Guidelines on the 'quasi-compulsory' treatment of adult drug-dependent offenders

Results from a survey of Council of Europe Member States

Tim McSweeney

Institute for Criminal Policy Research

School of Law

King's College London

UK

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I would like to express my gratitude to the Pompidou Group, Criminal Justice Platform for funding and facilitating this survey of 35 Member States. I am particularly grateful to the Platform Secretariat for their assistance in distributing and collating responses. Thanks also to the members of the working group that was convened to consider the scope, focus and content of this survey-based exercise. Finally none of this would have been possible without the respondents who gave their time to complete and return the survey.

Key points

- The picture that emerges in relation to the roles and responsibilities between central government, regional authorities and local municipalities for the implementation and delivery of guidance on QCT systems is a complex one in some countries, but less so in others.
- Legislation and guidance in many countries is frequently being adapted, refined and developed in response to new knowledge, changing circumstances and shifting priorities.
- 16 of 22 responding countries have legislation facilitating and governing the use of QCT measures.
- Legislation in five countries addressed all or most aspects of 13 peer-reviewed and published best practice principles. By contrast, only one country's laws made no reference to any of these issues.
- The most common principles addressed by legislation included targeting and eligibility criteria, the use of compliance monitoring/judicial review, client rights, funding, programme objectives and treatment philosophy.
- 11 countries (or two-thirds of those which legislate for QCT provisions) indicated that they had specific national guidelines in relation to QCT measures.
- These included standard national drug treatment guidelines, ones developed specifically for criminal justice interventions, or both.
- This guidance was aimed at a range of both criminal justice and health professionals and addressed QCT measures at different stages of the criminal justice process.
- The development of national QCT guidelines from the mid-1990s onwards reflects a desire to refine processes, procedures, cooperation and outcomes relating to drug-dependent offenders.

- Four-fifths said their national QCT guidelines were evidence-based. The same number monitors and evaluates the use and implementation of these guidelines in some way, and felt there was consistency between legislation and national guidance on QCT issues.

- Some direction is offered on all major best practice principles in at least half the countries which had developed such guidance. This was most prominent for issues like documentation (e.g. protocols and procedures for referral and assessment processes), roles and responsibilities and treatment philosophy.

- Only two countries specifically indicated that they had developed separate regional guidelines in relation to QCT measures.

- There appears to be scope for developing and refining some aspects of national guidance on QCT in a number of jurisdictions to ensure that they are more closely aligned with existing best practice principles. This could include, for example, a greater focus on reintegration and monitoring and evaluation.

- The results from the survey involving those countries currently offering QCT measures are encouraging. However, there is likely to be much more that can be learnt about QCT practices and principles, drawing on the considerable experiences and knowledge accumulated between these 11 European countries.

1. Background

The Council of Europe's (CoE) Pompidou Group, Criminal Justice Platform (PGCJP), commissioned the Institute for Criminal Policy Research, based at King's College London, to conduct a survey on the 'quasi-compulsory' treatment (QCT)[1] of drug-dependent offenders. QCT refers to any form of drug treatment that is ordered, motivated or supervised by the criminal justice system. While most European countries have various QCT options enshrined within their laws[2], it is not clear if there are any guidelines[3] advising various professionals on the effective use of these measures. The aim of the survey was to provide an overview of existing guidelines on QCT disposals for adult drug-dependent offenders within 35 Member States of the Council of Europe. It sought to do this by answering the following questions:

- Do Member States have any legislation governing the use of QCT measures?
- Do Member States have specific guidelines in relation to QCT options?
- If so, what guidelines do they use and how were they developed?
- What aspects of QCT provision do these guidelines address and to what extent do they adhere to established best practice principles?
- Is the use and implementation of these guidelines monitored and evaluated in any way?

The scope, focus and content of the survey was initially discussed and refined by a working group of members from the PGCJP which convened during February 2008 (see Appendix A). Their suggestions and recommendations were subsequently discussed and approved by all members of the PGCJP and questionnaires were distributed to Permanent Correspondents of the Pompidou Group (35 in total) at the end of April 2008. The Permanent Correspondents were tasked with the responsibility of identifying the most suitable and appropriate respondents to complete the survey. By the end of October 2008, 22 responses (63%) had been returned and analysed. Respondents to the survey included

[1] Stevens, A., Berto, D., Heckmann, W., Kerschl, V., Oeuvray, K., van Ooyen, M., Steffan, E. and Uchtenhagen, A. (2005) 'Quasi-Compulsory Treatment of Drug Dependent Offenders: An International Literature Review', *Substance Use and Misuse*, 40 (3): 269–283.

[2] Hughes, B. (2007) *'Treatment alternatives to prison/punishment: Overview of existing mechanisms across the EU'*. European conference on quasi-coerced treatment and other alternatives to imprisonment. Bucharest, Romania. 11-12 October 2007.

[3] Guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate interventions for specific circumstances. Commonly guidelines include a set of recommendations or steps that can be followed when implementing an intervention. The content of guidelines are commonly based on the available research evidence (EMCDDA, 2007).

senior representatives, policy advisors and specialists drawn largely from central government departments including justice, law enforcement and public health.

The picture that emerges in relation to the roles and responsibilities between central government, regional authorities and local municipalities for the implementation and delivery of QCT systems is more complex in some countries than in others. In Germany, for example, responsibility for drug and addiction policy is shared between the Federal Government and the Länder. The former has legislative authority over drugs law, penal law, and social welfare law; the implementation and execution of these federal laws is the responsibility of the Länder, who have their own legislative authority in areas which are of relevance for drug and addiction policy, and can thus develop their own priorities within the framework of legal guidelines and common agreed goals. Such arrangements clearly make an overall assessment of the current situation that much more difficult.

Furthermore, as the German response to the survey highlights, “funding of treatment and rehabilitation is for the most part provided by the health or pension insurance funds respectively. Alternatively, funding is taken over by social welfare providers. Costs caused by (secondary) disorders resulting from drug use and withdrawal (detoxification) are generally borne by the health insurance funds whereas outpatient and inpatient medical rehabilitation is paid for by the pension insurance funds. Social insurance providers act as independent self-governing bodies under public law. Therefore, political decisions often do not have a direct impact on the funding practice with regard to certain treatment offers. In Germany, health care and social work in particular are governed by the principle of subsidiarity. The associations of SHI-accredited doctors (i.e. general practitioners) are tasked to guarantee outpatient medical care. Private charity organizations in particular, organize large parts of the measures of socio-therapeutic care for drug users for which they receive public funding – from national, Länder- and municipal budgets according to certain criteria. Only in few cases (e.g. counselling facilities run by public health offices or psychiatric clinics), the Federal Government itself provides special treatment offers and services for persons with addiction problems”.

In addition, legislation and guidance in many countries is frequently being adapted, refined and developed in response to new knowledge, changing circumstances and shifting priorities.

2. National legislation on QCT

Three-quarters of the respondents (16) indicated that they had national legislation governing the use of QCT measures. These represented a mix of common and civil law jurisdictions. Legislation in five countries addressed all or most aspects of 13 pre-defined best practice principles[4] (i.e. between 9 and 13 of them). By contrast, only one country's laws made no reference to any of these issues[5].

The most common principles addressed by legislation included:

- eligibility (e.g. setting out criteria for the targeting and identification of eligible suspects/offenders) (11);
- compliance monitoring/judicial review (e.g. setting out clear criteria for monitoring compliance and non-compliance of QCT conditions, the use of sanctions and rewards, and processes allowing for judicial review of progress) (11);
- client rights (e.g. whether informed consent from the suspect/offender is required and how to secure this) (10);
- funding (e.g. clearly establishing where responsibility lies for ensuring funding is available for delivering all aspects of QCT provision) (8);
- programme objectives (e.g. by articulating the overall aim of QCT, such as crime reduction or preventing future drug use) (7); and
- treatment philosophy (e.g. stating whether the drug treatment component of QCT should be abstinence-based or harm reduction in focus; residential or community-based) (7).

Fewer countries legislating for QCT also made reference to management and communication (6), roles and responsibilities (6), monitoring and evaluation (6), documentation (6), reintegration (6), training (5) and partnership working (4) issues in their legal frameworks for such provision.

[4] Bull, M. (2005) 'A comparative review of best practice guidelines for the diversion of drug related offenders', *International Journal of Drug Policy*, 16 (4): 223–234.
[5] Responses from two countries provided no details on the extent to which their national legislation adhered to these principles.

3. National QCT guidelines

Eleven countries (or two-thirds of those which legislate for QCT provisions) indicated that they had specific national guidelines in relation to QCT measures.

These included standard national drug treatment guidelines (2), ones developed specifically for criminal justice interventions (4) or both (4). In some countries these national QCT guidelines were universal (4) while in others separate ones have been developed for different professional groups (e.g. there is one set of guidelines for prosecutors and another for health) (5).

The groups or agencies principally targeted by these national guidelines on QCT included drug treatment providers (9), health services (7), the prison service (7), prosecutors (6) and Magistrates/Judges/Prefects (5).

These national guidelines related to varying stages of the criminal justice process in each of the 11 countries, including at arrest (4), court (pre-sentence) (6), prosecutor (6), imprisonment (7) and post-release (5). In only two countries (Romania and Sweden) were these guidelines focussed on all stages.

In most countries interest in developing QCT guidance appears to have gathered pace during the mid-1990s. These developments reflected a desire to refine processes, procedures, cooperation and outcomes relating to drug-dependent offenders. This typically involved expert consultation between relevant government departments and stakeholders groups. Two countries (Denmark and Romania) specifically stated that their guidelines had proactively drawn on models and experiences from other jurisdictions.

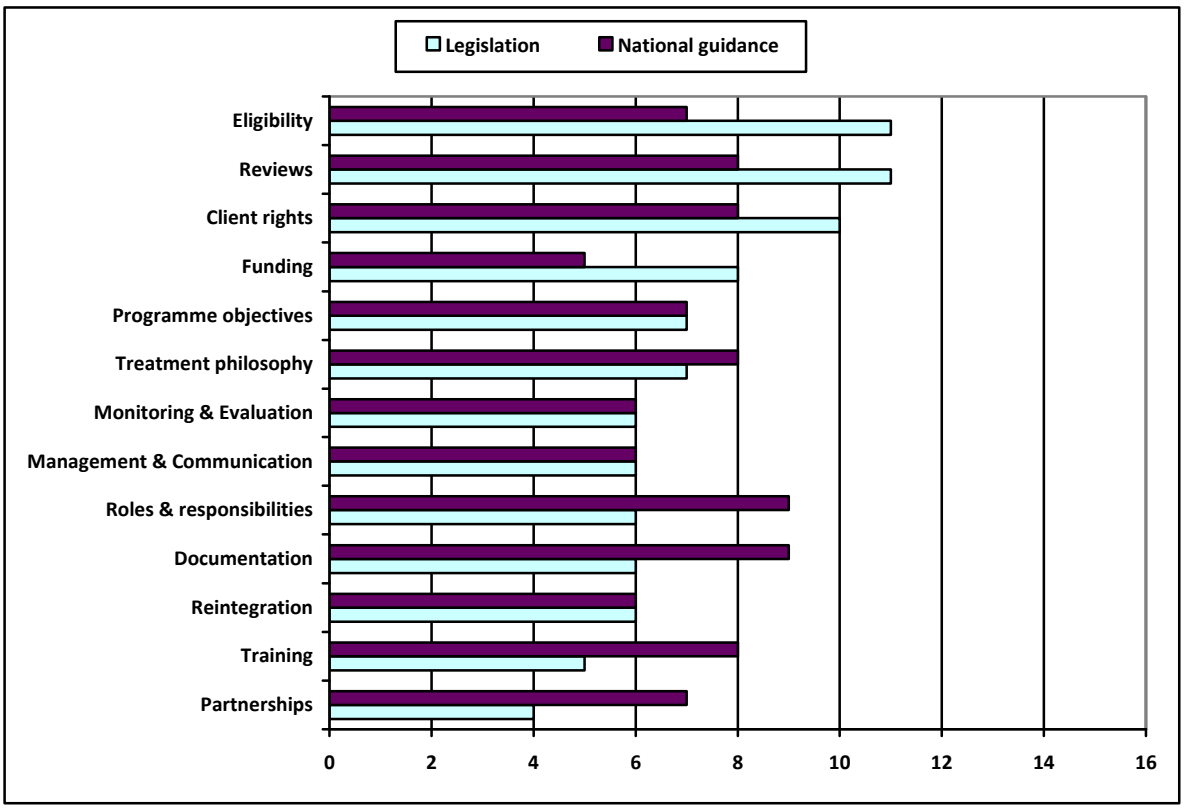
When asked to indicate to what extent their national QCT guidelines were evidence-based (i.e. where relevant research findings were taken into consideration to inform their development) most respondents stated that this had happened either completely (2) or to some extent (7). Two respondents felt unable to comment on the extent to which their guidelines were evidence-based.

Eight of the 11 jurisdictions that have developed national guidelines on QCT monitor and evaluate their use and implementation in some way. This was achieved using a range of strategies: performance managing levels of adherence to them, through routine inspections or evaluations, and/or linking this adherence and performance to continued funding and accreditation. Similarly, most respondents (9) felt that their legislation and national

guidelines on QCT measures were consistent with each other (again, either completely or to some extent).

Figure 1 illustrates the different aspects of QCT provision addressed by national guidance and compares this with those areas addressed by national legislation. It shows that while some direction is offered on all these major best practice principles in at least half the countries which had developed such guidance, this was most prominent for issues like documentation (e.g. establishing protocols and procedures for all aspects of QCT provision - from referral and assessment to monitoring and evaluation) (9), roles and responsibilities (e.g. defining and demarcating roles and responsibilities of different stakeholders involved in the QCT enterprise, such as probation officers and drug treatment workers) (9) and treatment philosophy (e.g. indicating the preferred orientation and setting for delivering drug treatment) (8). Client rights (8), judicial monitoring/review (8) and training (8) issues also feature prominently in national guidance on QCT.

Figure 1: Aspects of QCT provision addressed by national legislation and guidance



4. Regional guidelines

Only two countries indicated that they had developed separate regional guidelines in relation to QCT measures. In one (Belgium) these guidelines have been developed to support a pilot project in one particular district involving ‘probationary care’ as an alternative to a custodial sentence through the integration of criminal justice, health and social care responses. A treatment plan is developed for each participant and progress is monitored and supervised by a case manager. In the event of non-compliance the case is brought back before the court. The scheme enjoys a high level of take up amongst offenders and early research findings on the scheme have been positive. The intention is to roll the model out into other districts.

A second project in this jurisdiction also uses specific regional guidance to inform the implementation and development of a specialist drugs court involving the bench, barristers and helping services.

In the other (Switzerland) various forms of regional guidance have been developed to suit the specific needs and circumstances of different regions.

Finally in Romania, regional guidelines, consistent with national ones, are currently being developed to support projects focusing on QCT in an effort to promote alternatives to imprisonment for drug-addicted prison inmates.

5. Overview and implications

Table 1 sets out the current position in the 22 responding countries in relation to legislation on QCT measures and indicates whether there is any national and regional guidance on the optimum use of these options.

Table 1: Legislation and national and regional guidelines on QCT, by country

Country	National legislation	National guidelines	Regional guidelines
Azerbaijan			
Belgium	☑		☑
Bulgaria			
Croatia	☑		
Cyprus	☑		
Czech Republic			
Denmark	☑	☑	
Estonia			
France	☑		
Germany	☑	☑	
Hungary	☑	☑	
Ireland			

Country	National legislation	National guidelines	Regional guidelines
Lithuania	☑	☑	
Luxembourg			
Netherlands	☑	☑	
Norway	☑	☑	
Romania	☑	☑	
Slovak Republic	☑	☑	
Slovenia	☑	☑	
Sweden	☑	☑	
Switzerland	☑		☑
United Kingdom	☑	☑	

The results from the survey involving those countries currently offering QCT measures are encouraging. Nevertheless, they suggest that there is still scope for developing and refining some aspects of national guidance on QCT in a number of these jurisdictions to ensure that they are more closely aligned with existing best practice principles. This could include, for example, a greater focus on reintegration and monitoring and evaluation.

There may also be a case for exploring options for adopting QCT in the six countries indicating an absence of legislation to facilitate these measures. For instance, during September 2005, three of the four countries for which data were available had prison

systems operating at or above capacity[6]. The scope for introducing these measures will clearly be dependent upon the extent to which QCT is considered feasible and compatible with existing legal/health frameworks and whether the drug treatment infrastructure is sufficiently well developed within these countries to support this expansion.

Perhaps a reasonable question is whether there is any scope for, or perceived value in, assimilating and refining a set of transnational guidelines on QCT practices and principles, by drawing on the considerable experiences and knowledge accumulated between the 11 European countries with existing national guidance on QCT measures? An obvious challenge though would be to ensure that any such guidelines could be applied in a meaningful way given the contextual, cultural and organisational differences between the health, criminal justice and social care systems of the various Member States.

[6] Stevens, A. (2007) *'Why do we need alternatives to imprisonment? Do we need quasi-compulsory treatment?'* European conference on quasi-coerced treatment and other alternatives to imprisonment. Bucharest, Romania. 11-12 October 2007.

Appendix A: PGCJP Working Group on QCT

Notes of a meeting in Paris, 5th February 2008

Present:

- Lidija Vugrinec (PGCJ Platform Co-ordinator, Croatia)
- Tim McSweeney (Consultant, UK)
- Brendan Hughes (EMCDDA)
- Theano Mavromoustaki (Cyprus)
- Rune Fjeld (Norway)
- Lars Meling (Norway)
- Constantin Duvac (Romania)

The Chair opened the meeting and apologised for absences. Participants then introduced themselves.

The Consultant overviewed a discussion paper that had been circulated to all participants in advance of the meeting. It proposed two potential themes for consideration: adherence to best practice principles and/or explaining the limited use currently being made of QCT options. These proposals were set against the context of the findings to emerge from the QCT conference hosted by Romania in October 2007, and previous and current work programmes of the EMCDDA.

The group was informed that the EMCDDA had completed a one-year project as part of their best practice portal which will contain details of current demand reduction responses and will absorb EIB (Evaluation Instruments Bank) and EDDRA (Exchange on Drug Demand Reduction Action) functions. It therefore has a much broader scope and is due to appear online in March 2008.

The EMCDDA also has an interest in pursuing best practice issues as they relate to QCT with particular reference to guidelines (which are evidence-based and inform clinical practice) and quality standards (more policy orientated documents). It was noted that these terms are often used interchangeably without any real definitions provided. It was suggested that the best practice principles set out by Bull (2005) in the discussion paper did not distinguish between these two common formats for imparting best practice advice. (The EMCDDA had developed some and was willing to share these with the working group.)

It was then proposed that it would be particularly useful to assess what guidelines currently exist in relation to QCT and what evidence they were based on.

However, if best practice in relation to QCT was to be pursued by the group then at least two issues would need to be considered in greater detail: what are these best practice principles based on and how have they been devised? Do they take into account contextual/cultural/organisational differences (i.e. whether a QCT system operates within a common or civil law framework)? It was suggested that the principles established by Bull (2005) might introduce an element of bias into a survey as they were informed largely from countries with common law legal systems (UK, US, AUS, CAN).

It was then suggested that the following issues would be worthy of further exploration in relation to QCT:

- Do Member States have guidelines in relation to QCT?
- If so, what guidelines do they use?
- How were these guidelines developed?
- Is the use and implementation of these guidelines monitored and evaluated in any way?

ELDD responses suggest that around half of all countries responding to the EMCDDA survey on alternatives to prison (ATP) had developed specific guidelines. More European data on these issues will better inform the development of European specific guidelines on QCT. The EMCDDA would be willing to share its knowledge and data on ATP in order to inform this exercise.

In order to avoid duplication of effort there was also a suggestion that the PGCJP could focus specifically on the criminal justice system as the EMCDDA intends to pursue this issue in relation to its remit around drug treatment. Another member expressed concern about asking for treatment guidelines as this was (a) too broad a theme and (b) may have already been considered by the PG treatment platform.

The Chair would liaise with the PG treatment platform and indicated that the ethics panel were also interested in the proposed work. It was then suggested that we may wish to include one or two specific questions relating to ethical issues arising from QCT.

Discussions then focussed on the main ‘selling point’ to entice respondents to complete the survey? Participants noted that although QCT is endorsed at the highest levels there is still little evidence about what works with whom. Helping us with the survey will ultimately help Member States deliver more effective forms of QCT.

One member expressed some uncertainty about who would be targeted with the questionnaire (as this would largely influence the nature of the questions to be asked). It was noted that in Norway the treatment system operates with one set of guidelines while the CJS has another. The Consultant confirmed that similar arrangements exist in the UK.

It was suggested that the questionnaire might need be structured accordingly (one section for treatment another for the CJS) to reflect this and circulated as considered appropriate by the Permanent Correspondent, depending on the arrangements within each country.

The group agreed that the survey should be qualitative in focus (as reliable quantitative data is likely to be lacking). The group agreed that it would no be possible to audit the accuracy of responses we receive.

The group then considered at which stage(s) of the sentencing process should the survey focus (e.g. pre-trail, post-sentence, post-imprisonment)? ELDD responses to the earlier ATP survey indicated that most options operate at the court stage.

There was a general consensus amongst the working group that the survey should aim to identify the extent to which QCT guidelines are available at all stages of the criminal justice process.

It was also considered appropriate that the Permanent Correspondent in each Member State should determine who were the most appropriate people to complete the survey.

The group was then asked to consider whether the focus of the survey should be on national or local guidelines (where both exist[7])? One member pointed towards the likelihood of a large number of local guidelines from countries like Germany and Spain.

The group felt that the survey should focus on national guidelines where these are available. It was suggested that the survey should also ask about the existence of regional guidelines and have the option of exploring these in more detail – perhaps as case studies – at a later date, if considered appropriate.

Participants also commented that we would have to clearly state and define the distinction between guidelines and standards. The EMCDDA offered to share the definitions they had previously developed on this.

Distributing and returning the survey

There were unlikely to be any resources made available to help Member States complete the survey.

Permanent Correspondents would be given between 4-6 months to complete and return the survey. It was proposed that a first deadline be set for July 2008 (and a follow-up date of September 2008 for non-responders). It was noted that any early responses could be used to identify any conceptual difficulties that might be preventing other Member States from completing the survey.

This would then leave scope for the findings from the survey to be presented and discussed at the PGCJP meeting scheduled for November 2008.

[7] Only two responses to the earlier EMCDDA survey on alternatives to prison indicated that they "might have regional guidelines".

Next steps

The Consultant would circulate amongst the working group a template of questions to be included in the survey by 29th February 2008.

Responses will then be incorporated prior to the next PGCJP meeting on 3-4 April 2008 when the survey will be discussed and ratified by the platform before finally being considered (and approved) by the Permanent Correspondents at their meeting on 16-17 April 2008.