

Research into the nature and effectiveness of drugs throughcare

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Foreword

This report summarises the results of a study examining the nature of drugs throughcare for prisoners with serious drug misuse problems. Drugs Throughcare refers to the treatment and support offered to prisoners making the transition from prison to the community. The research gauges the impact of these interventions on ex-prisoners' drug taking and offending behaviour on their release.

A range of different agencies and organisations share the responsibility for organising and delivering drug throughcare services, including the Prison and Probation Services, Health Authorities, Social Service Departments, Drug Action Teams, as well as both statutory and independent drug agencies. The research set out to assess how this complex network organises throughcare provision, as well as what constitutes good practice in this area.

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The aims of this study were to:

- describe the nature of throughcare procedures for prisoners with serious drug misuse problems; and
- gauge the impact of interventions on offenders' drug taking, and offending behaviour, following their release from prison.

A principal objective of the study was to establish what constitutes good practice in drugs throughcare, with a view to disseminating the lessons learnt.

A range of different agencies and organisations share the responsibility for organising and delivering drug throughcare services for released prisoners, including the Prison Service, the Probation Service, Health Authorities, Social Service Departments, Drug Action Teams and – of course – both statutory and independent drug services. Indeed, in this complex network, knowing 'where the buck stops' is not clear in every case – particularly for those who are not released under statutory supervision (remand or short-term prisoners).

Aside from the very real human costs to drug users themselves, the problem addressed by this research imposes substantial costs on the wider community. These are best viewed as 'opportunity costs', where substantial savings may be made as a result of appropriate intervention. It can be estimated that 8,000 sentenced offenders might be released from prisons in England and Wales each year with a significant drug dependency – if no action has been taken to break drug habits. However, if drug throughcare could effect a 40 per cent reduction in drug dependency amongst ex-prisoners, the number of crimes expected to be committed by these individuals each year would fall from some 5 million to 3 million. The costs incurred by victims of crime might reduce from some £250 million to about £150 million. There would, in addition, be many other savings realised in the criminal justice system, health service and elsewhere.

Method

In the course of the study a wide range of professionals from the Prison Service, the Probation Service, drugs services and other agencies were interviewed about their practices. They were also consulted more generally on the issues they saw as important to the effective delivery of drugs throughcare, as well as any impediments. Consultations were also held with those responsible for formulating and implementing national policy, academics in the field and others.

The subjects of the research – prisoners with drug problems – were also widely consulted. A central feature of the study was to 'track' prisoners with drugs problems on their release. Seventeen prisons which run drug pilot programmes were selected to participate in this exercise. Between them they represented the range of different institutions in the prison estate, running a variety of drug treatment programmes. All prisoners who had drug problems (and had undergone some form of treatment) who were to be released from these establishments during the period October 1998 to January 1999 were invited to complete a questionnaire.

The exercise represented the first substantial 'tracking' study to be carried out in this country into prisoners with drug problems. In total, 179 prisoners completed a questionnaire prior to their release. Of this number 170 agreed to complete a follow up questionnaire four months after their release. Of these, 112 completed and returned the second questionnaire: this response rate – of 66 per cent – is about double that achieved in similar tracking exercises of drug users conducted into other aspects of the criminal justice system. Even so, the sample cannot be viewed as representative of all prisoners with drug problems – and probably fails to adequately reflect the experiences of the most dependant users.

In addition to the formal tracking exercise, prisoners were consulted in focus group discussions. Focus groups were held at 7 of the 17 institutions and some prisoners and ex-prisoners were interviewed individually.

Principal findings

The experiences of prisoners in the tracking exercise

This exercise found:

- Most of the prisoners surveyed had experienced serious drugs problems prior to their imprisonment: 66 per cent said that in the 30 days prior to going into prison they had been taking heroin every day, and about the same number cited heroin as their 'main' drug. In addition, a third said they took crack, and about one half said they took cannabis, every day. Overall, most were polydrug users.
- Prisoners spent considerable sums of money in support of their habit. In a typical week the average spent was £550. Four out of five said that they committed crimes of theft, and a third said they had dealt in drugs, to support their habits. However, legitimate income (wages and benefits) was being spent on drugs, and a third of respondents had resorted to selling their own possessions.
- The motivation the prisoners had for seeking drug treatment in prison varied, but the predominant reason they sought help (cited by 44%) was to stop their drug taking altogether.
- Nine out of ten prisoners thought that the treatment received in prison helped them, but about half of these reported that it had only helped them "a little".
- Three quarters reported that they took drugs in prison - mainly heroin and cannabis (53% and 55%, respectively). However, their drug taking was radically curtailed, with most taking these drugs less than weekly.
- 50 per cent of those surveyed indicated that they were offered help to obtain treatment on release. However, only 11 per cent were fixed with an appointment at a drug agency, and most were given more indirect assistance, such as the name of a drug service within the prison or near their home.
- Some four months after their release 86 per cent reported that they had used some form of drug, and 14 per cent had not done so. About half were using heroin every day: this represents a decline of about 20 percentage points on the proportion using heroin before going into prison.
- Spending on drugs (by those taking drugs) had, however, approximately halved.
- Drug use was not the only difficulty faced: about half either had nowhere to live, or were staying with friends and relatives (mainly the latter). Only 16 per cent had any form of employment.

- At this point, three-quarters felt they needed help in dealing with their drug problem. A third had sought and received help, mainly from drug services they used before their imprisonment.

Addressing the challenge

Providing effective throughcare is by no means simple. The consultation process with professionals involved, and prisoners themselves, highlighted a range of difficulties. These included:

- The difficulties posed to inter-agency co-operation and community links by the fact that relevant agencies rarely share the same boundaries. In addition, prisoners are often imprisoned some distance from their home. (Thus any one of the country's 123 prisons may need to confer with any of the 54 different probation services or with any of the many other local agencies.)
- A general reluctance by prisoners to volunteer information about their drug misuse for fear of being targeted by staff in some way: by, for example, increased surveillance, more frequent cell searches or having their visitors subjected to more rigorous searching.
- An uneven provision of drug services throughout the prison estate and insufficient community drug services to deal with the scale of the problem.
- The focus of programmes within prisons on abstinence from drugs rather than on harm reduction. For remand prisoners in particular, advice on harm reduction might be the best help that could be offered especially as there appeared to be a great deal of ignorance about risks amongst the young remand population.
- The difficulties of liaison between professionals, especially where there were marked differences of opinion as to whether policy should focus on prevention through treatment, harm reduction or security.
- The lack of statutory obligation to provide throughcare for prisoners serving less than 12 months, although many offenders in this group are serving sentences for drug-related acquisitive crime.
- Drug Action Teams (DATs) not assuming any role in planning and co-ordinating services for prisoners and ex-prisoners with drug problems.
- The length of drug services' waiting lists – a number of prisoners put their failure to stay off drugs following previous sentences to the fact that they did not get support quickly enough.

Practice 'on the ground': practitioners' assessments

The research served to document that the issue of drug throughcare is being accorded increased attention by many key agencies. Equally it showed that examples of good practice are presented by a variety of different schemes.

These schemes are, however, limited in number and in their coverage, and certainly not representative. The managers and staff working within them are the first to stress that much of their effort is directed at overcoming *structural impediments* to the provision of throughcare. The hallmark of many is that they are the product of one or two charismatic individuals and unusually strong inter-agency partnerships. They typically survive on fragile funding only while these conditions persist.

In short, the report argues that drug throughcare constitutes a "Cinderella service" largely because *responsibility for this issue does not fall to any single agency or postholder*.

However, this research was conducted during a period of rapid policy development in this area. Above all, in April 1999, the Prison Service launched its 'CARAT' (Counselling, Assessment, Referral, Advice, and Throughcare) service for prisoners with drug problems. The main focus of CARAT is on more specialist drug treatment services provided on either a prison area or national basis. It aims to provide a range of interventions, starting with an initial assessment on a prisoner's entry into custody, and to link prisons with community agencies in order to ensure continuity of care. CARAT also states that funding "should include provision for staff to continue their direct service provision to clients where necessary, for a short period after release".

The implications for the future of drug throughcare

The common theme of the criticism made in this report is that drug throughcare for ex-prisoners falls between different agencies, presents almost insuperable logistical difficulties and is hampered by a lack of funds. In the eyes of many, major improvements will only be effected if prisons only serve 'local' prisoners. Developing the links between prisons and the other services in any locality is highly desirable, but – for a range of other reasons – it seems unlikely that it will be possible to arrive at a situation where local prisons serve only local inmates.

A radical re-assessment of the organisation and funding of throughcare seems called for. But falling short of this, there are also lesser changes that promise improvements:

The radical route

The most dramatic root and branch reform of the system would involve applying highly traditional remedies, namely:

- the designation of responsibility for throughcare to *one specific service*, and
- the 'ring fencing' of funds for this purpose.

The front runners to take on a national responsibility would be either the Probation Service or the Prison Service. Whatever organisation proved best suited, the principle might be that they adopted a very simple and straightforward formula – with local area services taking responsibility for:

- tracking the progress of all inmates receiving drug treatment in 'their' prison area – to the point of having a responsibility to ensure that those needing support on release have arrangements made for them in their home area
- liaison with all the community drug services available in the locality, so that they receive referrals of ex-prisoners to be released to 'their' area from prisons elsewhere, and take over responsibility for placing them.

Such an arrangement would need to be supported by a guarantee of funding for each prisoner, who met a common set of assessment criteria, for a finite period after their release. The arrangements would firmly tackle the primary 'structural difficulties' that beset current arrangements.

The 'step by step' approach

A more modest set of reforms could be built on the lessons of existing examples of 'good practice', and seek to shape and develop the way that the CARAT service develops. The suggested priorities here should be to:

Within prisons:

- promote a wider awareness of drug issues amongst prison officers
- broaden the range of drug services available
- overcome issues that prevent transfers to drug programmes in other prisons
- promote inter-agency collaboration between services within prisons, and develop protocols on confidentiality
- strengthen accountability in the sentence planning process
- facilitate other channels of communication between prisoners and their 'home' probation officers.

Towards release:

- provide specialist personnel to arrange drug support on release
- develop directories of community drug services
- facilitate direct contact with treatment agencies
- encourage pre-release courses dealing with drugs.

On, or soon after, release:

- address the funding shortfall and chart the complexities of funding sources
- promote the 'holistic' approach.

Above all, any improvements made in these key areas need to be built on a solid foundation, and the key components here are:

- ensuring drug throughcare receives a higher profile
- encouraging DATs to take the lead in both promoting this message and in co-ordinating the efforts of different agencies to ensure local service delivery.

The introduction of the CARAT programme – and in particular the promotion of the concept of area planning – promises a great deal, but it would be naïve to assume it will be a panacea. The continuing threat to drug throughcare will be that it remains a shared responsibility, but where – in the absence of any accountability – each agency can argue “it’s not my baby”.

The main aims of this research were to describe the nature of throughcare procedures for prison inmates who receive treatment for drug misuse, and to assess how well these procedures help to maintain continuity of care and treatment following their release from prison.

Given this wide-ranging remit, a number of key themes were identified as being of special interest. For example:

- what happens to those offenders with identified drug problems who are not eligible for statutory supervision?
- what agencies, apart from the Probation Service, deal with prisoner referrals and what specialist services do they provide?
- how do 'home' or field probation services respond to offenders' needs and what use do they make of existing support services in the community?
- how do prisoners who have received treatment for drug misuse during their time in prison cope when they return to the community?

A principal objective of the study was to establish what constitutes 'good practice' in drugs throughcare, with a view to disseminating the lessons learnt.

The 'vicious circle'

Drug dependent offenders are caught in a vicious circle. Unless the treatment they receive in prison for their addiction is maintained on their return to the community, the chances are that they will relapse and begin offending again to support their drug use. Failure to access appropriate support services in the community can result in offenders returning to prison time and time again, as the cycle of offending is perpetuated.

Prisoners with drug problems

It is difficult not only to determine the prevalence of drug misuse among offenders prior to imprisonment but also to ascertain exactly how much illegal drug use takes place in prison. A substantial body of research has addressed both issues, employing a variety of different research methods¹. This consistently shows that, compared with the general population, the prison population contains a much higher proportion of people who have used illegal drugs (Joyce, 1996). Some examples will serve to give an insight into the key findings.

Findings from retrospective surveys of inmates serve to show the generally high levels of drug use amongst prisoners. Studies of prisoners in various types of institutions – like those by Maden et al. (1991 and 1992), Mason et al. (1997), Bridgwood and Malbon (1995) which have investigated prisoner's drug use *at any time* before entering prison – have consistently found that between about 60 per cent to 70 per cent had used drugs. However, narrowing down the time-span in which drugs might have been taken, or the type of drug

1. There are of course important questions of validity and reliability to consider when using the predominant 'self-report' methods to investigate addictive behaviour (Babor et al. 1990).

under consideration leads to different results. Thus, Swann and James (1998) carried out a survey of the physical health of 992 randomly selected sentenced prisoners from 32 establishments and found that 63 per cent claimed to have misused drugs *in the twelve months* prior to their imprisonment. In a recent survey of drug dependence among prisoners, Singleton et al. (1998) reported that 43 per cent of male and 41 per cent of female sentenced prisoners experienced some degree of drug dependence in the year before entering custody. Interestingly, the comparable figures for remand prisoners were higher at 51 per cent and 54 per cent.

Not only does the research evidence suggest that drug taking amongst those entering prison is high, but findings from self-report studies also reveal that many prisoners continue to use illegal drugs while in custody. (See, for example, Turnbull et al. 1991 and 1992; Edgar and O'Donnell, 1998; Advisory Council on the Misuse of Drugs, 1996; Keene *et al.*, 1993). In Swann and James' study (*op. cit.*), all but two of the respondents who confessed to having taken drugs prior to imprisonment admitted to continuing their drug taking behaviour in prison. Commenting on a number of studies of offenders who reported injecting drugs prior to imprisonment, Turnbull *et al.* (1994) observe that the proportion claiming to have injected while in custody ranged from 23 per cent to 33 per cent.

Further evidence of drug misuse in prison is provided by the increase in drug finds by prison staff, and by data from the mandatory drug testing programme that was introduced in all penal establishments in England and Wales by March 1996.

In the light of this sort of evidence, the general case for treating drug users while in custody has been recognised for some time. For example, in 1996 a guidance note issued to Drug Action Team (DAT) chairs by the Central Drugs Co-ordination Unit (CDCU) stated that:

"Given that various studies have suggested high levels of drug misuse by the prisoner population, including upwards of 20 per cent male prisoners and around 30 per cent of women prisoners having ever used drugs intravenously, the consequences of focusing on this group – in terms of increasing community safety and reducing health risks – are readily apparent" (CDCU, 1996).

A 'business case' for managing drug problems on release

A critical issue that the many studies in this area have failed to address is the scale, and cost, of the crime likely to be committed by problem drug users who re-offend following their release. This can serve to illustrate the *opportunity costs* that are lost if the chance is not taken to tackle drug misuse while offenders are in custody and thereby break the pattern of drug-related offending. Estimates of the costs incurred can also provide a powerful economic case for investing in drug treatment and rehabilitation services for offenders.

In considering the relationship between illicit drug use and acquisitive crime (such as burglary, theft and shoplifting), it is essential to distinguish between casual and problematic drug use (Hough, 1996). The vast majority of illicit drug users do not develop a career of problematic use and do not resort to crime to finance their drug taking. It has been estimated that for as many as 97 per cent of illicit drug users there is no convincing evidence of causal links between drug use and acquisitive crime (Edmunds *et al.*, 1998). However, in the case of the relatively small proportion of problematic users, there is ample evidence of a clear link: a growing body of research has established that for a large proportion of dependent drug users crime is a way of financing their addiction. For example, in a survey of young heroin users, Jarvis and Parker (1989) found that two-thirds of their respondents said that they committed acquisitive crime to fund their drug use. In a more recent survey of prisoners, Singleton *et al.* (*op. cit.*) found that the highest reported rates of drug dependence were found among men charged with burglary and women on remand

for theft; the rates being 70 per cent and 60 per cent respectively. Despite the existence of strong empirical evidence of a link between drug taking and acquisitive crime, the nature of the underlying causal sequence is a matter of some complexity. The link is neatly summed up by Edmunds *et al.* (*op. cit.*):

“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 crime” (1998: 10).

A first step in any economic calculation is to determine the opportunities for intervention. This figure should be based, not on the average population in custody², but on the numbers actually released from prison during a specified period. Prison statistics show that in 1998 some 76,981 *sentenced* prisoners were released from custody: this number consisting of 57,177 adult males, 4,155 adult females and 15,649 young male offenders (and a small number of young female offenders).

A second step is to separate the likely number of *problem* drug users from the much larger number of casual, or recreational, users. Defining problem drug use is not in itself straightforward, but a reasonably close alternative is to rely on the definition of ‘dependence’. Maden *et al.* (*op. cit.*) define dependence as “daily use, plus withdrawal symptoms, and an apparent acceptance by the prisoner that he or she has dependence”. Using these terms, they calculated that (in 1992) 11 per cent of male prisoners, 23 per cent of women prisoners, and 6 per cent of male young offenders were dependent.

Thirdly, when making this kind of calculation, an estimate has to be made as to how far prisoners sustain, or halt, their drug taking while in custody. Illicit drug use within prisons is well documented (as the studies cited above illustrate) and many prisoners, particularly those serving short sentences or held on remand, will have little incentive, or indeed opportunity, to undergo detoxification. However, many prisoners will be forced to break their habit, and others may be helped to do so. Applying the numbers released from prison in 1997/8 (above) and the dependency rate calculated by Maden *et al.* 1992, Table 1.1. presents three scenarios: one where there is no change in drug dependency on release or soon after, one where 20 per cent of released prisoners remain drug-free and one where 40 per cent of discharged inmates cease to be drug dependent.

Table 1.1: Estimates of the number of drug dependent sentenced prisoners likely to be released in England and Wales annually who may resume dependency.

Estimated dependency rates *	Total dependant no change effected	Total dependant 20% reduction in dependency	Total dependant 40% reduction in dependency
11% of released adult males	6,289	5,031	3,773
23% of released adult females	956	765	574
6% of released male young offenders	939	751	563
Total	8,184	6,547	4,910

* Estimates based on Maden *et al.* (1992)

2. This was 62,582 in England and Wales in 1997-98.

As the table illustrates, under these three scenarios the number of drug dependent prisoners likely to be released from prison each year ranges from just under 5,000 to more than 8,000. On the basis of these figures, and the well established view that many problem drug users need to resort to crime to finance their drug use, it is possible to calculate the incidence and associated costs of drug-related crime attributable to ex-prisoners.

In terms of offences, the recent National Treatment Outcome Research study found that 664 drug addicts were responsible for committing around 70,000 offences over a three-month period, while Edmunds et al. (1998) found that 80 addicts admitted to committing a total of 10,800 offences in one month. These two studies provide figures of 35 offences and 135 offences per offender per month, respectively. Taking a conservative estimate that an offender commits 50 offences per month to fund a drug habit, it can be extrapolated from the figures in Table 1.1 that the number of offences committed by drug dependent ex-prisoners would range from:

- 409,200 offences per month (or 4.9 million per annum), if none desisted from drug use: and
- 245,500 offences per month (or 2.9 million per annum), if 40 per cent managed to remain drug-free.

In terms of the associated costs, Edmunds et al. (1998) provide a summary of the weekly spends of problem drug users derived from seven different studies: the amounts range from £100 per week to £400 per week. They argue that £200 is a realistic figure. Applying this, and multiplying by a factor of 3 to reflect the fact that stolen goods are likely to be sold at a price well below their market value (a convention applied in the White Paper: 'Tackling Drugs Together' (HM Government, 1995), costs can be estimated as follows:

- If no drug dependent ex-prisoners desisted from drug use, £85 million would be required to fund their drug addiction each year. If this were raised by means of acquisitive crime the costs to the victims would be around £255 million pa.
- If 40 per cent of formerly drug dependent prisoners desisted from acquisitive crime, the figures would be £51 million to fund drug addiction and £153 million in terms of acquisitive crime.

These sizeable estimates of the costs of failing to tackle drug dependency amongst prisoners do not of course take into account the opportunity costs of tackling drug misuse amongst remand prisoners, too. Nor do they consider other substantial benefits, such as the decreased workload on the criminal justice system or the health service. While throughcare research is still in its infancy, evidence from a small-scale study in the US (Inciardi et al.1997) provides encouraging results suggesting that savings may be made as a result of throughcare provision. Prisoners who received treatment during sentence and on release were less likely to be re-arrested 18 months later than those who had only received treatment while in prison.

The policy response

The first national drug strategy for England and Wales was introduced by the White Paper entitled 'Tackling Drugs Together' (HM Government, 1995). The framework for the provision of drug services adopted in this initiative was grounded in a multi-agency approach. The importance of maintaining continuity of care by means of an integrated strategy was clearly evident when it was stated that the Prison Service, together with the Department of Health, should consider "the most effective way to ensure that drug misusers in prison have access to cost-effective and appropriate services during remand, when sentenced to custody and, if appropriate, after release" (HM Government, *op. cit.*).

The core principles and general philosophy of this policy response were clearly reflected in the first Prison Service drug strategy, entitled 'Drug Misuse in Prison', which was launched the same year (Prison Service, 1995). In essence, this strategy had three broad objectives regarding drugs in prison: controlling the supply of drugs, reducing the demand for drugs, and preventing the damage caused by drugs. Tighter security arrangements and improved surveillance techniques were introduced to reduce the amount of illegal drugs available in prison. Drug rehabilitation facilities and related support services were developed in order to reduce the demand for drugs. One of the underlying principles of the strategy was that the Prison Service made a commitment to liaise with community-based agencies, as part of the throughcare process, in order to ensure that there was continuity of care for prisoners on release.

The present study was commissioned at a time when the throughcare element of this strategy faced criticism. In 1998, a report by the All-Party Parliamentary Drugs Misuse Group described the throughcare and aftercare for drug misusers as "appalling" and commented on the "piecemeal" nature of existing arrangements. Reflecting the economic implications of this shortcoming, it stated categorically:

"Releasing drug offenders undergoing treatment, without appropriate after-care (which should include accommodation, training and employment) is not cost-effective" (Parliamentary All-Party Drugs Misuse Group, 1998).

But a number of significant policy developments were introduced at this time: three of which warrant special mention. First, in April 1998, the Government launched its new national ten-year strategy for drug misuse entitled 'Tackling Drugs to Build a Better Britain' (UKADCU, 1998). This was followed one month later by the launch of a revised Prison Service drug strategy, 'Tackling Drugs in Prison', in which it was announced that the Prison Service was to set up its own Drug Strategy Unit (DSU) to oversee the implementation of the new strategy (Prison Service, 1998). Finally, in August of the same year, the Prison Service announced that it had secured funding under the Comprehensive Spending Review to provide treatment and after-care for drug users in prison. Prison areas were invited to submit bids for new funding to deal with drug misuse under the CARAT (Counselling, Assessment, Referral, Advice, and Throughcare) service.

'Tackling Drugs to Build a Better Britain'

Building on the key themes contained in the 'Tackling Drugs Together' initiative, this new strategy on drug misuse presented its main aims as:

1. to help young people resist drug misuse in order to achieve their full potential in society
2. to protect communities from drug-related anti-social and criminal behaviour
3. to enable people with drug problems to overcome them and live healthy and crime-free lives,
and
4. to stifle the availability of drugs on the streets.

Furthermore, one of the action points of particular relevance to the Prison Service was to "ensure that the throughcare and aftercare arrangements for drug misusing prisoners are coherent, focused and linked to community provision".

The Guidance Notes that accompanied the new strategy placed considerable emphasis on the *pre-custody opportunities* that can be adopted to help offenders tackle their drug problems. At the same time it was acknowledged that evidence of the value of drug treatment services in prisons was "limited", largely due to

the fact that the schemes were in their infancy. However, reference was made in the notes of guidance to the evaluation of the first tranche of the pilot treatment programmes, commissioned by the Prison Service and conducted by PDM Consulting (1998). In summarising their findings, emphasis was laid on the value of *throughcare*, “*Emerging good practice is that programmes should be professionally run according to clear objectives and methodologies, be fully integrated into the running of the prison, and ensure that there is continuity and consistency in throughcare and the planning of the prisoner’s return to the community*”.

‘Tackling Drugs in Prisons’

The new Prison Service drug strategy, introduced in May 1998, outlined what the Prison Service intended to do to address each of the strategic aims set out in the new national strategy. The policy response was informed by the findings of: an internal review of the initial strategy, carried out by the Directorate of Health Care and the Directorate of Regimes; external evaluations of both prison-based drug treatment and rehabilitation services (PDM Consulting, *op. cit.*) and the mandatory drug testing programme (Edgar and O’Donnell, *op. cit.*: National Addiction Centre, 1997).

Several elements of the new strategy related to throughcare. Under the third aim of the Government’s national strategy the Prison Service undertook to “ensure that drug issues are effectively tackled in sentence planning and throughcare arrangements” and to “devise effective strategies to help short term and remand prisoners, and develop strategies to increase referrals to community based agencies”. In general terms the Prison Service expressed the wish to “work effectively with local communities to ensure that gains made in prison are not dissipated on release”. The responsibility for implementing the new strategy fell to the DSU, with Area Co-ordinators playing a key role in monitoring and promoting effective practice.

The CARAT service

Following the Comprehensive Spending Review decision to grant the Prison Service an additional £22.5 million to spend on drug services in 1999/2000 (and £25 million in each of the subsequent two years), the DSU announced its intention to set up a basic multi-disciplinary drug treatment service in each prison. It was further proposed that more specialist drug treatment services, such as enhanced detoxification services, rehabilitation programmes and therapeutic communities, would be provided on either a prison area or national basis.

The broad details of the new framework were first issued in August 1998, when prison areas, along with the Probation Service where appropriate, were invited to develop their initial bids. Funding for the new framework was, however, only made available from April 1999. In effect this timetable meant that CARAT was taking shape, but not in place, during the course of this study. The implications of this important service are however explored in the final section of this report.

Throughcare in principle: roles and responsibilities

While official acknowledgement of the problem of drug use within prisons has been a major step forward in addressing the issue, determining an appropriate response – and specifically which organisation or agency should do what – has been far from straightforward. Policy directives have been presented in a range of different documents, not all of which appear to have reached their intended targets. The most comprehensive summary of the overall framework comes in the form of a guidance note issued by the CDCU (now UKADCU)

– but prepared jointly by the Department of Health, HM Prison Service and the Home Office – in 1996 (CDCU, *op. cit.*). This was put together following a review of services for prisoners during their imprisonment and on release – which led to a “recognition of the importance of a clear statement of roles, responsibilities and resources in this complex area”.

In summary it took the line that:

While offenders are in custody and just prior to their release, the key responsibilities are that:

The Prison Service should:

- identify prisoners with drug problems
- provide effective drug services to meet these prisoners’ needs
- ensure that – prior to the release of any prisoner requiring drug services – the prison drugs co-ordinator passes information to the supervising Probation Service, and any other appropriate services, to establish suitable throughcare.

The Probation Service should:

- provide drug misusers with support while they are in custody, and liaise with their supervising Probation Service, and other services, about them
- on the release of those on licence, set in train suitable supervision and management – including access to drug services
- where possible also manage “other priority misusers” in the same manner.

It should be noted here that ‘*where the buck stops*’ on the arrangements for any necessary throughcare is not absolutely clear in every case. It is self-evident that, in the case of those released on licence, the duty rests with the Probation Service itself. In the case of other prisoners, the implication is that it is the duty of the prison to inform probation and other agencies, but that probation need only make arrangements “where possible”.

On the release of prisoners with drug problems, the roles and responsibilities are considerably widened to embrace many other organisations:

Health Authorities are expected to:

- assess whether those returning from prison need drug services, and
- purchase the services to meet those needs.

But, equally, local authorities are expected to:

- provide the support of social services in the shape of counselling, day-care and residential care
- liaise with housing and other internal departments .

And, naturally, both statutory and independent drug services are responsible for:

- delivering drug services to prisoners on their release.

Here, of course, part of the complexity is attributable to the necessary interplay between the purchasers (health, probation and local authorities in general) and the providers of drug services (funded drug agencies and social services³), and of course the independent drug agencies. The delivery of services is made more complex because prisoners with drug problems are competing with other drug users in the community for limited resources.

Last, but by no means least, the CDCU guidance places a responsibility for *cross-agency liaison and planning* on all the organisations mentioned. Thus health authorities are expected to liaise with prisons and probation to ensure continuity of service for those released; local authorities to deal with health and probation on the delivery of community care, and so forth. In this area the guidance places a strong emphasis on DATs taking a lead, particularly in:

- providing a “collective overview” of drug services for prisoners locally, and
- tasking specific agencies on their roles.

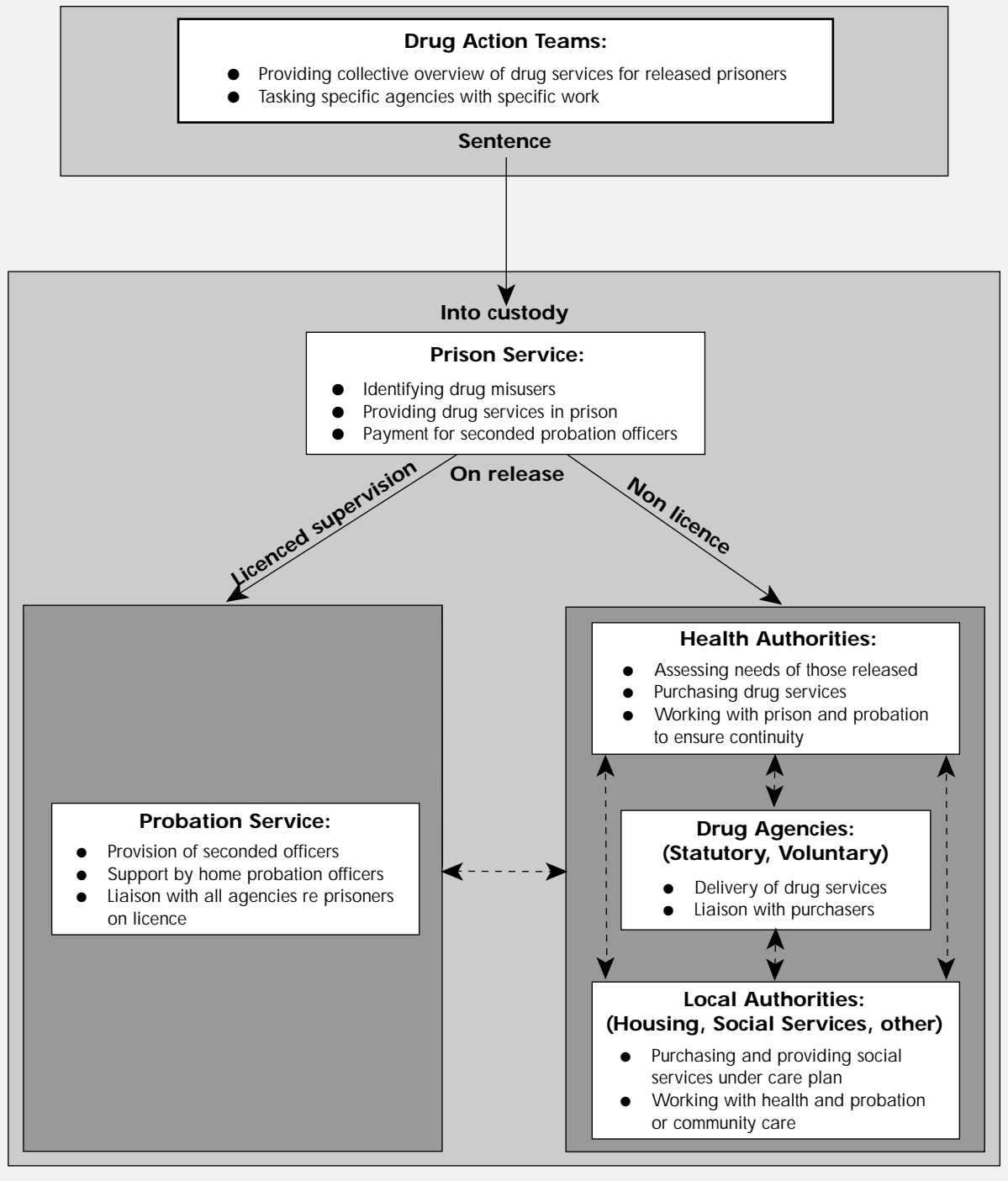
The complexity of interagency co-operation is shown graphically in Figure 1.1, which presents the primary roles and responsibilities of the six ‘agencies’ (some of which represent clusters of different organisations) which need to collaborate in the delivery of throughcare at the local level.

Structure of this report

The remainder of this report is split into three sections. Section 2 describes the research mechanisms adopted in this study. Section 3 focuses on the findings that have emerged from the various investigations conducted into policy and practice in this area. It includes illustrative examples of good practice (although the mention of one organisation or prison does not mean that the same or similar examples of good practice are absent in other prisons or organisations). Finally, Section 4 sets out the implications of the findings for the future development of effective throughcare.

3. Social Services have a duty to assess those with drug and alcohol problems but are only required to provide a service if this assessment defines the applicant as being in need. Therefore, if the LA criteria are set above or actively exclude ex-prisoners, then they will not be entitled to any funding or support.

Figure 1.1 *Key roles and responsibilities of delivering drugs throughcare for prisoners on their release*



As outlined in the previous section the joint aims of the study were to describe the nature of throughcare procedures for prisoners with drug misuse problems and to gauge the impact of interventions on offenders' behaviour following their release. To meet this remit, the study was conceived in terms of two broadly distinct strands: one descriptive and the other evaluative. From a descriptive perspective the objective was to identify how drugs-related throughcare prepares prisoners for release and what kind of help they receive on their return to the community. The purpose behind the evaluative focus was to gain an insight into the short-term impact of treatments and procedures on ex-prisoners' drug taking behaviour and criminal activity. A key feature of the overall research design was to 'track' a cohort of released prisoners for up to four months after their release.

The 'descriptive' strand

The institutional perspective

As part of the preliminary fieldwork the research team carried out interviews with the 'principal authorities' in the field of drugs throughcare. A number of individuals and organisations were approached. These included those prisons and probation services, identified by members of the project Steering Group and others as being 'advanced' in their throughcare procedures; drug services involved in delivering throughcare; and research organisations who had carried out tracking studies or similar work. A list of the primary agencies and individuals consulted is presented at Annex 1.

In consultation with the Steering Group, the research team identified 17 institutions (15 prisons and 2 young offender institutions) for the implementation of the tracking exercise. These were selected from the 63 establishments running drug treatment pilot schemes by applying six key criteria. These were that the sample as a whole should:

- include prisons with different types of programmes drawn from the drug pilot programme
- represent a cross-section of the prison estate by incorporating a range of different types of prison such as male (local); male (training); male (dispersal); female (training or open) and young offender institutions⁴
- contain establishments with recognised high standards of sentence planning⁵
- comprise institutions where there is some evidence of a partnership between the prison and community-based drugs agencies
- include pilot programmes run by a cross-section of different drug services ('spreading the net' in this way was intended to yield a wide variety of working arrangements from which examples of good practice could be drawn)
- represent broad geographic clusters (so as to maximise the ability of the research team to retain a 'hands on' relationship with those responsible for local data collection).

4. It should be noted that no male open prisons operate drug pilot programmes.

5. Data on this issue was provided by the Prisons Service Standards Audit.

A broad description of the prisons selected is presented in the Table 2.1 below.

Prison	Type	Drug programme	Input from:
Askham Grange	F(O)	<ul style="list-style-type: none"> – One-to-one counselling and throughcare – Sessional drug worker – Detox facility – Relapse prevention course (3 – 4 per year) – Peer education programme (6 weeks, 2 hours per week) 	SARU
Bristol	M(L)	<ul style="list-style-type: none"> – Detoxification unit with 12 beds – Post detox two week programme of 30 sessions – One-to-one counselling – 12-step residential relapse unit (four weeks – 48 sessions) – Voluntary testing unit (92 beds) 	In-house + input from Bristol Drugs Project
Channings Wood	M(CT)	<ul style="list-style-type: none"> – Therapeutic community with 84 beds (12 month programme in three stages) – One-to-one counselling provided by other outside agencies 	Addaction
Deerbolt	YOI	<ul style="list-style-type: none"> – Substance misuse worker providing education, counselling and rehabilitative support – One and two day substance misuse group 	In-house
Elmley	M(L)	<ul style="list-style-type: none"> – Detox facilities – Drug dependency programme – Self support community (six month intensive groupwork programme) 	Cranstoun
Full Sutton	M (CT)(dis)	<ul style="list-style-type: none"> – In-patient detox programme – Community-linked education, counselling and throughcare – Sessional drug worker – Drug awareness groups (six per year) 	SARU
Haverigg	M(CT)	<ul style="list-style-type: none"> – One-to-one counselling – Intensive four-week programme addressing substance misuse and drug-related offending – Voluntary drug testing unit (for 80 inmates) 	in-house
Holloway	F(L)	<ul style="list-style-type: none"> – Detoxification unit (with 33 beds) – Short term rehabilitation unit (with 33 beds, running six week intensive programme) 	Cranstoun

Holme House	M(L)	<ul style="list-style-type: none"> - Intensive therapeutic community with 65 beds (average stay 9 months) - Detox unit - One-to-one counselling - Training for prison staff 	Phoenix House		
Leeds	M(L)	<ul style="list-style-type: none"> - Five drugs workers providing counselling - Relapse prevention group (meets once a month) 	SARU		
Norwich	M(L)(CT) RP YO	<ul style="list-style-type: none"> - Relapse prevention therapy unit 12-step programme (accommodation for 19 inmates, minimum length of stay 16 weeks) - Detox facilities - Two voluntary testing units (for 96 adults and 26 young offenders) - Individual counselling provided by three community-based drug agencies 	RAPt		
Portland	YOI	<ul style="list-style-type: none"> - Therapeutic community (with 72 beds, 12 month programme covering anger management, victim awareness and chemical dependency) 	In-house		
Rochester	M(L) RP YO	<ul style="list-style-type: none"> - Detox facilities - One-to-one counselling - Education courses in drug awareness - Harm minimisation courses 	Thames Gateway NHS Trust		
Swaleside	M(CT)	<ul style="list-style-type: none"> - Drug rehabilitation unit running a six month cognitive behaviour programme) - Voluntary testing unit 	Addaction		
Wandsworth	M(L)	<ul style="list-style-type: none"> - Detox facilities - 12-step programme (16 bed unit, three month programme) 	RAPt and In-house		
Wealstun	M(CT)	<ul style="list-style-type: none"> - Detox facilities - Eight week intensive drug course catering for 150 inmates per year) - Voluntary testing unit (33 beds) - Drugs workers provide counselling 	SARU		
Wymott	M(CT)	<ul style="list-style-type: none"> - An external drug worker is in the prison two days a week to provide counselling and rehabilitation support - An inmate-led drug support group meets once a month - A six week modular drug-related offending behaviour course 	Lifeline		
Key:					
M(L)	male local	M(CT)	male closed training	F(L)	female local
F(O)	female open	RP	remand prisoners	YO	young offenders
YOI	young offender institution	Dis	dispersal prison		

As well as visiting these institutions to set up the tracking mechanisms, members of the research team also interviewed members of staff involved in the delivery of throughcare services and drug treatment programmes. In addition, a self-completion questionnaire was compiled and given to those professionals it was not possible to interview because of their busy work schedules and patterns of working. Interviews and questionnaires covered a range of issues concerning the role played by the major statutory and non-statutory agencies (specifically, the Prison Service, Probation Service, drug agencies, social services, health authorities and DATs) in delivering throughcare. Respondents were also invited to identify what they considered to be good practice on the part of the different agencies.

In total nearly 100 professionals and policy makers were interviewed and a further 22 questionnaires were completed.

The offender perspective

In order to complement the 'institutional' perspective, focus groups and interviews were held with inmates who had experience of drugs-related throughcare from a previous custodial sentence. Focus groups of between 6 and 10 inmates were held in 7 of the 17 institutions participating in the study: Bristol, Channings Wood, Holloway, Leeds, Norwich, Portland and Wymott. Individual interviews were held with four inmates in Full Sutton. A focus group was also held with participants of the North Street Project – a new structured day programme aimed (principally) at offenders with drug misuse problems run by SARO in Brighton. The purpose of the exercise was to explore inmates' views about access to drug services within the prisons where they had been incarcerated, identify what preparations had been made for their release and discover if their return to prison was in any way connected with their continued misuse of drugs. The focus groups and interviews also provided an opportunity to discuss the problems faced by prisoners with a history of drug misuse when they are released into the community.

Responses to the tracking questionnaires were also used to obtain offenders' perspectives on throughcare practices and procedures. The tracking exercise was a central element in the evaluative strand of the study.

The 'evaluative' strand

Developing the tracking instruments

The tracking of a cohort of prisoners following their release from prison formed the main component of the present study. In order to inform the shape and content of the tracking exercise a review of research studies that have attempted tracking drug users in the community was undertaken. Clearly, tracking individuals who have had any contact with the criminal justice system represents a major challenge. Previous experience shows that, despite the apparent readiness of subjects to participate in the early stages, few tracking exercises seem to have been able to contact more than a third of those in their initial sample at a later date (Inspectorate of Probation, 1997; Edmunds et al. 1998; Mitchell and McCarthy, 1998). Some of the difficulties involved in tracking prisoners on their release from custody were graphically illustrated in a recent study of those released from Pentonville and Holloway prisons, where only 9 of the 27 subjects were able to be located and interviewed (Mitchell and McCarthy, *op. cit.*). Other studies of this type are, however, underway in particular a follow up by The Institute for the Study of Drug Dependence (ISTD) of offenders who have attended RAPT programmes.

A number of steps were taken in response to the predicted high sample attrition rate.

First, it was decided to select a reasonably large initial sample of prisoners, so as to increase the likelihood of securing a significant number of prisoners who would continue to participate in the study following their release. While the primary objective was to follow-up a group of released prisoners over a three to four month period, a secondary aim was to provide information on this group so as to enable the Home Office Research, Development and Statistics Directorate to conduct a reconviction study at a later date. Second, incentive payments were offered to those who agreed to take part in the study. Respondents were required to complete one questionnaire shortly before their release from prison and a second questionnaire three to four months later. On completion of the second questionnaire they received a fee of £20. Third, prisoners were asked to complete a written consent form as part of the first questionnaire, so as to overcome any problems concerning confidentiality that might arise when members of the research team contacted field probation officers and drug agency staff as part of the follow-up exercise. Fourth, at the time of completing the first questionnaire, inmates were asked to provide up to four addresses where they could be contacted following their release from prison. Finally, for those respondents who were on licence, a copy of the follow up questionnaire was also sent to the supervising probation officer with a request that it be handed on to the client.

The first questionnaire was designed to cover a number of issues including self-reported drug use prior to imprisonment, the type of drug treatment received while in prison and the help given within prison with regard to obtaining treatment or support in the community. Respondents were asked to give details of their drug use in the 30 days prior to imprisonment. This required them to name the drug(s) taken during this period, provide an estimate of how much money they spent on drugs in a typical week and state how they raised the money to pay for the drugs.

The second questionnaire, which was sent out approximately four months after the prisoner's discharge date, was designed to elicit information about drug use both before and after release from prison. There were also questions dealing with employment status, living arrangements, the type of community drug services used since leaving prison and involvement in criminal activity. For those released on licence there were questions about contact with supervising probation officers and the arrangements made for drugs throughcare.

In the case of ex-prisoners released on licence, a separate survey questionnaire was sent to the supervising probation officer. This was designed to collect information about the nature and amount of contact the probation officer had with the client, the extent to which the probation officer had been involved in arranging access to community-based drug services and the response of the client to treatment.

Another survey questionnaire was also sent to any drug agency which prisoners mentioned they had an appointment with on release from custody, or which they stated they would contact if in need of help. This short follow-up questionnaire was designed primarily to ascertain whether the appointment was kept; if there was any contact with the agency; what treatment, if any, was provided and what contact the agency had had with the prison.

Implementation of the tracking mechanism

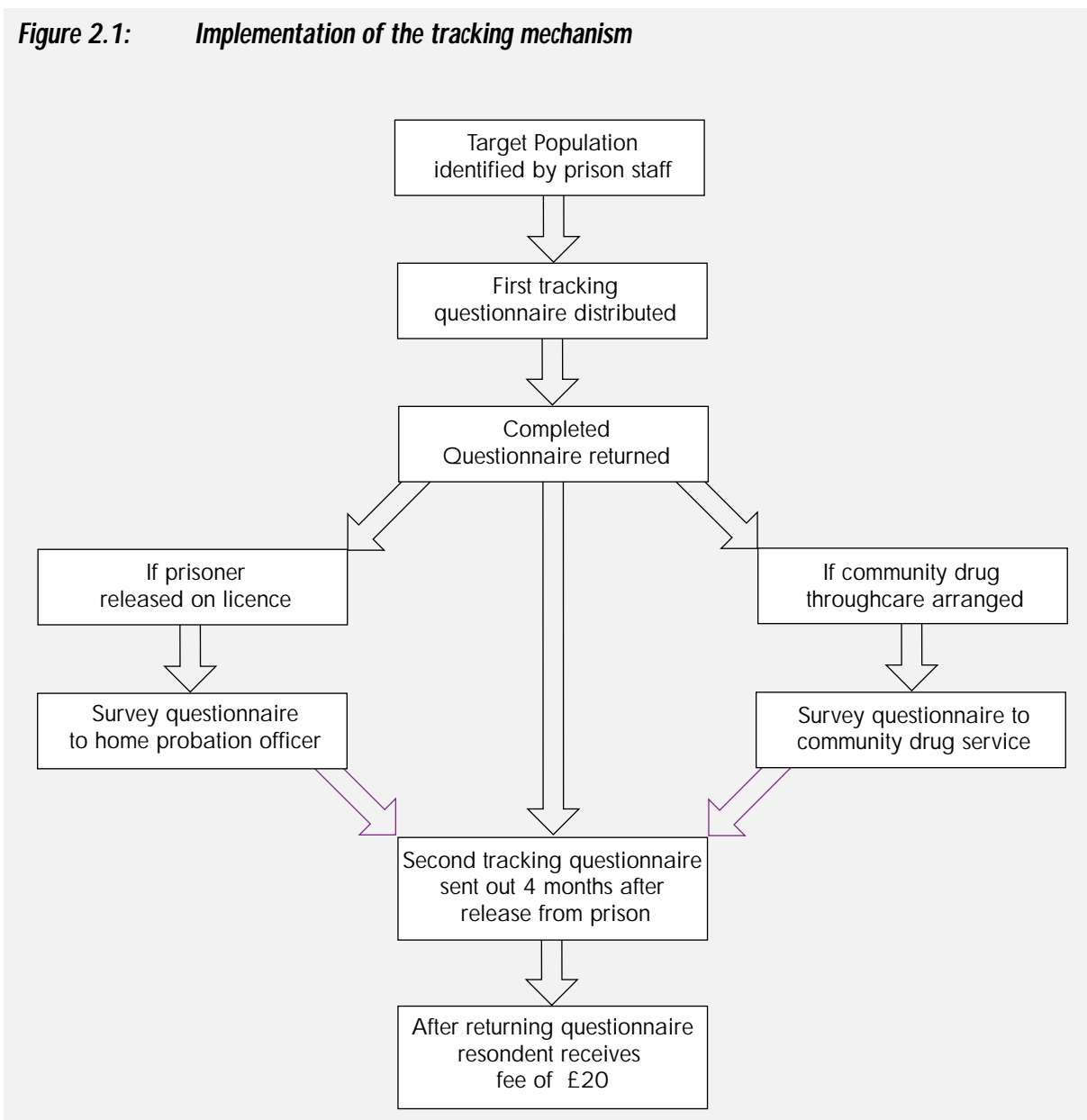
Initially one or two difficulties were experienced in eliciting responses from some of the 17 targeted institutions, but eventually all those approached agreed to participate in the study. By mid-September 1998 the research team had visited all the establishments, to explain the study in more detail, meet staff engaged in drugs work and throughcare, discuss the implementation of the tracking mechanism and enlist the co-operation of key staff. The support of prison staff was vital in identifying inmates who had received treatment for a drug misuse problem during the course of their current sentence and who were due to be released

during the four month period from October 1998 to January 1999. Each inmate identified in this way was handed a letter that described the study and invited him or her to take part by completing a questionnaire prior to being discharged.

Arrangements for identifying inmates in the target group and distributing the questionnaires varied between institutions. For example, in one institution the whole process was co-ordinated by a member of the throughcare team, while in another establishment the task was undertaken by drug caseworkers. Once the tracking mechanism had been established, the mechanics of the process ran reasonably smoothly. The only exception was in one prison where a number of issues relating to data protection and subject confidentiality were raised. This resulted in progress with the implementation of the tracking exercise being delayed until these matters had been resolved.

The principal components of the tracking mechanism are shown in Figure 2.1.

Figure 2.1: Implementation of the tracking mechanism



Given that the Prison Service do not hold central statistics on the number of prisoners who have received drug treatment while in prison, it was difficult at the outset of the study to arrive at a realistic estimate of how many potential subjects would be identified. However, it was hoped to achieve a target of 400 prisoners. In the event, a total of 179 first tracking questionnaires were returned. These were unevenly distributed across the 17 participating institutions, as shown in Annex 2. For example, over three-quarters of the questionnaires were generated from three establishments: a female prison (Holloway), a male prison (Haverigg) and a male young offender institution (Deerbolt).

Explanations as to why the first phase of the tracking exercise failed to produce a higher return are wide ranging. First, some large drug treatment programmes tend to only deal with long-term prisoners, so that few are released in a limited time period. Second, in some cases the number of potential subjects was reduced as one or more tested positive for drugs and had to quit the programme (in one instance over half of the prisoners on a large programme were lost in this way). Third, after the introductory visits by the research team, several prisons delegated duties to more junior staff, who then needed to be visited again to be personally briefed about the nature of the tracking exercise and its implementation. Fourth, the redeployment of staff within prisons and transfers of staff to other establishments meant the loss of continuity, with local co-ordinators/contacts unable to meet their original commitments to support the study. Finally, despite initial agreement at Governor level, staff at some prisons were not as co-operative as they could have been.

The sample

The tracking procedures implemented produced an initial sample of 179 prisoners who completed and returned the first questionnaire. Of these, 170 agreed to complete a follow up questionnaire four months after release and 112 subsequently did so, giving a response rate of 66 per cent for those who agreed to participate further (and 63% of those who completed the first questionnaire). This compares very favourably with previous attempts at tracking drug misusers, which, as reported above, achieved response rates of around 30 per cent.

In relation to those prisoners on licence, a total of 114 survey questionnaires were sent out for probation officers to complete. Some 29 were returned: a response rate of 25 per cent. Of the 37 questionnaires sent to drug services, 14 were returned: a response rate of 38 per cent.

The nature of the sample and the way it was chosen places limitations on the generalisations that can be made from the responses. The sample is not representative of the prison population, nor was it intended to be. Thus it cannot provide reliable estimates of the proportion of prisoners who misuse drugs or who take drugs in prison. The sample was chosen to include only those prisoners who had been identified, or who had identified themselves, as having a drug problem and had received some form of treatment whilst in prison.

Of the 179 who completed the first questionnaire, 113 were men and 66 women. Thus women were over represented in this study compared with their representation in the prison population. The women tended to be older; one half of the women were over 30 compared with one third of the men.

Generally, men were serving much longer sentences than women. Around 30 per cent of the men were serving sentences of three years or more; about half two years or more. More importantly, 86 per cent were serving sentences of 12 months or more and were released on licence. Unfortunately, about one half of the women did not record the length of their sentence, but of those that did, a little over three quarters were in prison for sentences of less than one year (and many of these for much shorter periods). Thus in contrast with the men, many women were not released on licence.

Most of the prisoners in the sample had serious drugs problems: 66 per cent said that in the 30 days prior to going into prison they had been taking heroin every day and one half of them were also taking crack daily. However, it is evident that most of the sample were polydrug users, and about one half said they took cannabis every day too. Alcohol was included in the list of drugs and a third reported consuming alcohol every day.

Prisoners were also asked to state what they regarded as their 'main drug'. Some gave more than one response (further indicating the extent of their polydrug use) but heroin was the drug most often cited (63%) with crack (18%) and cannabis (16%) a long way behind in second and third place.

Prisoners spent considerable sums of money in support of their habit. In a typical week the average spent was £550⁶. Half the sample said they spent more than £300 a week on drugs. Legitimate income (wages and benefits) was being spent on drugs and a third of respondents had resorted to selling their own possessions. However, illegal methods of raising money were also adopted. Four out of five said that they committed crimes of theft, a third said they had dealt in drugs.

Examination of the characteristics of respondents indicated that women and younger people were slightly less likely to complete the follow up questionnaire. Of perhaps more importance, a lower proportion of those who had reported in the first questionnaire that their main drug prior to being imprisoned was cocaine or crack completed the second questionnaire. This had a bearing on the amount spent on drugs as crack users in particular recorded an average weekly spend of twice that for the sample as a whole. On the other hand, two-thirds of the heroin users completed the follow up questionnaire - the same response rate as for the entire sample.

6. This figure is higher than that found in other studies quoted in Section 1. In this study it appeared that some prisoners were giving amounts spent to support their partner's habit as well as their own.

3.

Throughcare in practice

This section provides a commentary on the treatment and support offered to prisoners with drug problems 'in practice'. It draws on interviews with policy-makers, service providers and practitioners⁷; observations drawn from the many prisons and drug programmes visited, and the points raised during the focus group discussions with prisoners. It also presents – at various points – the findings derived from the tracking exercise of prisoners (outlined in Section 2).

The complex set of roles and responsibilities falling to different agencies in delivering throughcare was set out in Section 1. To separate the many overlapping issues, this account seeks to examine these different functions, and give some commentary on them, *in broad chronological order* – in other words, 'as they arise'. It also separates – in italics – many examples of good practice.

Practice: action within prisons

Practices within prisons can best be addressed by distinguishing between action taken during the early to middle part of a term of imprisonment (which includes the approach to drug misuse taken by different institutions) and action taken in the weeks immediately prior to release.

Early to mid sentence

The key issues arising during this stage of a sentence were identified as follows:

Drugs strategies within prisons and institutional commitment

The nature and content of treatment practice for problem drug users vary between penal institutions. To some extent this is because local drug strategies are designed to meet local needs. However, these local strategies also reflect the inter-disciplinary approach to caring for drug misusers pursued by the Prison Service from the early 1990s (Prison Service, 1992).

Individual prisons now have Drug Strategy Teams (DSTs) responsible for developing and monitoring local programmes and initiatives. The composition of these groups varies between establishments, but by and large they include representatives from the main departments or operational groupings including Throughcare, Healthcare, Security, Psychology and Education. Where prisons have outside agencies delivering in-prison drug programmes, representatives of these agencies too are members of the DST. In some cases DSTs develop partnerships with external agencies and liaise with voluntary organisations providing community-based support services. A number of the prisons in the current study also had representatives on Drug Action Teams (DATs) and Drug Reference Groups (DRGs). For example, the governor of HMP Haverigg was a member of Cumbria DAT and the prison was represented on two local DRGs.

All the prisons visited by the research team had in place both a DST and a prison-wide drug strategy, the latter being clearly informed by the twin objectives of controlling the supply of, and reducing the demand for, drugs.

7. Including the questionnaires completed by professionals.

A strong commitment to drugs issues by prison management is of course critical in determining the priority attached to treatment. One way of ensuring commitment at the top is for Governors to include treatment programmes in their annual plans agreed with Area Managers. Prioritisation and commitment are also important in facilitating joint working arrangements, specialist training and the ability of dedicated staff to pursue appropriate action.

The identification of prisoners with drugs problems

Treatment can only be offered once drug misusers have been identified and their needs properly assessed. Identification of drug problems early in a prisoner's sentence will permit rapid intervention, and will increase the chances of the prisoner being able to take up the drug treatment opportunities available. Alternatively it provides sufficient time in which to secure a transfer to another establishment that has a structured programme to meet the specific needs of the inmate (time can sometimes be of the essence, given the duration of some programmes and the length of waiting lists). Thus, administrative mechanisms and practices that encourage detection at an early stage are important.

Prisoners with drug problems can be identified by a variety of means. Pre-sentence reports represent one key mechanism. Induction staff at HMYOI Deerbolt routinely scrutinised all the records of new inmates for evidence of drug misuse. Self-disclosure is, however, the primary means of identification. Prisoners have an opportunity to disclose details of any drug problems when they are interviewed by healthcare staff on reception. Most of the establishments visited by the research team ran induction courses for new inmates: these lasted from between 3 to 14 days and included sessions on drug awareness.

Another opportunity for self-disclosure occurs at the initial assessment stage of the sentencing planning process (dealt with below). An integral part of this process involves a personal officer collecting and collating information on individual inmates for the purpose of identifying needs and setting targets. The apparent emphasis placed on encouraging voluntary help-seeking has been described as a "cornerstone" of the overall drugs strategy adopted by the Prison Service (Joyce, 1996). However, evidence from the focus groups suggests that self-disclosure is not something that inmates feel comfortable with. Prisoners expressed a general reluctance to volunteer information about their drug misuse for fear of being targeted by staff in some way: by, for example, increased surveillance, more frequent cell searches or having their visitors subjected to more rigorous searching.

Mandatory drug testing (MDT)

From the point of view of the Prison Service's drug strategy, the MDT programme functions not only to control drug use (by acting as a deterrent), but also has a potentially supportive role to play: it detects problem drug users, who can then be directed to an appropriate treatment regime. Official policy states that all prisoners who test positive should be offered suitable help and advice, and be encouraged to accept treatment⁸. This dual role was not however recognised by the majority of prisoners in the present study. Data from the focus groups and individual interviews revealed that, in the main, the MDT programme was perceived in terms of control and punishment. Some prisoners claimed that many inmates were reluctant to discuss their drug problems with staff for fear of being subjected to a drug test at some later date on grounds of 'reasonable suspicion'. Similar opinions were expressed by inmates in a recent evaluation of MDT (Edgar and O'Donnell, 1998).

8. Although the policy guidelines stipulate that prisoners who fail drug tests should not be coerced into seeking and accepting treatment for drug misuse.

Offenders' motivation and staff attitudes

An offender's 'readiness to change' is likely to be a key determinant in the success of any intervention, either inside prison or in the community⁹. For the most severe users, the imposition of a term of imprisonment forces a massive reduction in their drug use – which can only be partly replaced by illegal usage within the prison. This was borne out by responses to the questionnaire¹⁰. Aside from those being prescribed methadone or tranquillisers, three-quarters said that they had taken drugs illegally while in prison; mainly heroin (53% of respondents) and cannabis (55% of respondents). Drug consumption was, however, 'less than weekly' which is a sharp contrast to most users' practices before imprisonment (when most admitted taking drugs daily).

However, in the words of one prisoner, this enforced reduction is not a solution in itself: "you don't stop, the prison stops you".

The HMP Elmley Signpost Unit targets persistent users and dealers. Residence on this unit is compulsory and inmates are selected following consistent MDT failures for hard drugs, evidence of being involved in drug dealing networks or by other security intelligence. To get off the unit, inmates have to satisfy staff that they have developed sufficient motivation to change. Groupwork provided by Cranstoun is aimed at developing and consolidating that motivation. Interestingly, in terms of the general conflict between treatment and security, this initiative has been introduced as part of the strategy to reduce the availability of drugs within Elmley.

Research evidence suggests that there is a prevalent belief among inmates that certain drugs have a calming effect and provide a way of coping with the boredom of life inside prison (Keene, et al. 1992). This was echoed in the focus groups and individual interviews with inmates. Mention was also made of the temptation to turn to drugs following the worry and anxiety caused when bad news was received from home.

It is important that when prisoners do request help they receive support as soon as possible - or a valuable opportunity to begin rehabilitation can be lost. Unfortunately, in some of the prisons visited by the research team, waiting lists for courses were commonplace and staff admitted that sometimes inmates would be released before a suitable place could be found for them.

Staff attitudes can play a crucial role in enabling inmates to recognise problems and seek help. A number of inmates referred to the negative attitude of some prison officers towards drug misusers and their attempts to seek help. They felt that some members of staff questioned the motives behind their help-seeking behaviour, conveying the impression that they considered it to be prompted by a desire to find ways of breaking the routine of prison life rather than a genuine attempt to address an addiction problem. The prevalence of such attitudes was not of course empirically investigated in the present study, but it would be surprising if suspicions of the motivation of drug users were not widespread: prisons have been increasingly forced into dealing with drug use, and it is not part of the traditional responsibilities of the prison officer. However, if prisoners feel that such attitudes are prevalent then it is likely to curb voluntary attempts to seek help.

Sentence planning

Sentence planning represents the formalised and systematic procedure for identifying prisoners' problems and needs, and for addressing them. It is "the mechanism through which the Prison Service and the supervising

9. While the offenders' willingness to seek help is hugely advantageous, there is however emerging evidence that some treatments can be effective even if administered to clients who are coerced into participation (Hough, 1996).
10. Information on drug taking in prison was sought on the second, follow up, questionnaire completed after the prisoner had been released - as it was felt that prisoners would not provide truthful answers to questions put to them while still in prison.

services deliver throughcare" (Prison Service, 1997, para 2.1). As "the focus for all work and interventions"(ibid.), it constitutes an opportunity for integrating drug rehabilitation work into the general framework of sentence management.

The process begins with the initial categorisation of the offender following sentence. This is followed by an initial assessment, which is conducted by the prisoner's personal officer in consultation with the seconded probation officer. A key element is a risk assessment, which covers not only the likelihood of re-offending but also the risk of substance abuse. Prisoners who are identified at this early stage as having drug misuse problems can be directed to appropriate treatment and support services.

HMP Wymott offer a six-week modular drug-related offender behaviour programme for prisoners identified by sentence plans as having committed crime to support a drug habit, offended while under the influence of drugs or been sentenced for supplying drugs.

The idea of a 'seamless sentence' is at the heart of sentence management. To this end, individual sentence plans are reviewed at periodic intervals to see if targets have been achieved and any new needs identified. A fundamental aim of the process is to establish continuity of decision making, especially when prisoners are transferred from one establishment to another and also when they are released into the community on licence.

A number of the prisons visited claimed that sentence management was an important element in their overall drug strategy. A number, too, claimed that details of MDT failures were routinely passed on to the sentence planning team and used in the setting of targets. Where specialist drug workers were employed they made a significant contribution to the sentence planning process.

Drug workers at HMP Leeds undertake initial assessments, draw up individual care plans and then pass the information to the unit responsible for sentence planning. At HMP Full Sutton, drug workers routinely provide the sentence management team with reports on their clients for the purposes of sentence planning. At HMP Channings Wood progress on the 12 month programme in their Therapeutic Community is regularly reported and integrated with sentence management and throughcare.

But while the various professionals interviewed expressed the view that sentencing planning was, in theory, a potentially valuable mechanism, nearly all considered it to have shortcomings. The principal criticisms were:

- sentence planning does not apply to all prisoners: adults serving sentences of less than 12 months, and young offenders with less than four weeks to serve after conviction, are excluded
- to be successful, the process requires the free and easy exchange of information between professionals. But prison staff claim that in many cases information they receive from documents such as pre-sentence reports is often of a poor quality. Furthermore, it is alleged that some groups that could make a valuable input into the development of individual plans, in particular healthcare staff, are reluctant to do so because of issues of confidentiality. Consequently, there are gaps in information that effectively undermine the validity of the whole process. Some probation staff felt that priority given to sentence planning (and throughcare) was dependent upon the 'whim of individual governors'
- for their part, many drug workers maintain that the lack of specialist knowledge of drug misuse by members of sentence planning teams led to unrealistic and inappropriate targets being set for prisoners with drug problems

- many maintain that when prisoners are transferred from one establishment to another, for reasons other than gaining access to drugs treatment, the implementation of the sentence plan is interrupted.

Prisoners also expressed negative views about the benefits of sentence management, with few feeling that it had been helpful. Some reported that they had had discussions early in their sentence but subsequent reviews had not taken place. In one focus group (comprising inmates serving sentences of less than four years), two claimed that they had not had a review in the past 18 months and one claimed not to have had a review for at least two years. Of those who had recent experience of a review, a number claimed that no specific targets had been set or that the targets were too broad – as in ‘attend a course’ or ‘go to a drug-free wing’. One told of prisoners being penalised for not reaching their objectives, which had included attending a drugs course although such a course was not available in the prison! One female prisoner, keen to address her drug misuse, claimed that she had been directed towards a landscape gardening course instead. Several inmates emphasised that if sentence plans were inadequate then there was little useful information to pass on to outside agencies who might assist the prisoner on release.

Where drugs workers were able to provide information to sentence planning teams about the specific needs of individual inmates, this enabled relevant targets to be set. However, if these targets involved access to specific drug programmes in other establishments prisoners might have to wait a long time before securing a transfer. A number of prisoners expressed frustration that they had gained a place on a programme in a particular prison, but were later informed that their transfer had been turned down on the grounds that they were unsuitable for the regime at the prison.

Availability of services and continuity of treatment

There is uneven provision of drug services throughout the prison estate, both in terms of the type of programmes offered and the number of places available. Critically, many prisons do not have proper detoxification facilities. Moreover the focus of all programmes within prisons is on abstinence from drugs – and not on harm reduction (not surprisingly, because the latter approach might be interpreted as condoning usage). While most accept it will be difficult to shift this emphasis, some commentators raised the telling point that – for remand prisoners – advice on safety might be the best help that could be offered especially as there was a great deal of ignorance about risks amongst the young remand population.

Inmates reported that the treatment actually received was not determined so much by the needs of the individual as by what was available within the prison to which they had been allocated. While it is possible to request a transfer to another prison with specialist services, this procedure was seen by prisoners and drug workers alike as slow and cumbersome. Where prisoners are transferred for reasons other than to gain access to drug programmes, their treatment regime can be adversely affected – especially given the variations in prescribing practices between prisons. For example, some prisons prescribe and others do not. Thus, a transfer can have radical implications, such as the sudden curtailment of a methadone maintenance programme and its replacement by enforced abstinence. The lack of consistency of treatment between prisons was commented on in a recent review of drug treatment services in England (Department of Health, 1996).

Continuity of treatment is not only an issue when prisoners are transferred between establishments. Within a single prison inmates who have undergone treatment in a rehabilitation unit or therapeutic community need after-care and monitoring following their discharge into the mainstream of the prison. Ideally such prisoners are best accommodated on drug-free wings or in voluntary testing units: such accommodation is, however, not always available or truly drug free.

Treatment received by the prisoners tracked

The prisoners under review had received a variety of different treatments during the course of the sentence that they were currently serving. The principal motivation for seeking treatment included wanting to stop taking drugs altogether (a view held by 44%). But 23 per cent wanted to continue to use drugs while keeping their drug use under control and a further 20 per cent wanted to reduce the harm that they could cause themselves and those close to them. The remaining 13 per cent gave a variety of other reasons or simply did not give a specific reason for seeking treatment.

The kind of treatment prisoners had received, and whether they thought it had helped them, is given in Table 3.1.

Table 3.1. Cohort of prisoners in the tracking exercise: treatment received and their assessment of its value

Type of treatment	Percent receiving treatment	Percent stating the treatment had helped 'a great deal'	Percent stating the treatment had helped 'a little'	Percent stating that the treatment had 'not helped at all'
Methadone maintenance	12	33	43	10
Methadone detoxification	35	31	50	13
Prescribed other drugs	35	39	48	10
Therapeutic community	8	87	13	0
Drug free counselling	34	55	35	8
Relapse prevention	21	66	29	5
Residential rehabilitation	13	67	29	4
Self-help group	20	49	37	11
Other	27	45	47	8

n=179 prisoners taking part in the initial tracking questionnaire. Many prisoners received more than one type of treatment.

The study was designed to include establishments offering a wide variety of treatment programmes and to sample prisoners who had been on those programmes; thus it is not surprising to find the widespread use of different treatments. Of more significance is the extent to which prisoners had found the treatment helpful. The vast majority stated that they had found their treatment had helped 'a great deal' or 'a little', particularly those who had undertaken a longer term programme such as therapeutic community (although caution in drawing too firm conclusions should be exercised given the small numbers receiving this form of treatment).

In response to an open-ended question about the perceived benefits, most mentioned the psychological payback – in increasing their self-esteem and re-evaluating their lives; others highlighted the physical benefits they derived and a few widened the focus to say how programmes helped them realise the consequences of their behaviour on others. Prisoners taking part in the tracking exercise were also asked what other help they would have liked, but which was not provided in the treatment programme attended. The most common response (mentioned by 35 subjects) was counselling support. This issue was raised in particular by women prisoners held in Holloway. Others mentioned the need for better drug withdrawal programmes and the need for practical help on their release.

Recording treatment history

If throughcare is to be effective then it is essential that information relating to the needs of individuals, as well as details of their participation in drug programmes, are recorded in such a way as to follow the prisoner as he or she progresses through the system. Such a flow of information is essential to maintaining the continuum of care. There is evidence that some prisons record sentence planning targets on LIDS (Local Inmate Database System), but this was far from common practice.

The Throughcare Office at HMP Preston records, as part of the drug referral system, the following information on LIDS about individual inmates:

- *if they have been referred and are awaiting assessment*
- *if they are on a waiting list for a drug awareness course*
- *if they have requested voluntary drug testing*
- *if a drug awareness course has been completed*
- *if they are continuing work with a keyworker.*

Drug misuse problems are also addressed as part of the sentence planning process at HMP Wymott, with sentence planning targets recorded on LIDS.

Prisons in Kent have put in place a 'Transfer of Information Document', which records details of a prisoner's identified needs, relevant interventions and the progress the prisoner has made. With the prisoner's consent this document moves with the prisoner within the prison, from one prison to another and sometimes to field probation officers and outside drug services. If it is not known where, or when, an inmate will end up, the document is sealed, put into the medical record and addressed to the drug worker at any 'receiving' prison.

Time available during sentence

Some structured treatment and rehabilitation programmes require inmates to undergo a period of screening and assessment prior to being accepted. Furthermore, programmes vary in their length and intensity. Consequently, selection procedures generally favour sentenced prisoners serving medium to long-term sentences. For remand prisoners and those serving short sentences there is a limit to what can be achieved during their stay in prison. For example, at HMP Holloway the average length of stay is 28 days. In the case of short-stay inmates, priority tends to be given to diagnosing the nature and extent of the drug misuse problem and setting up the means for dealing with it once the inmate is discharged into the community.

Multi-disciplinary working within prisons

The issue of joint working was raised by representatives from all professional groups interviewed during the course of field visits. While a multi-disciplinary approach was endorsed as a key element in providing effective drugs throughcare, the problematic nature of establishing such working practices in a prison environment was widely recognised. For example, there were instances cited of healthcare staff not passing on information about the drug-related problems experienced by individual prisoners, on the grounds that this constituted a breach of confidentiality. Liaison between professionals was also an issue, especially where there were marked differences of opinion as to whether policy should focus on prevention through treatment, harm reduction or security.

In addition to having a drug strategy team, HMP Wymott also have a drug practitioner group. While the former is responsible for the formulation of local policy, the latter concentrates on the development and delivery of that policy. The drug practitioner group includes prison officers responsible for discipline, induction, offending behaviour courses and drug awareness provision.

There are also representatives from probation, healthcare and education. The composition of the group encourages liaison between the different professionals engaged in the delivery of drugs throughcare. For example, one of the group's objectives is to establish effective liaison with healthcare in order to identify the medical and educational needs of individual drug misusers.

The extent to which prison officers receive specialist training in dealing with prisoners with drug problems provides a crude indication of the level of institutional commitment to drugs throughcare.

The drug strategy at HMYOI Deerbolt ensures that all officers are actively involved in the throughcare process, by giving personal officers a key role in identifying and assessing the needs of individual drug misusers. Given this aspect of their responsibility, all officers undergo training for working with young people. The aim of this training is to promote greater understanding of why young people take drugs. An information pack on drug misuse is given to all staff. The drug co-ordination role at both HMP Swaleside and HMP Wandsworth was undertaken by a prison officer with a special commitment to this area of work.

Several prisons in the study identified specialist officers to work with drug misusers. These officers were given different titles in the various institutions, for example Drug Support Officers, Drug Key Workers or Drug Offender Behaviour Tutors. They are typically located on the wings and in residential areas where they are able to give inmates advice and support and refer them to appropriate services. They are also allocated to treatment wings, rehabilitation areas and voluntary testing units. In some cases the officers contribute to drug awareness courses and offender behaviour programmes. Where a prison had outside drug workers visiting, these specially trained officers performed a useful liaison function. The drawback is that these officers tend to be few in number and, given the workings of Central Staff Profiling (whereby uniformed staff are re-deployed around a prison at short notice), they often find themselves removed from areas where their skills could be put to the best use.

Prior to release

A key feature of the revised Prison Service drug strategy is the emphasis placed on prisons becoming more 'outward-looking' and 'community-focused' (Prison Service, 1998). If throughcare is to be part of a seamless sentence then it is essential that links are developed with community-based agencies in order to ensure continuity of care for identified drug misusers as they are released from prison.

The help provided prior to release: different perspectives

Exactly one half of the prisoners taking part in the tracking exercise said that they had been offered help to obtain treatment or support on release. In the main this help came from a drugs worker or a prison or probation officer. Only rarely did help come from the medical staff. The kind of help that was provided is shown in Table 3.2.

Table 3.2. Pre-release help provided to those prisoners taking part in the tracking exercise (n=179)

Type of help provided	Percent of prisoners
A fixed appointment with a drug agency	11
Given details of drug agencies close to where prisoner lives	21
Given the number of a drug agency within the prison	5
Told to contact probation officer	18
Referred to another programme	6
Other	16

Percentages are for all prisoners in the sample. Some prisoners were offered more than one type of help.

Among the prisoners who took part in the focus groups and interviews – who had the benefit of hindsight in their observations (and whose experiences may have predated recent initiatives) – there was a marked difference in views. Most argued that they had received very little drug-related pre-release support on completing the custodial part of *their last sentence*. Although they had attended pre-release courses they felt that these had not really covered issues surrounding drugs. However, a few did report that they had been helped by staff in making contact with outside drug agencies prior to their release.

Co-terminosity and geographical location

Inter-agency co-operation and community links are inhibited by the fact that it is rare for relevant agencies to share the same boundaries. Added to this, prisoners are often imprisoned some distance from their home.

The net effect of this is that those arranging links with community agencies (whether the role is assumed by prison staff, probation or other specialists) have potentially an almost impossible number of connections that may need to be made in respect of any prisoner about to be discharged. Any one of the country's 123 prisons may have to confer with 54 different probation services, in excess of 700 drug agencies¹¹, and innumerable health authorities or social services and housing departments in local authorities – each of which may have a different structure, process or set of criteria for providing support.

Another consequence is that the DAT in whose area the prison is located (and there are over 100 DATs, based on different boundaries) may not feel any strong commitment to the inmates housed there. This may also apply in the case of social service departments and health authorities. Echoing one of the recommendations of the Woolf Report (1991), some professionals felt that prisoners should be located in prisons near to their homes in order to facilitate contact with community-based service providers.

The role of Probation

The Probation Service plays a significant role in the throughcare of those released on licence. Their services to their 'home' clients (i.e. those that reside in their areas, as opposed to those imprisoned there) are either offered through specialist throughcare teams, or fall on the caseload of individual officers. The service, however, has no statutory obligation to provide throughcare facilities for prisoners serving sentences of less than 12 months¹². Ironically, many offenders in this group are serving sentences for drug-related acquisitive crime, particularly theft, and are not subject to supervision on release.

11. As listed in the Standing Conference on Drug Abuse (SCODA) Directory, which does not claim to be comprehensive.

12. They are, however, required to provide voluntary aftercare if this is requested.

Most professional commentators accepted that swingeing cuts in probation have caused severe resource difficulties that have significantly reduced the ability of 'home' probation officers to visit their clients during the course of their sentence. In addition, since changes that have made prisons responsible for funding seconded probation posts, many reported there have been cuts in these posts, too. Added to these pressures many felt the service was in crisis with constant re-organisation, de-professionalisation and a strategic move from resettlement to public safety. In relation to the latter point, while there is a strong emphasis in throughcare on risk, and in particular danger to the public, it was accepted that while drug users are at high risk of reoffending, they rarely constitute a danger to the public.

The probation officers completing questionnaires as part of the tracking exercise cited both budget pressures and time constraints as the main reasons they could not maintain the levels of contact they desired with their clients. These pressures were particularly evident when prisoners were transferred to distant prisons.

The same themes were also evident in the comments from prisoners in the focus groups. Many inmates claimed that during their last sentence they had had very little contact with their home-based probation officer prior to release. Although they had met with their probation officers while under supervision many felt that this had been of limited value, as in their opinion probation officers did not have the expert knowledge to deal with the needs of clients with drug problems. Other points made were that:

- as drug use is criminal, many ex-prisoners are reluctant to speak truthfully with their probation officers and therefore will not be directed to the support that they need
- according to prisoners, most probation services are unwilling to accept responsibility for prisoners who wish to start afresh in a new area upon release.

Links to drug agencies and other services in the community

Effective throughcare is reliant upon multi-agency co-operation. Unfortunately, working relationships between agencies can be marred by disputes over professional boundaries and responsibilities. The work involved in liaising with community groups and establishing contacts for individual prisoners is also a time-consuming activity that requires a sound knowledge of the different drugs agencies and support groups in the community. As many of the professionals testified, this is a job for a dedicated worker with an understanding of the different types of treatment methods available and how they cater for different types of clients.

The prisons under review had adopted a variety of arrangements. These vary, in the main, according to the differing responsibilities given to key personnel.

- *Drugs co-ordinators*: some prisons have a drug co-ordinator whose role is to make links with the home probation officer and other agencies before a prisoner's release. However, where the co-ordinator is a prison officer, other time-consuming tasks invariably intervene to limit the commitment the co-ordinator can give to drugs work.
- *Seconded probation officers*: in some instances co-ordination is delegated to the seconded probation officer within the prison. This arrangement was felt to be satisfactory in certain circumstances (especially where there was a team of seconded probation officers within the prison). Seconded probation officers have better links with area probation services and can develop contacts with drug agencies. However, restrictions on resources have meant that not all prisons have seconded probation officers. Furthermore, some officers do not have specialist drugs knowledge. They inevitably tend to concentrate on the needs of inmates subject to statutory throughcare and, it was felt, give priority to the needs of other vulnerable prisoners, such as sex offenders, rather than those with drug problems.

- *Prison Link Workers:* Lancashire Probation Service has taken a different approach. Rather than placing responsibility on seconded probation officers it has appointed a prison link officer who visits prisons in the Lancashire area to contact inmates who have been identified as having a drug problem and are to be released to addresses in Lancashire. The visits take place shortly before release and the primary purpose is to put the prisoner in contact with a drug rehabilitation group or support group in the community. This is usually arranged through the home probation officer, although the link officer can contact outside agencies directly.
- *Dedicated drug worker:* co-ordination arrangements appear to operate most satisfactorily where there is a dedicated drug worker. Unencumbered with other duties, a dedicated drug worker can devote his or her time to addressing drug issues. The drug worker may be employed directly by the prison or provided via a contract with a drug agency.

Where drug workers are employed, their duties can vary and may include: providing one-to-one counselling for inmates; undertaking group work with identified drug misusers; contributing to drug awareness courses; organising inmate peer support groups in the prison; training prison staff to work with drug misusers and facilitating liaison between sentence planning, throughcare and health care. The drug worker can also play an important part in helping prisoners who are seeking a transfer to another prison in order to gain access to a drug rehabilitation programme. For those inmates due for release, the drug worker will help them make contact with community agencies and support groups.

Prisons in Kent have contracts with Addaction and Cranstoun to provide drug services. One condition of these contracts is that the agencies are required to follow up 15 per cent of inmates they have helped in order to find out how they are progressing in the community.

Wymott share the services of a part-time drug worker with nearby Garth Prison. Deerbolt employs a full-time dedicated substance misuse worker contracted under a service level agreement between Healthcare, the Governor and the Prison Service Area Manager. Initially the contract is for one year. In addition to carrying out the tasks listed above, the substance misuse worker establishes and maintains links with community drug workers through the Drug Workers' Forum. The Forum provides an opportunity to educate community groups about the specific needs of offenders on release. As a trained probation officer, the drug worker is well versed in the practices of the criminal justice system, which is important when dealing with home probation officers. An important aspect of the work of the substance misuse worker is the development of care plans or care packages for individual inmates on her caseload. These plans extend beyond the period of confinement and cover the return of the inmate to the community. A copy of the care plan is sent to the home probation officer and also any outside drug agency that will be providing support for the inmate on release.

HMP Rochester has sought to serve remand prisoners specifically by establishing contact with the New Road Project (a drug free project). A 'fast track' procedure has been put in place whereby a dedicated drug worker identifies remand prisoners who are about to attend court. If it is thought likely that the person will not be convicted, or receive a community penalty if convicted, information is faxed to the agency who sends back an appointment card to be given to the person while still inside the prison prior to appearing in court. The card specifies an appointment within 48 hours of the court appearance. If, in the event, the person is found guilty and receives a prison sentence the drug worker will telephone the agency and cancel the appointment.

Wandsworth Council has recently provided funds to appoint a worker to identify local residents who are arrested, convicted or sentenced on drug charges or who have a drug problem. The worker's responsibility is to visit people at the police station or in prison to set up referrals to community drug agencies. Wandsworth Prison also has a contract with Prisoner Resource Services (PRS) who work with prisoners in the last six months of their sentence and those on remand (if possible). The service includes getting prisoners into rehabilitation. In addition, prisoners are given a useful information pack, which provides details on options for follow-up services, addresses of services, how to get assessed for rehabilitation and a description of the process of 'kicking the habit'.

At HMP Channings Wood the Therapeutic Community had a structured 're-entry phase' at the nine month stage of the 12 month sentence. Inmates were encouraged to draw up a plan for themselves (guided by a checklist) and to contact outside agencies where appropriate.

Pre-release courses

As indicated above, most prisoners felt that the pre-release courses they had experienced during previous custodial sentences had failed to address adequately issues surrounding drug misuse. According to their accounts, these courses had merely addressed general issues such as finding accommodation, applying for a job and, in some cases, simply providing the inmate with the name and address of their home probation officer. In contrast, those who had attended pre-release courses that had addressed drugs issues specifically had found them very helpful; particularly those courses which had provided details about community drugs services.

Some of the prisons in the sample had identified preparation for release as requiring special attention and had either introduced new measures or were exploring how best to address the issue.

At HMYOI Deerbolt, inmates were provided with a two-week relapse prevention course and two weeks prior to release received instruction in relapse management. At HMP Wealstun, SARU were planning the introduction of a pre-release drug course. The detox manager at Holloway was involved in compiling a database of services available from the SCODA Directory and a list of local services was given to each prisoner.

Release from prison

Drug use after release: the prisoners tracked

While in prison the prisoners taking part in the tracking exercise were asked to predict what their drug usage was likely to be once they had been released from prison. One half thought that their drug use would decrease and a further 20 per cent thought their use would change to less serious drugs. The same proportion (20%) predicted little change in their drug use, while 6 per cent thought that their use would actually increase once they were back in the community.

From responses to the follow up questionnaire it was possible to assess how far these expectations proved to be accurate. The results were found to be generally discouraging although there were some indicators of success. The majority had returned to drugs following release from prison – 86 per cent said they had used some form of drug. Thus four months after release 14 per cent were still drug free. However, daily use of

heroin had reduced. Four months after release 48 per cent said that they were using heroin every day compared with 66 per cent who reported using heroin every day prior to imprisonment. This result was not affected by non-response to the second questionnaire. Confining the analysis to the 112 who completed both questionnaires, daily use of heroin fell significantly from 64 per cent to 48 per cent ($z = 2.64$; $p < .01$).

Amongst those who had resumed drug taking, spending on drugs had more than halved. Prior to imprisonment the average amount spent each week was £550 but following release the average weekly expenditure for those using drugs was £275. However, this comparison was affected somewhat by differences in those responding to the two questionnaires. It was pointed out that many crack users, who were amongst the highest spenders, did not complete the second questionnaire reporting their drug taking in the community four months following release from prison. If comparative spending is confined to the 112 who completed both questionnaires, average spending fell significantly by 44 per cent from £400 to £225 ($z = 3.95$; $p < .01$).

Given the high proportion returning to drugs it is inevitable that many had returned to crime too. One half said that they were committing crimes to support their habit and 30 per cent had been arrested; 13 per cent of arrests were for possessing or supplying drugs.

Closer examination of the 16 ex-prisoners (14% of the sample) who had not returned to drugs revealed that they had been on a wide variety of treatment programmes, some more than once, and many had attended longer term programmes such as counselling and therapeutic community. They were highly motivated to change (all but two had expressed their firm intention to stop taking drugs). Strikingly, all but two were on licence and had the benefit of supervision on release.

Practice: action on release

The 'proof of the throughcare pudding' is in what actually happens to prisoners once they are released. In theory there are a wide range of support options depending on:

- the throughcare practice of the prison a prisoner is leaving
- the range and quality of the links the prison has with community or rehabilitation services
- whether the prisoner is subject to statutory supervision from the Probation Service
- the ability of that Probation Service/supervising probation officer to provide, or access, support
- where the prisoner is returning to, and
- whether they wish to remain drug-free or keep to a formal prescribing regime until they are ready to attempt abstinence.

In short, there is no simple protocol for released prisoners.

Timing: confronting 'the brick wall of freedom'

Most prisoners will maintain that drug abuse is not at the forefront of their thinking on their release date. Certainly the prisoners interviewed confirmed that a return to drug use (if this is what happened) was more or less immediate. For some this was because they wanted to, and had been looking forward to being able to do so. For some it was the consequence of 'partying' on release and the dis-inhibiting effect of alcohol. For others – particularly those who have served long periods of imprisonment that had severed links with family,

work and accommodation – it was because they were unable to access support for this period of considerable vulnerability. In many cases the influences interact: in the words of one ex-offender, “if you’ve nowhere to go, and you pitch up with your £94 to grab a bed with a bunch of smackheads, the outcome is pretty predictable”.

Most of the prisoners interviewed recognised the temptations to revert to previous behaviour when returning to the drug and criminogenic communities from which they had come (and the majority of those completing the follow-up questionnaire had returned to live with relatives and former friends). One or two felt that assistance in transferring to a new area would give them a better opportunity for a “fresh start”.

Range and funding of drug services

There are a broad range of services which might offer support to ex-prisoners. The SCODA Directory lists around 700 services across England and Wales aimed at substance misusers. These include some generic services but there will be more generic ones, not included in the directory. Services are likely to be provided by health authorities, probation, the voluntary and private sectors, and the principal categories include:

- community advice and information services (‘street agencies’)
- community drug teams (CDT)
- criminal justice intervention services
- drug dependency units
- residential rehabilitation service (1st stage)
- hostel/ supported accommodation (2nd stage)
- semi-supported accommodation (2nd stage)
- structured day programme
- family service group/ centres
- needle Syringe/ exchanges
- general practitioners (possibly involved in shared care schemes)
- self-help groups and
- specialist hospital in-patient scheme.

There are also a range of more generic organisations such as church and charitable organisations that will offer some form of support. (More detail on the type of service is provided in Annex 3.)

ADFAM, the network for families of drug users, has recently received funding to extend a London-wide project nationally. The project looks at ways of working with families of drug using prisoners to offer appropriate support whilst still ‘inside’ and on release. As the co-ordinator pointed out; “whilst there is usually a waiting list for support from specialist services, access to support for family members is likely to be available immediately”.

The principal purchasers of services for drug users are health authorities, local authorities and the Probation Service. Grant funding may be raised from other sources such as the European Social Fund, the Lotteries Board and charitable sources.

Home Office/ probation responsibility for purchasing services has been largely devolved to individual probation services. They are, in the view of one large national service provider, unsophisticated purchasers who demand more and more services for less money – to the point where that particular provider has

reduced the proportion of its ex-offender work in favour of mental health provision. Because probation funding has moved away from central control, there seems to be little awareness at the Home Office that services for ex-offenders are being lost.

The Probation Service themselves have conceded that cuts in resources have led to a need to 'spot fund' rather than grant-fund services, which they acknowledge makes it difficult for service providers to plan and provide for a quality level of service. Despite this, commentators drew attention to several examples of probation services working constructively with local providers to ensure that provision most accurately met the needs of their client group (e.g. South West London Probation Service and Stonham Housing).

Despite the wide range of services nationally, the consensus view – from both professionals interviewed, and the potential/actual clients of these services – is that there are insufficient community services to deal with the scale of the problem. Those that do exist are straining at the seams. A number of professionals reported a particular shortage of services for women (with or without children), young people and ethnic minorities. There is also an inevitable gap between changes in drug use and the ability of those services to react to those changes: for example most services are aimed at opiate use, and are unable to respond to the dramatic surge in the use of crack cocaine.

In addition, the availability of drug services is not uniform across the country. Services are more likely to be found in metropolitan areas, whereas evidence suggests that problems of drug use are spreading into smaller urban and rural areas. Prisoners returning to more isolated areas are finding that there are no suitable services in existence. For example, inmates at one target prison came from different towns and cities in the North West region and testified to the fact that the quality and level of provision varied from area to area. Those living in the smaller towns and semi-rural areas faced a particular problem, as local support services were either thin on the ground, or non-existent.

The co-ordination of local services

Drug Action Teams (DATs) are viewed – in the CDCU guidance (Section 1) – as the key players in the planning and co-ordination of services for drug users. There was, however, very little evidence of them assuming this role, and a widespread belief that the needs of ex-prisoners are overlooked unless there is a local prison, serving a local population. It is important to have prisons represented on DATs.

In practice, therefore, the responsibility for services for ex-offenders requiring drug services often falls between the relevant agencies. This is sometimes compounded by local politics and unhelpful competition between service providers.

In terms of the provision of a 'seamless service', there are considerable advantages when a prison contracts with a drug agency to provide a service within the prison, but also links to the community agency's follow-up services. The downside is that this can often lead to an exclusive relationship, which marginalises other community drug agencies, which may have a significant contribution to make.

Direct access services and waiting lists

Some drug services are 'direct access' in that there is no requirement for funding to be secured before a client will be accepted into the service¹³.

13. These typically include the street agencies, DDUs, CDTs, needle exchanges, GPs, self-help groups, most church and charitable organisations, Family Support Centres and some Structured Day Programmes.

The principal difficulty with direct access services lies in the length of their waiting lists. A number of inmates put their failure to stay off drugs following previous sentences to the fact that they did not get support quickly enough. Many prisoners taking part in focus groups reported being sent away from agencies with an appointment booked for several weeks hence and this same theme was evident from those taking part in the tracking exercise. In the words of one: "Got to wait up to 12 week before I can get any help." Or another: "I have been waiting 3 to 4 weeks now for them to put me on a methadone script. The whole process takes so long, it's ridiculous really I'm still waiting now." For some, the waiting lists were so long that they were not even given an appointment, but asked to try again at a later date.

Professionals interviewed confirmed that this was a common scenario. For those who are 'clean' and want some counselling/support this is difficult. There were similar problems for those requiring methadone scripts. Waiting lists at DDUs, though generally shorter, are still too long to prevent many users returning to street drugs (and the concomitant criminal activity). Finding GPs who were willing to take users onto their lists was also difficult. In the view of many professionals, immediate access to methadone, if someone is unable to stay clean, at least 'keys them into services' so that they may be able to attempt abstinence at a later date.

Ex-prisoners on a new structured day programme run by SARO in Brighton reported that they had been assessed by the programme manager on the day of release; a facility made possible by the close links between the substance misuse worker at the local prison and SARO.

Overall, all professionals agreed that quick response services were vital if the progress made in prison was not to be lost. As one commentator pointed out, even where a community programme is available there is an inevitable delay between assessment and commencement of treatment. This suggests that in an ideal world assessment should take place while the inmate is in prison – in order that he or she can start the programme immediately upon release. Telephone helplines are also considered to be important in offering immediate crisis support, particularly out of hours (for example the National Drugs Helpline).

Access to longer term programmes

Longer-term programmes almost always require prior funding, and the source of this funding can be complex. Thus funding for residential rehabilitation (and some structured day programmes) will usually come from the Community Care, or Drug and Alcohol Specific Grant, budgets of local authorities; though in recent years this funding has been tied to social exclusion via the Rough Sleepers Initiative. Some rehabilitation is funded by DSS benefits with top-up funding from Probation (for example). Second stage accommodation is usually funded using Housing Benefits and additional monies from Probation or local authorities. The complexity of these arrangements and the lack of funds deter many professionals in the field.

Access to aftercare services was reported as a major difficulty. Problems in obtaining places in residential rehabilitation stemmed from a general lack of community care funds, local authority eligibility criteria that exclude prisoners and a reluctance on the part of some establishments to take ex-prisoners. Prisoners also needed a lot of help in working through the bureaucracy of getting an assessment and funding (which may, or may not, be forthcoming).

'Mixing' with non-offenders

It is important, when planning services for ex-offenders, to take account of the fact that they (and other drug users) are not a homogenous group. Some will emerge from prison relatively stable and motivated to continue the progress they have made inside. Others will quickly take up (or resume) a more chaotic lifestyle.

This has implications for the structure and management of services. For example, there are issues around mixing 'hardened recidivists' with less serious cases. One structured day programme reported a serious criminal setting up a burglary and recruiting a shoplifter from the others on his course. Certainly, many services offering quality programmes state that they cannot accommodate the more chaotic clients.

Addressing complex needs

In the view of many specialists, drugs are often only part of a spectrum of problems faced by those following a prison sentence. Even when ex-prisoners do manage to access services, there is a risk that focusing exclusively on drug use is not the most appropriate way forward. There is therefore a gradual move to look at recipients of services in terms of their complex needs.

Increasingly, there are agencies – such as HARP in Birmingham and the Rugby House Project – who address the complex needs of ex-prisoners. Principally they cover mental health and substance misuse (by dual diagnosis) but can also incorporate housing/ accommodation, criminal justice involvement, history of abuse, eating disorders, personality disorders, deliberate self-harm etc.

Problems with accommodation were certainly given considerable emphasis by professionals and ex-prisoners alike. Staff from many of the agencies/programmes reported that a significant amount of their time was spent sorting out accommodation problems for the clients. There is a shortage of suitable accommodation. Many hostels are full of drug users and staying with previous associates can easily lead to relapse. Bed and breakfast accommodation is not subject to inspection and is unlikely to provide an environment conducive to recovery. The stability of reasonable accommodation was considered by all commentators to be important for making progress. Other services, such as Addaction in Brighton, found that work on developing educational and vocational opportunities was very popular and increased the clients' confidence.

From their responses to the tracking exercise, many released prisoners appeared to be experiencing a range of difficulties. Only 16 per cent had any form of employment (and for half of those it was only part-time or casual). Few had nowhere to live (5% said they had 'no fixed abode') but 40 per cent were staying with friends or relatives. Less than half had any security of tenure.

Locating services that support drug abstinence

In the options available to drug users, there is often a reliance on stabilisation (by prescribing) rather than programmes geared towards abstinence. Many ex-offenders are reluctant to visit services where people are still 'using', particularly in the early stages when they feel vulnerable to relapse (and may know many of the users).

Some agencies, such as Mainliners, have taken steps to address this by setting aside some days and half-days for those who are abstinent. SARO in Brighton set up a structured day programme in response to surveys of ex-offenders who said that they wanted to be drug free rather than on methadone. As one CPO said, methadone prescribing has its place but it is also a commonly abused service.

Engagement with services: the need for 'pro-activity'

Clearly, for services to be effective, it is necessary for the target client group to successfully engage with that service. Following release, three-quarters of prisoners felt that they needed help in dealing with their drug problem, but only a third had sought and received help. Many had contacted the drug service that they had

used before being sent to prison and had received methadone maintenance or detoxification. Relatively few, no more than 5 per cent in each case, had received any form of counselling, residential rehabilitation or relapse prevention.

The focus groups run in prisons revealed that prisoners often lacked the necessary information and confidence to contact services 'cold': as one ex-prisoner said: "[I did not turn up] because I was too paranoid to travel to these places." And, as well as the issues previously mentioned, such as timing and access, there are other factors that promote or impede engagement.

'Turn-up rates' at services are often disappointing, even when the contact has been initiated from within the prison. This was a point often made by the drugs services who were sent questionnaires as part of the tracking exercise. In many cases where questionnaires were returned, the prisoner had made perhaps one appointment, but no more. Often attempts to re-establish contact were impossible as the prisoner had no fixed address. Arguably, one reason for the generally low return of questionnaires may have been that 'their' client had never turned up at all.

One way to improve this is to promote contact between the prisoner and the agency beforehand: either by prison workers visiting the prison, telephone contact from the prisoner to the service, or release on temporary licence to visit the service prior to release. (The Kent Council for Addiction, or KCA, estimated that the turn-up rate went from 30 per cent to 60 per cent when the drug counsellors started to give presentations within the prison.) This is generally only practical when the service is local to the prison and when the prisoner intends to resettle in that area. South-West London Probation Service, for example, is proposing to reposition the counselling service which it funds to its own premises in an attempt to cut down the level of clients who do not appear.

The 'Breaking the Chain' project in Hull provides a throughcare service funded by East Riding Health. The throughcare worker visits clients in prison two to three months prior to their release to conduct an individual's needs' assessment. Following discussions with probation staff a treatment package is agreed. The throughcare worker maintains regular contact with both the prisoner and the community agency that will support the discharged prisoner to ensure that the treatment plan remains in place up to the point of release. Following release the throughcare worker remains in touch with the client for a period of up to six weeks. This means that should the client fail to keep an appointment with a community drug counselling service this can be quickly detected and followed-up by the throughcare worker.

Attendance at drug services as a condition of licence can be problematic, depending on how breaches are treated. As many ex-offenders are leading chaotic lives, compliance can be difficult. A return to prison as the result of breach will generally be counter-productive.

The view has been expressed that securing 'engagement' is a key challenge in dealing with all 'complex needs' groups (which would have a high proportion of ex and repeat offenders). In this view, many substance misuse services do not work sufficiently to follow up clients who do not fully engage or who disengage. In the words of one expert, "it is ludicrous to follow up an ex-prisoner with a severe mental illness – or a proneness to chaotic drug use – who has not turned up, with a simple letter".

Assertive follow up was found to be effective in the Surrey Oakland's Outreach Project. In a sample of clients who disengaged from alcohol services after the briefest of contact, 80 per cent re-engaged following phone calls and personal visits.

There is a common view that care equates only to treatment with a view to change, improvement or 'cure'. But to take the view that you can only work with those people who are motivated to change is hostile to working with this particular client group. In fact there is also a need to address more basic challenges – such as simply keeping someone alive, or controlling/containing the chaos surrounding those who are unwilling or unable to address their drug habit. These are the people who present a greater risk to themselves and others (a recent inquiry into homicides has shown that a vast majority of the perpetrators have a substance misuse problem: Ward and Applin, 1998).

The problem is that chaotic drug users are a very 'unattractive' client group to work with and drug agencies generally are not short of clients. Engagement with this group requires a more proactive approach on the part of agencies, including more aggressive outreach work. But the need for such approaches also needs to be resourced by funders. In the words of one drug service manager: "due to waiting lists and demands from other agencies, it is difficult/impossible to provide a smooth throughcare for offenders being released from prison – this should be highlighted and resources found to overcome it."

Offenders on licence: the role of probation

Young offenders and those released from sentences of twelve months and above are subject to a period of statutory supervision. There is also a facility for prisoners on shorter sentences to opt for voluntary aftercare, although commonly this does not happen. Ex-prisoners would usually be required to report to their probation officer shortly after release. Probation officers then have the opportunity to direct clients to services to meet their support needs (where links with services are made, some of these may have been initiated when the prisoner was still in custody).

Although there were examples of successful and supportive relationships with home probation officers, most ex-prisoners did not express positive views. The majority claimed that their contact was cursory and they simply told the probation officer what they felt they would wish to hear. For many there was a clear conflict between being open about their drug use – in order to access support – and impressing the probation officer with their ability to stay clean. Both parties confirmed a change in emphasis on the part of the Probation Service, from resettlement to public safety. The throughput of those on licence was also viewed as so considerable that it was unlikely that a resource-stretched Probation Service would be able to offer much help.

That said, the Probation Service is still an important funder of services, with a requirement that 7 per cent of its budget is spent on partnership work (Probation Circular 64/1998 encourages probation services to develop partnerships in support of the UK Anti-Drug Strategy and to discuss their plans with DATs). Examples of the kind of services which are probation-funded (at least in part) include residential rehabilitation (e.g. Bridge House in Bristol) and structured day programmes (Addaction in Brighton). This again can be a double-edged sword. A representative of the Probation Service stated that probation officers would be more likely to refer clients to probation-funded services. This is undoubtedly a good facility but the concern was expressed that this sometimes narrowed the options available to drug users.

Another difficulty reported by prison drug workers and community agencies was that probation officers simply lacked the training and skills to deal with a client's substance misuse problems, or were not always aware of the range of available facilities. Two examples were given of areas where probation officers failed to use accommodation services for their clients because they were unaware of their existence. In one area, clients were left to queue up for services from a local housing provider on a 'first come, first served' basis, despite the fact that provision for fast track appointments (funded by partnership money) had been set up.

4. The way forward: developing good practice

In Section 1 of this report, it was conservatively calculated that between 5,000 and 8,000 sentenced prisoners, with a significant drug-dependency, might be released from prisons in England and Wales each year. It was also suggested that the number of crimes committed by these individuals each year could number between 3 and 5 million¹⁴, and the costs incurred by victims of crime to between £150 and £250 million. These figures are of course crude estimates, but they serve to indicate that – aside from the very real human costs to drug users themselves – the problem addressed by this research imposes substantial costs on the wider community.

The opportunity to intervene – to break drugs habits while offenders are incarcerated and support their rehabilitation on release – offers immense dividends. This sort of thinking explains, to a large extent, the emphasis placed on arrest referral schemes and the new Drug and Treatment Testing Order in the latest ‘national drugs plan’ (UKADC, 1999). But the importance of follow up treatment and support is widely overlooked, almost on the assumption that improvements made in prison will be automatically sustained. Despite the welcome priority attached to drug treatment, throughcare as a specific topic remains conspicuously absent from the recently announced national targets.

The evidence from this study, however, is that a very substantial proportion of prisoners who receive drug treatment within prisons revert to their habit. The tracking study carried out – which represents the first large-scale exercise of this kind – indicates that almost all ex-prisoners had taken drugs since their release and that 45 per cent were taking heroin daily. The lessons of the exercise were not, however, entirely negative: for example the number taking heroin daily had fallen by some 30 per cent (from 66% of the sample to 45%) and 14 per cent had stopped taking drugs altogether for four months. Spending on drugs fell by 50 per cent, and while half admitted committing crimes to support their habit, half said that they had not returned to crime following their release.

This research has been conducted during a period of rapid policy development in this area. Above all the CARAT service, announced during the course of this enquiry and now starting to take shape, represents the first substantial financial commitment shown to throughcare. Of course the main focus of CARAT is on services within prisons – on more specialist drug treatment services being provided on either a prison area, or national, basis. But in terms of drugs throughcare, the two core defining characteristics of CARAT services are that they are intended to “function as a bridge from drug services in prison to those in the community” and provide “post-release support to promote successful transfer” (CARAT specification document, p. 1).

The CARAT service constitutes an ambitious initiative that has been designed to encourage prisons, probation services and specialist community-based drug agencies to develop active working partnerships through the exchange of knowledge and skills. It is aimed at providing a range of interventions, starting with an initial assessment on a prisoner’s entry into custody, which are easily accessible to all prisoners. The objective of linking prisons with community agencies in order to ensure continuity of care is of special relevance. It is anticipated that prisons will become responsible for the negotiation of placements in community-based services. This will require them both to have close links with local services, but also a means of linking with

14. Obviously a sizeable proportion may not be reported to the police, especially offences of shoplifting.

services throughout the country. In a radical move, the CARAT proposals suggest “funding...should include provision for staff to continue their direct service provision to clients where necessary, for a short period after release up to a maximum of two or three months (to be decided)”.

Structural impediments to action?

The research has served to document that the issue of drug throughcare is being accorded increased attention by many key agencies. Equally it shows that examples of good practice are presented by a variety of different schemes. On the other side of the coin, it has to be recognised that these schemes are limited in number and in their coverage, and certainly not representative¹⁵. The managers and staff working within them are the first to stress that much of their effort is directed at overcoming structural impediments to the provision of throughcare. The hallmark of many of the schemes is that they are the product of one or two charismatic individuals and unusually strong inter-agency partnerships, and survive on fragile funding only while these conditions persist. Though they appear effective, none has been the subject of rigorous evaluation. In these circumstances, it is important that serious consideration is paid to these structural obstacles.

Undoubtedly one of the primary reasons that drug throughcare constitutes a “Cinderella service” is that *responsibility for this issue does not fall to any single agency or post-holder*. Indeed, it is not the top priority for any of the six or more agencies who have been identified as critical to the delivery of an effective service (see Section 1), each of whom have alternative, pressing, agendas to pursue. Thus the Prison Service can, with some justification, argue that security issues must take precedence while offenders remain in their charge (“no governor was ever sacked for a lapse in throughcare...”), and that on release their primary responsibilities have been discharged. By the same token, health authorities, social services and housing departments (to select only a few) have to meet the demands of many groups in the community, and ex-prisoners will often appear to be the least deserving.

It can, justifiably, be argued that the Probation Service provides the lynchpin here – but this overlooks several important considerations. One is that probation officers only have a formal remit over those released on licence and that the remainder – remand-prisoners and those serving sentences of less than one year – constitute the great majority of released prisoners. Paradoxically, too, because of their sentence length, those on licence are more likely than their counterparts to have abstained from major drug use for a longer period and received drug treatment while in custody. A second point is that the service is severely hampered in meeting both their formal responsibilities to offenders on licence, and less formal responsibilities to other offenders, by the organisation of the prison estate. The cost – both in financial and human resource terms – of any local probation service having to support prisoners spread across the whole estate is huge. Both these constraints have deep structural foundations, but the desirability of ‘local’ prisons was repeatedly raised in discussion of this issue with probation services (not by any means a new argument: see Woolf, 1991). Moreover, the fact that many of the examples of effective throughcare are located in areas where prisons serve an identifiable ‘local’ community should not be overlooked. Arguably, too, the association with locality – if it could be strengthened – would serve as a powerful incentive to health and social services, and other local agencies, to increase the priority attached to providing support.

The other major ‘in-built’ difficulty associated with the provision of drug throughcare is that offenders in custody – as well as failing to warrant much sympathy and support – are often faced with a range of other difficulties on their release. Many have housing and financial difficulties and even psychiatric problems. They may be released to either poor family support or indeed deeply dysfunctional families and friends. In these circumstances it is not entirely surprising that many of the innovative programmes reviewed in this research,

¹⁵ The research team not only actively canvassed to locate and visit ‘good practice’ schemes, but the tracking exercise was focused only on prisons hosting drug pilot schemes.

which initially aimed at providing drug services alone (such as detoxification or counselling), have been obliged to widen their remit to providing a general support function – such as helping ex-prisoners with obtaining housing, social security benefits. This explains the increasing emphasis placed by drug services on providing a ‘holistic’ approach. Indeed in the circumstances where other aspects of throughcare have not been delivered, it is sometimes difficult not to view the resumption of drug taking as a symptom, rather than a cause.

The points made here constitute only a selection of the much wider range presented in Section 3, but arguably they comprise the main challenges that policy making in the drugs throughcare area should firmly address if substantive, and durable, improvements are to be made.

Meeting the challenge

The common theme of the criticism made in this report is that drug throughcare for ex-prisoners falls between different agencies, presents almost insuperable logistical difficulties and is hampered by lack of funds. In these circumstances a radical re-assessment of the organisation and funding of throughcare seems called for. But falling short of this, there are also lesser changes that promise improvements¹⁶.

The radical route

Developing the links between prisons and the other services in their locality is highly desirable, but – for a range of other reasons – it seems unlikely that it will be possible to arrive at a situation where local prisons serve only local inmates. There are, however, other routes to achieving the necessary ‘ownership’ of the problem of prisoners with drug problems.

The most dramatic root and branch reform of the system would involve applying highly traditional remedies: the designation of responsibility for throughcare to one specific service, and the ‘ring fencing’ of funds for this purpose. If this course was pursued, the front runners to take on a national responsibility would either be the Probation Service, in line with its longstanding functions, or the Prison Service, who have adopted a new role in this area through the appointment of Area Drug Co-ordinators (ADCs), and the commitment to fund a measure of support for ex-prisoners. Whatever organisation proved best suited, the principle might be that they adopted a very simple and straightforward formula – with local area services taking responsibility for:

- tracking the progress of all inmates receiving drug treatment in ‘their’ prison area – to the point of having a responsibility for ensuring those needing support on release have arrangements made for them in their home area
- liaison with all the community drug services available in the locality, so that they receive referrals of ex-prisoners to be released to ‘their’ area from prisons elsewhere, and take over responsibility for placing them.

Such an arrangement would need to be supported by a guarantee of funding for each prisoner, who met a common set of assessment criteria, for a finite period after their release. It would also need resources to be rationed to each area dependant on both the size of the ‘population served’ locally (both in terms of the number of inmates with drug problems in local prisons, and the number returning to the area). The arrangements themselves would obviously not prove a ‘cure all’ (with the national shortage of places on community drug programmes remaining an obvious obstacle), but they would firmly tackle the structural difficulties discussed above.

16. In formulating recommendations, the research team also reflected upon the views expressed in the following reports: Cranstoun (1999), Inner London Probation Service (1997), Mitchell and McCarthy (1998) and Penal Affairs Consortium (1996).

The 'step by step' approach

A more modest set of reforms could be built on the lessons of existing examples of 'good practice' and seek to shape and develop the way that the CARAT service develops in the three years it is expected to run. It is right that 'local' approaches should be developed to fit with local circumstances, but a number of other generic themes have also appeared regularly in the assessment of professionals and prisoners alike. Within prisons, a range of priorities are outlined.

- *Promote a wider awareness of drug issues amongst prison officers.* Prison staff have, in many institutions, received drug awareness training, but more needs to be done to increase their receptivity to prisoners who are ready to seek treatment.
- *Broaden the range of drug services available.* Drug services within prisons have been greatly enlarged and indeed some argue that drug services are more accessible in prisons than they are in the wider community. But, as CARAT recognises, there is a need for a wider selection of services to be available for inmates with drug problems.
- *Overcome issues that prevent transfers to drug programmes in other prisons.* The availability of services within the prison estate will account for little if prisons are unable to address the difficulties that often obstruct the transfer of prisoners to programmes in different institutions.
- *Promote inter-agency collaboration between services within prisons, and develop protocols on confidentiality.* The CARAT programme, through the appointment of ADCs, recognises the need for improved co-operation: not only between prisons, but also with all other interested agencies. Joint training can achieve much. Common agreement also needs to be reached on the access and transfer of personal information about prisoners.
- *Strengthen accountability in the sentence planning process.* Nearly all commentators – including prisoners themselves – support the thinking behind sentence planning, but criticise its practical application. Improvements will accrue from better collaboration between agencies, but there is arguably a need to make individual players more accountable for 'their' part in the process.
- *Facilitate other channels of communication between prisoner and their 'home' probation officers.* As the scope for prison visits has dwindled, a number of commentators are suggesting that probation officers should be adopting alternative means – from letters, phone calls to video conferencing facilities (if available) – to maintain contact with those imprisoned at some distance from their homes.

Towards release there are several issues.

- *Provide specialist posts to arrange drug support on release.* Effective throughcare is best achieved if someone is designated to act as a 'go between' prisoners and outside agencies. The key is to ensure that staff charged with this function are not encumbered with other, distracting, functions imposed by their host institution.
- *Develop directories of community drug services.* One function of such a dedicated drug worker could be to build up a comprehensive knowledge of local drug services. It will also be invaluable to establish a means of identifying all the information required by the different players, and of exchanging this information between prisons.

- *Facilitate direct contact with treatment agencies.* The prospects of prisoners attending drug services on release are much improved if they have had prior contact with the service. Personal contact is preferable (perhaps through day release arrangements) but a letter or a phone call may often be sufficient. Fixed appointments and – better still – secured places on a programme arranged prior to release are necessary.
- *Encourage pre-release courses dealing with drugs.* There is scope for pre-release courses to deal more specifically with drug issues – and to provide prisoners with information on the drug services available and the procedures for accessing them. Experience suggests that prisoners are easily deterred if agencies and services appear to discourage their initial requests for help.

On, or soon after, release the following areas need to be addressed.

- *Address the funding shortfall and chart the complexities of funding sources.* CARAT addresses, for the first time, the short term difficulties of funding places with community drug services but questions surrounding the funding of medium to long-term still remain, and need to be addressed.
- *Promote the ‘holistic’ approach.* For many, drug taking is a symptom of the many other problems faced by ex-prisoners, not the cause. While incarcerated, many prisoners will have lost any tenure to their accommodation, any job they may have had and their spouse or partner. Others suffer from mental health problems. These wider issues often need to be addressed to improve the prospects of drug treatment.

Above all, any improvements made in these key areas need to be built on a solid foundation.

- *Ensuring drugs throughcare receives a higher profile by:* promoting awareness of the argument that drug treatment provided to prisoners offers a unique opportunity – not only to address the needs of some of the most chaotic users, but also to check the huge social costs they will impose if they are released without effective intervention. To be effective, however, this support needs to continue beyond the prison gates.
- *Encouraging DATs to take the lead* in both promoting this message and in co-ordinating the efforts of different agencies to ensure delivery of local services to ex-prisoners¹⁷.

The recommendation that substantial structural changes might be made in an area that has already been the subject of much innovation might appear rash. The introduction of the CARAT programme – and in particular the promotion of the concept of area planning – promises a great deal, but it would be naïve to assume it will be a panacea. One risk is that drug services will not have the trained staff to meet the demand created by the new funding available. It is also sensible to recognise that the lessons of previous years have taught that ‘external’ factors – such as changes in housing rules, or in the funding arrangements for the Probation Service – can have a profound impact. But, perhaps above all, the programme may fall victim to its own high visibility. It appears to indicate that the Prison Service is taking responsibility for the short-term support of ex-prisoners with drug problems, and there are already signs that – on this basis – health authorities and other hard-pressed agencies are considering withdrawing the support they have previously offered to ex-prisoners. The continuing threat to drugs throughcare will be that it remains a shared responsibility, but where – in the absence of any accountability – each agency can argue “it’s not my baby”.

17. Supportive links between DATs are soon to be strengthened by the new Drug Prevention Advisory Service.

Annex 1

Individuals and organisations consulted

Central Co-ordination and Policy Making Organisations

Association of Chief Officers of Probation
Central Drug Prevention Unit
Inspectorate of Probation
Prison Service
Probation Unit
Research Development and Statistics Directorate
UK Anti-Drugs Co-ordination Unit

Prisons

Askham Grange	Haverigg	Rochester	Bristol
Holloway	Swaleside	Channings Wood	Holme House
Wandsworth	Deerbolt	Lancaster Castle	Wealstun
Elmley	Leeds	Wymott	Full Sutton
Norwich	Garth	Portland	

Kent Prisons Drug Co-ordinator
NE Area Prisons Drugs Co-ordinator
NW Area Prisons Drugs Co-ordinator

Probation

Inner London Probation Service
East Sussex Probation Service
Kent Probation Service
Lancashire Probation Service
South East London Probation Service
South West London Probation Service

Community and Prison Based Drug Services

Addaction	Bridge Project	Phoenix House	SARO
Cranstoun	SARU	Bristol Drugs Project	PRS
Lifeline	RAPt	Thames Gateway	North Street Project
Compass	Breaking the Chain	Kent Council on Addiction	Matthew Project
ADFAM	Milestones		

Academics/Consultants

Mike Hough	PDM
George Mair	ISTD
Imperial College	UCL Medical School

Other

Leicester DAT

Lancashire DAT Co-ordinator

STORS (East Sussex and Brighton and Hove Drug Action Team Monitoring Programme)

Stonham Housing

Surrey Social Services

Annex 2 Number of initial questionnaires completed by prisoners in prison and number of follow up questionnaires completed four months after release from prison.

Prison	Number of questionnaires completed in prison	Number of questionnaires completed following release
Askham Grange	0	0
Bristol	7	3
Channings Wood	1	0
Deerbolt	40	30
Elmley	8	6
Full Sutton	3	2
Haverigg	24	20
Holloway	67	31
Holme House	3	2
Leeds	1	1
Norwich	4	2
Portland	3	3
Rochester	3	2
Swaleside	1	0
Wandsworth	3	3
Wealstun	5	3
Wymott	6	4
Total	179	112

Community advice and information service – ‘street agency’

These are usually non-statutory services, based in the community and offering direct access. Some services will offer drop-in facilities while others will only operate an appointment system. The remit of these services might include information, advice, counselling, group-work, outreach/ detached workers, needle/ syringe exchanges. Some street agencies work with GPs to provide primary health care and a prescribing service for maintenance, reduction or detoxification.

Community drug team (CDT)

These are multi-disciplinary and usually statutory services, based either in the community or in hospitals. They offer similar services to a ‘street agency’ but usually with more emphasis on prescribing.

Drug dependency unit (DDU)

These are statutory services often based on hospital sites. Generally they provide medical intervention, including psychiatric and psychological treatment. Drug prescriptions and detoxification may be accompanied by information, advice, needle/ syringe exchange, counselling and group-work.

Residential rehabilitation service (1st stage of intensive treatment)

Usually non-statutory, they are often drug-free services offering programmes which may include detoxification, therapy, groupwork, counselling, educational activities and preparation for re-entry into the community. Programmes would generally last from 3 - 9 months. Most funding would come from local authority community care budgets or Department of Health Drug and Alcohol Specific Grant. Some residential establishments may be funded by DSS payments topped up with funding from, for example, Probation.

Hostel/ supported accommodation (2nd stage of intensive treatment)

These are residential services for those having completed a residential rehabilitation programme or requiring a medium level of staffing and support. They are often directed at reintegrating drug users into the community and include, education, training, employment and re-housing. They may also provide counselling and/or group-work aimed at relapse prevention.

Semi-supported accommodation (alternative 2nd stage of intensive treatment)

These facilities are similar to hostel/ supported accommodation. They provide limited staff cover and probably no treatment/ therapeutic intervention. They are looking to promote re-entry into the community.

Specialist hospital in-patient unit

These programmes include in-patient detoxification and (often) a hospital-based treatment programme, including group-work, therapy and sometimes prescribing.

Structured day programme

These are intensive community-based support, treatment and rehabilitation programmes. They usually comprise a full-time programme of a defined length of around 8–12 weeks. As well as counselling and group-work, the programme may include work towards educational or vocational opportunities.

Self – help service group/ centre

Narcotics Anonymous and Families Anonymous are the principal self-help groups where ex-users or their families meet regularly to offer mutual support.

Family service group/ centres

These are services for whole families in which adult members are experiencing drug problems which affect the whole family.

Criminal justice intervention service

Work with drug using offenders at stages in the criminal justice process, e.g. before sentence (i.e. bail or remand), and while on probation, in prison and on parole, are the focus of these programmes. They may provide a range of services including assessment, advice, counselling, release planning and referral to other services. They may be a 'stand alone' service or part of a local service.

References

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