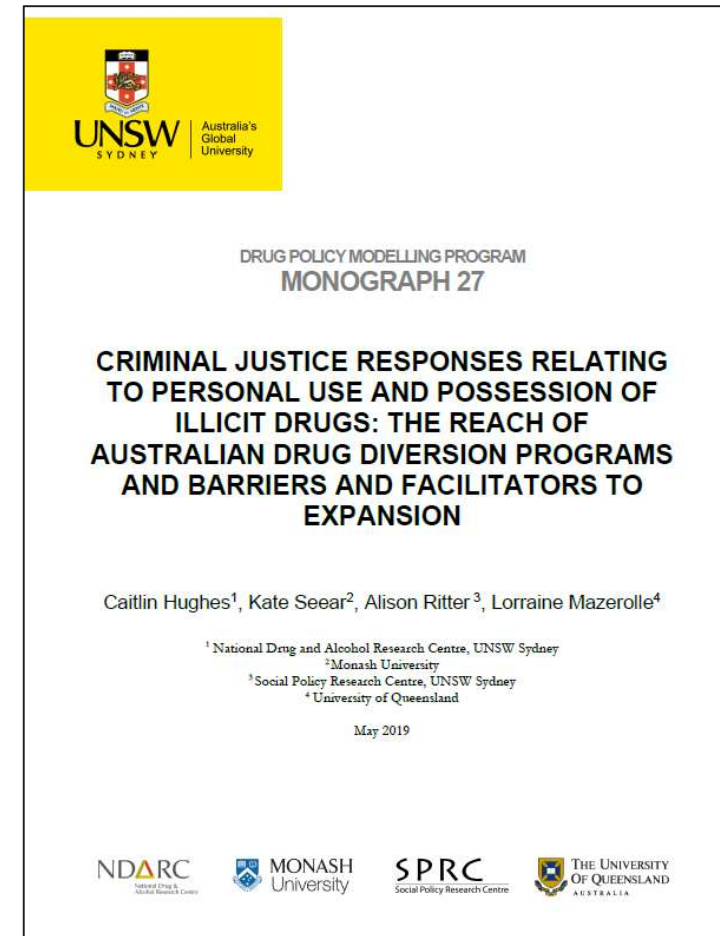
- **Practical** and **administrative** factors were also reported to affect the extent to which ACS are used:
  - Availability of financial resources to fund treatment.
  - Where ACS involves lengthy and/or bureaucratic procedures.
  - Levels of partnership working within and between systems.
  - Extent to which there is feedback from those delivering treatment (for example, health professionals) to those monitoring compliance (such as judges).
  - Without this, those imposing ACS may lack confidence in the quality, content and effectiveness of support, which may serve as a barrier to use.
  - Unintended consequences of broader changes to policy or practice.



# Barriers identified in other jurisdictions

Key barriers include:

- Absence of a full spectrum of programmes
- Changes in drug trends & policing capacity
- Narrow eligibility criteria
- Lack of treatment access
- Cultural resistance among (some) police sources



# Facilitators identified in other jurisdictions

Key facilitators thought to include:

- Establishing diversion options for ***all illicit drugs*** in ***all states*** and ***territories***
- Considering ***newer models*** of diversion delivery
- ***Streamlining referral systems*** for police
- Increasing ***feedback mechanisms to police*** about drug diversion
- Adding drug diversion into ***police performance monitoring*** systems
- Evidence on ***what works*** and the reach of drug diversion
- Introducing a legislative or hybrid ***legislative requirement to divert*** eligible offenders
- A ***supportive national policy*** framework

# So how do we develop appropriate responses to facilitate greater use of ACS?

There are at least six ways in which work in this area might progress:

- Identify and address existing barriers to ACS use
- Improve awareness and understanding
- Increase resourcing and capacity for ACS
- Enhance co-ordination between systems and services
- Ensure adherence to best practice principles
- Develop, disseminate and use the evidence base

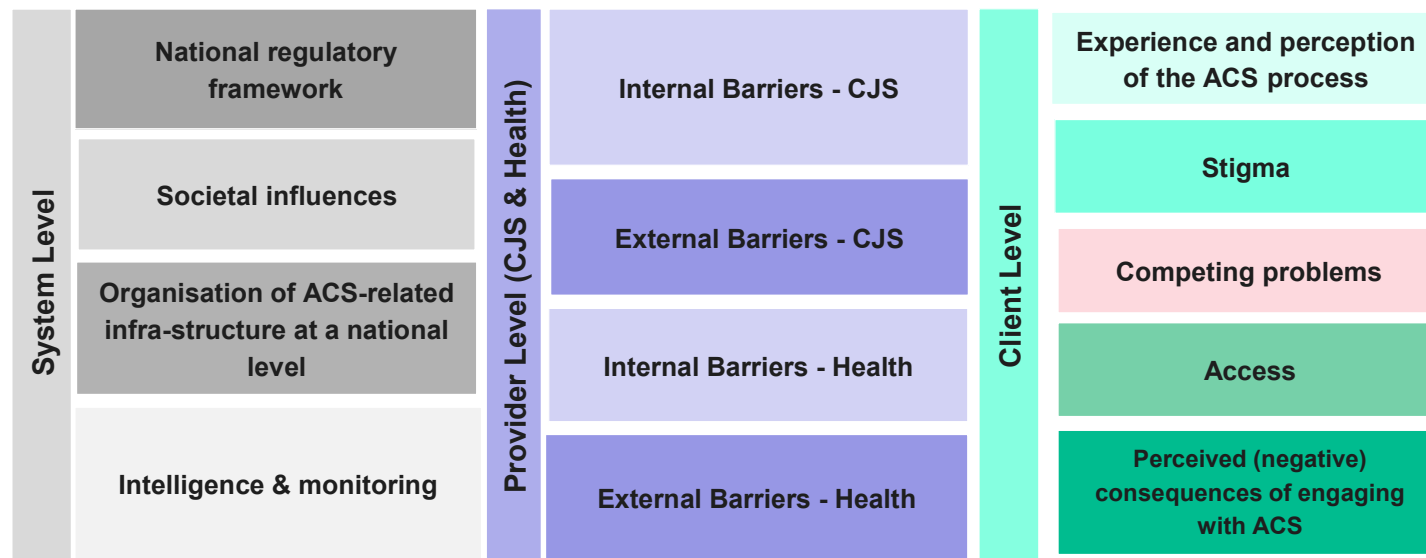
1. System Level

2. Provider Level

3. Client Level

# Identify and address existing barriers to ACS use

Develop a 'tool' to support a review of ACS in a given country through the identification of internal and external implementation barriers and areas for action to improve their utilisation in that country.



# Consider system-level factors: e.g. National regulatory frameworks

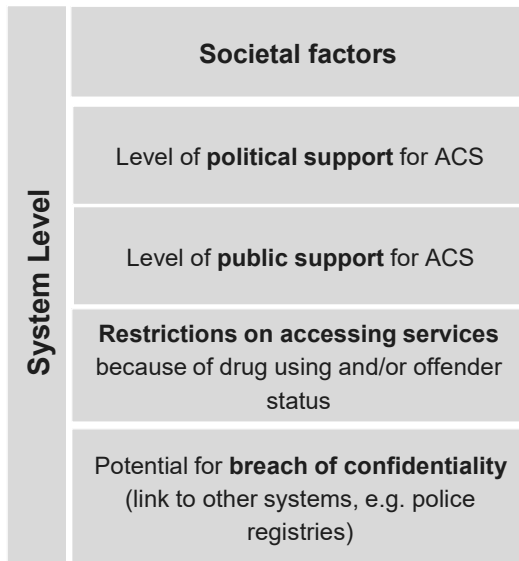
## Potential considerations:

System Level	National regulatory framework	
	Legislation governing the use of ACS	National and/or local <b>policy in place</b> promoting and monitoring the use of ACS
	National and/or local <b>guidance available</b> on the use of ACS	Dedicated (public) <b>funding and resourcing</b> available for ACS

- Is there **legislation** in place which facilitates the use of ACS?
- Is there a national/local **strategy** in place promoting and monitoring the use of ACS?
- Is there evidence-based national/local **guidance** available on how to implement & deliver ACS?
- Does this guidance attend to **best practice** principles?
- Is there **dedicated funding** and/or resourcing available for ACS?
- Any other system-level factors linked to regulatory frameworks?

# Consider system-level factors: Societal influences

## Potential considerations:



- Is there **political support** for the use of ACS?
- Is there **public support** for the use of ACS?
- Are there **restrictions in place** on accessing services or support because of drug using and/or offender status e.g. workplaces or public institutions?
- Is there potential for **breach of confidentiality** arising from involvement in ACS e.g. auto-enrolment on an administrative system e.g. police registries or child protection services?
- Other system-level variables linked to societal factors?

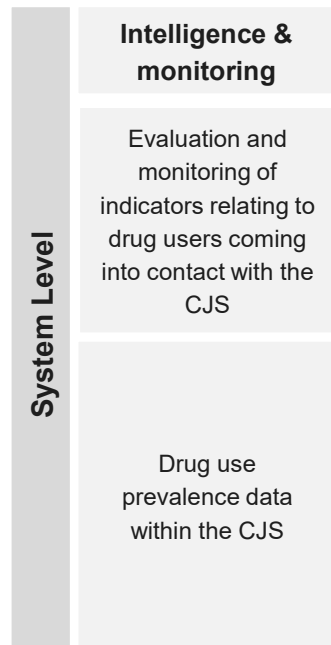
# System-level factors: Organisation of ACS-related infrastructure

## Potential considerations:

System Level	Organisation of ACS-related infrastructure at a national level	
	ACS provision at arrest/bail/pre-sentence	ACS provision available post-sentence
	Capacity within the CJS to deliver ACS	Capacity within the health/treatment system to deliver ACS

- Is there currently ACS provision **available at arrest/bail/pre-sentence** stages?
- Is there currently ACS provision **available post-sentence**?
- Is there **sufficient capacity within the CJS** to deliver ACS?
- Is there **sufficient capacity with the health/treatment system** to deliver ACS?
- Any other system-level variables linked to organisational factors?

# System-level factors: Intelligence & monitoring



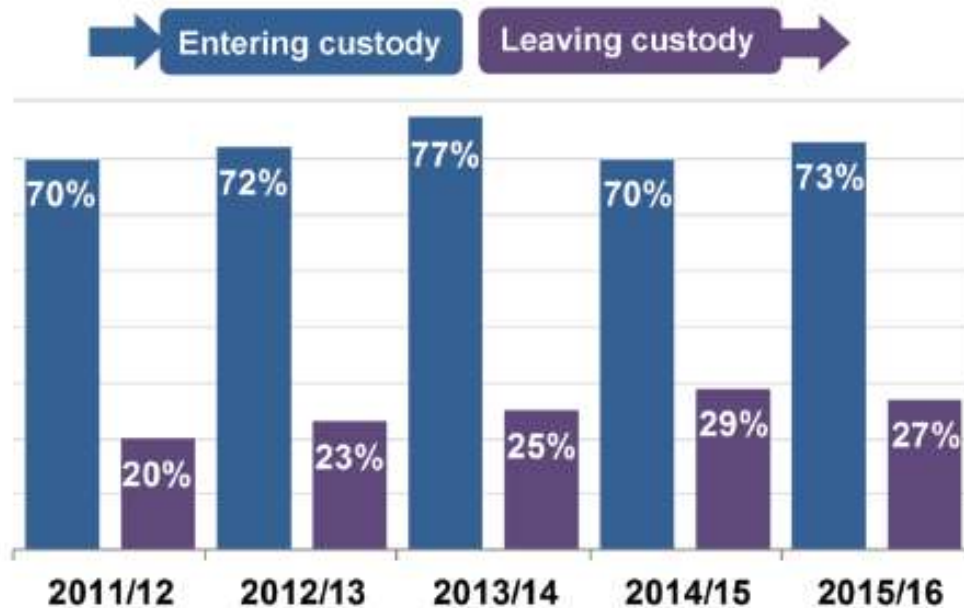
## Potential considerations:

- Is there any **monitoring or evaluation of indicators** relating to illicit drug users coming into contact with the criminal justice system (CJS)
- Is there reliable data available on **illicit drug use prevalence** among suspects, defendants and convicted offenders?
- Any other system-level variables linked to intelligence & monitoring?

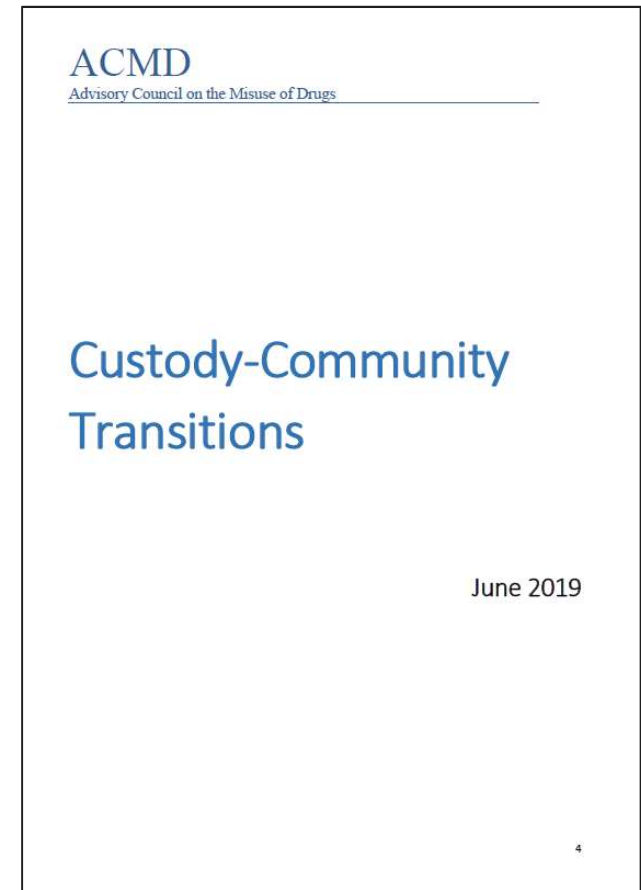


# An example of effective intelligence & monitoring from Scottish prisons

Figure 12: Percentage of prisoners testing positive for illegal drugs when entering and leaving custody by year.

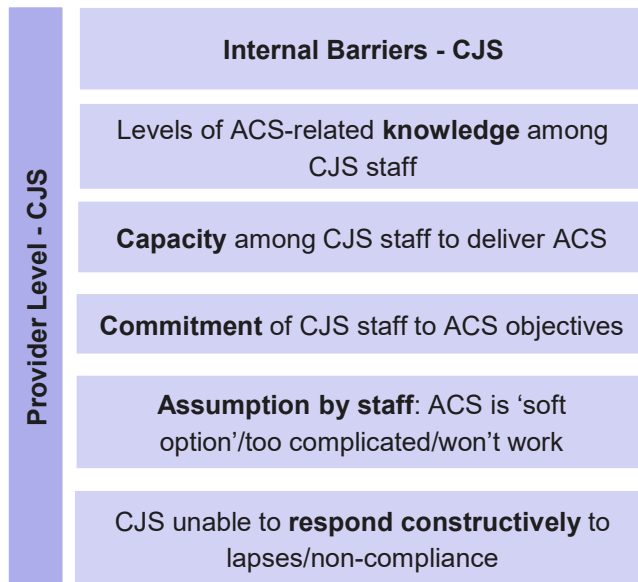


Source: SPS Addiction Prevalence Testing statistics. Available at [ScotPHO](http://www.scotpho.gov.uk/).



# CJS providers: Internal barriers

## Potential considerations:



- Is there sufficient **knowledge** and **understanding** of ACS-related issues among CJS staff?
- Is there sufficient **capacity** among CJS staff to deliver ACS?
- Are CJS staff **committed** to ACS objectives (e.g. ACS not perceived as an area of responsibility for CJS staff)?
- **Attitudes & assumptions:** Do CJS staff consider ACS processes to be inappropriate, too complicated or ineffective?
- Is the CJS sufficiently **flexible to respond constructively** to lapses/non-compliance?
- Any other CJS provider-level variables linked to internal barriers?

# CJS providers: External barriers

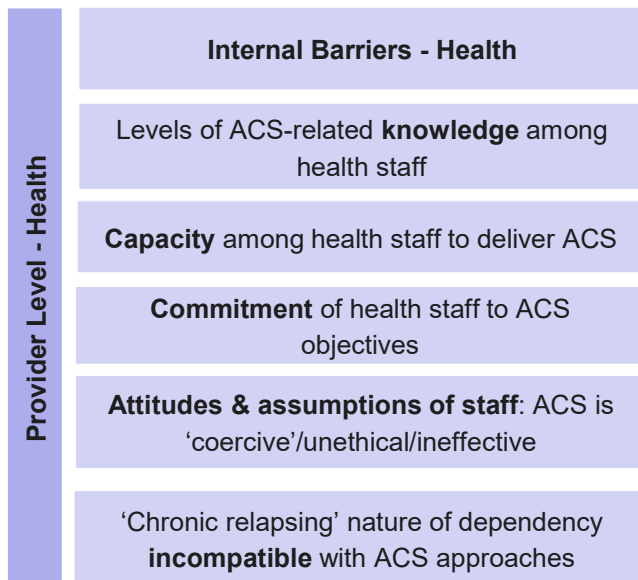
## Potential considerations:

Provider Level - CJS	External Barriers - CJS	
	Ways of working with health and social care partners	Availability and range of health services
	Accessibility of health services	Clarify around intervention objectives
	Consensus around treatment settings and philosophy	Referral and care pathways
	Lack of collaboration with health and social care	Information sharing

- On what basis will the ACS intervention be **commissioned** and **delivered** (e.g. have health services been contracted specifically for this role)? Is there **clarity around respective roles and responsibilities**?
- Is there an **appropriate range of services available** to meet the needs of different service users (based on demographics, social circumstances, drug-using profile)?
- Can these services be **accessed in a timely manner**?
- Is there **agreement** with health partners around ACS **intervention objectives**?
- Is there consensus with health partners around **treatment settings** and **philosophy** for delivering ACS?
- Are referral and care **pathways** sufficiently developed?
- Is there a proven **track record of collaborative working** with health and social care agencies?
- Are there protocols and procedures in place relating to **information sharing** with health partners?
- Any other CJS provider-level variables linked to external barriers?

# Health providers: Internal barriers

## Potential considerations:



- Is there sufficient **knowledge and understanding** of ACS-related issues among health staff?
- Is there sufficient **capacity** among health staff to deliver ACS?
- Are health staff **committed** to ACS objectives (e.g. crime reduction is not a priority for public health; health priorities are subordinate to CJS ones)?
- **Attitudes/assumptions:** Do health staff consider ACS processes to be 'coercive', unethical, or ineffective?
- Is ACS **incompatible with public health** understanding of the 'chronic relapsing' nature of dependency?
- Any other health provider-level variables linked to internal barriers?

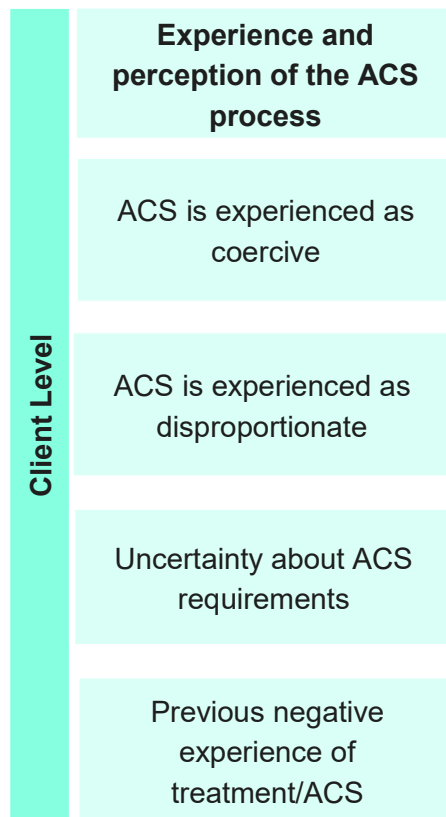
# Health providers: External barriers

## Potential considerations:

External Barriers - Health	
Ways of working with CJS partners	Availability and range of health services
Accessibility of health services	Clarify around intervention objectives
Consensus around treatment settings and philosophy	Referral and care pathways
Lack of collaboration with CJS	Information sharing/client confidentiality

- On what basis will the ACS intervention be **commissioned** and **delivered** (e.g. have health services been contracted specifically for this role)? Is there **clarity around respective roles and responsibilities**?
- Is there an appropriate **range of services** available to meet the needs of different service users (based on demographics, social circumstances, drug-using profile)?
- Can these services be **accessed in a timely manner**?
- Is there agreement with CJS partners around ACS **intervention objectives**?
- Is there consensus with CJS partners around **treatment settings** and **philosophy** for delivering ACS?
- Are **referral** and **care pathways** sufficiently developed?
- Is there a proven track record of **collaborative working** with CJS agencies?
- Are there protocols and procedures in place relating to **information sharing** with CJS partners?
- Any other health provider-level variables linked to external barriers?

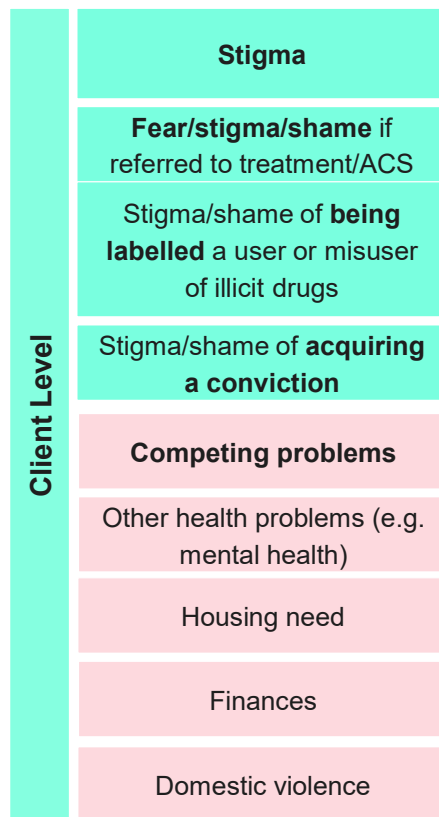
# Client-level barriers: Experience and perception of the ACS process



## Potential considerations:

- Are ACS options **experienced as coercive** by participants?
- Is **informed consent** required of participants?
- Are ACS options experienced as **disproportionate or excessive** by participants?
- Do participants **understand ACS processes** and requirements?
- Is prior negative **experience of treatment/ACS** a factor when considering suitability?
- Other client-level variables linked to experiences and perceptions of ACS?

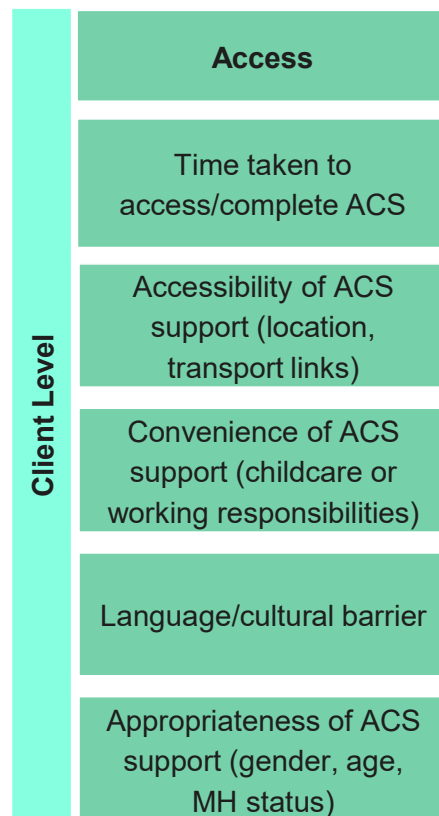
# Client-level barriers: The impact of stigma and other competing problems



## Potential considerations:

- Is the **fear of stigma** a concern for participants referred to treatment/ACS?
- Do participants experience stigma/shame **from being labelled** a user or misuser of illicit drugs?
- Do participants experience stigma/shame at the **prospect of acquiring a conviction?**
- To what extent might **other health problems act as a barrier** to engagement with ACS?
- To what extent might **needs around housing/finances/literacy/DV/mixing with other users** impact upon participants' ability to engage with ACS?
- Any other client-level variables linked to stigma and/or competing problems?

# Client-level barriers: Problems linked to ACS accessibility

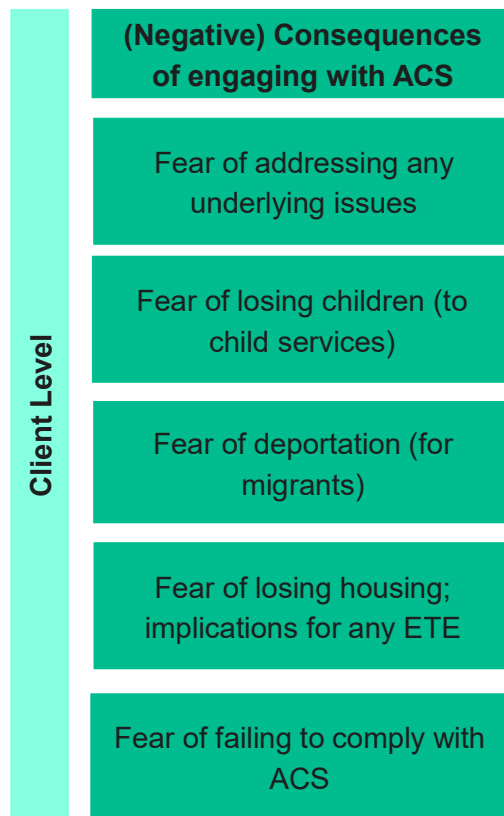


## Potential considerations:

- Do participants express concerns about the **time taken to access/complete ACS**?
- Are ACS services **accessible to participants** (in terms of their location, being serviced by appropriate transport links)?
- What provision is made for those ACS participants who have **childcare or work commitments**?
- Is ACS provision suitably responsive to participants experiencing **language/cultural barriers**?
- Is ACS support **appropriate for a range of participant groups** (e.g. based on gender, age, mental health status, drug-using profile)?
- Any other client-level variables linked to access problems?



# Client-level barriers: Perceived (negative) consequences of engaging with ACS



## Potential considerations:

- Are participants adequately supported through ACS in **addressing issues underlying drug use/offending** behaviours?
- Are participants assured that they will **not lose their child(ren)** if they engage with ACS?
- Are participants assured that they will **not be deported** if they engage with ACS?
- Are participants assured that they will **not lose their housing** if they engage with ACS?
- Are participants adequately supported in addressing any **implications for education, training and/or employment** arising from their involvement in ACS?
- Are participants supported to identify and **minimise any risks associated with breaching** ACS conditions?
- Any other client-level variables linked to consequences of engaging with ACS?

Important that best practice principles for diverting DUOs are adhered to (e.g. Bull, 2005)

roles-responsibilities  
eligibility reintegration  
monitoring-evaluation  
client rights  
judicial review  
partnership working  
funding training  
programme objectives documentation  
treatment philosophy  
management & communication

# Input from the Legal and Policy Correspondents

- 1) How much are alternatives to coercive sanctions used in your country? (There may be more than one). Are there easily accessible records of use rates, completion rates?
- 2) Has there been research or evaluation on the situation, at national or even local level, commissioned or published since 2016?
- 3) Were barriers to implementation identified, such as those above or others? Are you aware of any such barriers?
- 4) Was action taken to reduce the barriers or otherwise to increase/facilitate use of the alternatives? Did they appear to have the desired effect, or could they be further improved? What could or should be done to ease them?

Any questions, comments or observations?

