Throughcare
Working in partnership

Directorate-General Justice,

Freedom and
Security

LITERATURE REVIEW:
UNITED KINGDOM

THROUGHCARE

WORKING IN PARTNERSHIP

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1.0 Introduction

The following literature review for the *Throughcare services for prisoners with problematic drug use* will address the criminal justice systems of England and Wales in order to provide the context for the research that will take place both in Scotland and England. The key areas that will be addressed by the literature review are:

1. the current national drug situation
2. the structure of the prison systems to include drug use in prison settings and prison health systems
3. Organisation of existing throughcare
4. key debates and issues in current research on prisons and throughcare

For the purpose of this literature review, it is proposed to use the definition of throughcare used by Fox and Khan (2005:49) as it encompasses the criminal justice system and the community:

> *The term "Throughcare" refers to arrangements for managing the continuity of care which started in the community[added] or at an offender's first point of contact with the criminal justice system through custody, court, sentence, and beyond into resettlement. "Aftercare" is the package of support that needs to be in place after a drug-misusing offender reaches the end of a prison-based treatment programme, completes a community sentence or leaves treatment. It is not one simple, discrete process involving only treatment but includes access to additional support for issues which may include mental health, housing, managing finance, family problems, learning new skills and employment.*

Previous literature reviews have concluded that throughcare is an under-researched field. Most primary studies conducted with sound methodology are from the United States, and focus on interventions which are broadly similar (Webster, 2004).

Turnbull and McSweeney (2000), in their literature review based on a survey of 26 European countries, argue that the literature on aftercare is not well developed. In their European literature review, they note that:

> *In the literature the importance of aftercare for recently released prisoners who have received treatment in prisons is highlighted. Many studies … report on how aftercare help can have a dramatic impact upon post-prison drug use and re-offending rates (Turnbull & McSweeney, 2000; 9).*

Although the literature is under-developed in this field of study; there is strong agreement between the principal authors in the field that:

> *aftercare is vital to sustaining and promoting abstinence in drug using prisoners released into the community. There is a consensus that there are many difficulties to overcome and that meaningful partnership between criminal justice and treatment agencies planning aftercare services within prison and in the community by means of a carefully designed case management system is perhaps the best way forward (Webster,2004).*

2.0 The current national drug situation

This section discusses the existing literature relating to the UK drug situation and explores trends and different types of drug offences. The section also identifies specific groups which have been found to have problematic drug use.

2.1 UK strategy documents

A new United Kingdom Drug Strategy was launched in February 2008. Within this, policies concerning health, education, housing and social care are confined to England; policing and the criminal justice system, cover England and Wales. The Scottish Government and the Welsh Assembly Government also launched new strategies in 2008, the latter addressing drugs, alcohol and prescription drugs. All aim to make further progress on reducing the harms of problematic drug and alcohol use and each places greater focus on recovery. All three strategy documents are accompanied by an action or implementation plan.

2.2 Trends by drug

Latest survey data for England and Wales, from the 2007/08 British Crime Survey

(BCS), (Kershaw, 2008) show that prevalence of drug use amongst the general population continues to fall, largely due to a decrease in cannabis use. Recent increases in cocaine use have stabilised while reported use of crack cocaine remains low (0.1%). Recent use of ecstasy and magic mushrooms is at its lowest level since the BCS started asking drug use questions. Similar trends can be seen among young adults. This is reflected in two recent surveys in Northern Ireland, the Northern Ireland Crime Survey for 2006/07 (Freel and French, 2008) and the 2006/07 Drug Prevalence Survey (Department of Health, Social Services and Public Safety, 2008). These two surveys, while reporting similar prevalence, indicate conflicting trends. The former survey, similar in methodology to the BCS, shows a decrease in recent and current drug use, with stability in lifetime use. The latter suggests an increase in both lifetime and recent use since the previous survey in 2002/03, but a decrease in current use. However, there have been changes in methodology that could affect trends. In both surveys, trends that are similar for all adults can also be seen in young adults (Reitox National Focal Point, UK, 2008).

Males were much more likely to report drug use than females across all recall periods but especially recent and current drug use. The latest findings from the 2007/08 British Crime Survey shows that 9.3 % of 16 to 59 year olds have used drugs in the last year and 5.3 % have used drugs in the last month (Table 1). Cannabis was the most commonly used drug across all recall periods followed by cocaine for recent and current use. Males were much more likely to report drug use than females across all recall periods but especially recent and current drug use.

Table 1: Percentage of 16-59 year olds reporting having used individual drugs in lifetime, last year and last month in England and Wales, 2007/08

	Lifetime use			Last Year use			Last Month use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	41.8	29.9	35.8	12.6	6.2	9.3	7.5	3.2	5.3
Amphetamines	14.4	9.0	11.7	1.3	0.7	1.0	0.5	0.2	0.4
Cannabis	35.9	24.4	30.0	10.1	4.8	7.4	6.0	2.4	4.2
Cocaine	10.3	5.1	7.6	3.3	1.3	2.3	1.5	0.6	1.0
Ecstasy	9.7	5.3	7.5	2.1	0.8	1.5	0.8	0.3	0.5
LSD	7.4	3.0	5.2	0.4	0.1	0.3	0.1	0.1	0.1
Magic mushrooms	9.7	4.1	6.9	0.8	0.2	0.5	0.1	0.1	0.1
Opiates	1.2	0.5	0.8	0.3	0.1	0.2	0.2	0.1	0.1
Base	*13,209*	*15,291*	*28,500*	*13,120*	*15,211*	*28,331*	*13,103*	*15,202*	*28,305*

Source: Standard Table prepared for the United Kingdom Focal Point

There is a decline in overall drug use since 2003/04 from 12.3 % to 9.3 %and a corresponding decline in cannabis use from 10.8 % in 2003/04 to 7.4 % in 2007/08 in respect of those indicating recent use. An increase in cocaine powder use and decrease in use of amphetamines since 1996 is also evident, with the greatest change occurring before 2001/02. However, while the use of amphetamines continues to fall, the recent increase in cocaine powder use appears to be stabilising with last year use falling slightly from 2.6 % in 2006/07, to 2.3 % in 2007/08. In 2007/08, recent use of ecstasy and “magic mushrooms” was similar to the levels reported when the BCS started collecting drug use data, 1.5 % and 0.5 % respectively (Reitox National Focal Point, UK, 2008).

2.3 Drug offences

The Arrests for Recorded Crime (Notifiable Offences) and the Operation of Certain Police Powers under PACE England and Wales 2006/07 survey found that In England and Wales in 2006/07, 89,200 persons were arrested for drug offences; an increase of less than 1%from 2005/06. In Northern Ireland in 2007/08 1,896 persons were arrested for drug offences; an increase of 9.8 % from the previous year (Ministry of Justice Statistics bulletin, 2008).

In England and Wales however, arrests for possession have reduced considerably since 2004 with the introduction of a ‘cannabis warning’, rather than an arrest for possession of cannabis for personal use. In 2006/07, there were 22,900 cannabis warnings; an increase of 28 % from 2006/07 (Ministry of Justice Statistics bulletin, 2008).

Data gathered in 2007 suggests that 9.1 % of the prison population use drugs while in custody in England and Wales. However, survey data suggests the proportion in Scottish prisons to be 51 % in 2007. New research supports the already well documented evidence that problem drug users, particularly those using opiates and crack cocaine, commit a considerable amount of acquisitive crime to support their drug use (Scottish Prison Service, 2007).

2.4 Drug use amongst specific groups

The UK Drug Policy Commission (2008) observes that “drug-using and drug-dependent offenders are a diverse group”. Recent surveys indicate that drug use is higher in particular groups. The following groups are identified:

1. Gender

A higher proportion of males than females reported recent use of any drug; 13.7 % compared to 5.2 % (Reitox National Focal Point, UK, 2008).

2. Ethnicity

Findings from the 2007/08 BCS in England and Wales suggest that people who described themselves as non-white were significantly less likely to be recent drug users (5%) than those who described themselves as white (10%)., Amongst 16 to 24 year olds, the difference is much larger: eight % of non-white respondents and 23 % of white respondents were recent drug users (Reitox National Focal Point, UK, 2008).

3. Exclusion/ Truancy at school

School pupils in England who had truanted or been excluded are much more likely to be regular drug users, 14 % of truants and excludes reported drug use at least once a month compared to two % of other pupils. There has, however, been a decrease in the proportion reporting regular drug use from 21 % in 2003 (Fuller, 2008).

4. Sexuality

A survey conducted in 2008 found that lesbian and bisexual women were five times more likely to report recent drug use than women in general; 30 % reported recent use compared to 7 % in the BCS 2006/07 (Stonewall, 2008).

5. Looked–after Children

In 2006, the Department for Children, Schools and Families (DCFS) (formerly the Department for Education and Skills) started collecting information on the number of looked after children identified as having a substance misuse problem. Of the 44,200 children looked after for at least 12 months in the year ending 30th September 2007, 2,400 (5.4%) were identified as having a substance misuse problem (DCSF, 2007). This is a slight increase from 5.1 % in 2006 (Reitox National Focal Point, UK, 2008).

6. Socio-economic disadvantage

In Scotland, although some children and young people experiment with drugs (including tobacco, alcohol and cannabis) in their teenage years, few progress to be problem drug users. Any progression from experimentation with drugs at a young age to regular use is rare but its occurrence is strongly linked to socio-economic disadvantage and other activities such as involvement in offending. Despite the impact on the juvenile justice system, very little attention has been paid to assessing and treating young offenders for substance-related problems. Although most young female offenders are found to have some substance involvement, treatment via the system is scarce. Young offenders from ethnic minority groups are treated more severely and minority drug offenders in particular are more likely to be at increased risk of formal handling, detention and being placed in custody (UK Drug Policy Commission , 2008)

This section discusses the current literature on the nature and structure of the UK prison system and drug use within prison settings.

Offender management England and Wales has undergone a period of change in the last 10 years. In 2001-02 the UK government recognised that a joined up approach was needed if the rate of recidivism was to be reduced. In 2001, a key joint report by the HM Inspectors of Prison and Probation on resettlement, *Through the Prison Gate*, noted that no strategy existed to implement the National Correctional Policy Framework and made several recommendations for improved joint working between the Prison and Probation Services (HM Inspectorate of Prisons, 2001).

The Social Exclusion Unit's (SEU) 2002 report *Reducing re-offending by ex-prisoners* identified nine factors that were considered to influence re-offending. These were:

1. Education
2. Employment;
3. Drug and alcohol misuse,
4. Mental and physical health;
5. Attitudes and self-control;
6. Institutionalisation and life-skills;
7. Housing;
8. Financial support and debt;
9. Family networks (ibid, p.6).

These factors were taken forward in the seven pathways, identified in the *National Reducing Re-offending Action Plan*, which drive the national reducing re-offending delivery plan. The seven pathways are:

1. Accommodation;
2. Education, Training and Employment;
3. Health;
4. Drugs and Alcohol;
5. Finance, Benefit and Debt;
6. Children and Families;
7. Attitudes, thinking and behaviour;

More recently, two more pathways have been identified that recognise the specific issues relating to some women offenders. The SEU report recommended a 'fully integrated approach,' which they believed 'should deliver many of the key changes necessary to reduce the levels of re-offending among ex-prisoners' (ibid, p. 134).

3.0 National Offender Management Service (NOMS)

The government published its five year strategy for protecting the public and reducing re-offending in 2006 (Home Office, 2006). This document underlined the commitment to both protect the public and reduce reoffending with the creation of NOMS and

partnerships 'to address the many linked problems that contribute to offending' (Home Office, 2006:8).

NOMS came into existence in 2004 with the aim to create a seamless service by bringing prison and probation together. In 2007, NOMS became part of the newly created Ministry of Justice which brought together the headquarters of the Probation Service and HM Prison Service to enable more effective delivery of services. In England and Wales, NOMS is responsible for commissioning and delivering adult offender management services both in custody and in the community.

Offenders who are on probation are required to meet with their probation office on a regular basis and if they miss more than one meeting they can be sent back to court where further punishment may be ordered. There can be a variety of conditions that come with a probation order such as completing alcohol and drug treatment, living in approved premises, obeying a curfew, wearing an electronic tag and so on. Probation officers are based both in prison and in the community. In prison their role is to assist with sentence planning and to liaise with the probation service operating in the area to which a prisoner is being released. Prisoners with a sentence of more than one year are supervised by the national probation service.

In England and Wales, there are 140 prison establishments. The prison population (including pre-trial detainees/remand prisoners) was 85,009 (30/07/10), the percentage of pre-trial detainees/remand prisoners was 15.3 (30/06/10), the percentage of women prisoners was 5% (30/07/10) and the percentage of Juveniles / minors / young prisoners (under 18 years) was 2% (30/06/10). In June 2010 foreign prisoners made up 13.1% of the prison population (the nationality of an additional 3.4% was unrecorded). The prison population has been steadily rising since 1992 as can be seen in Table 2 below.[1]

Table 2: Prison population, England and Wales, 1992–2007

Year	Prison population
1992	44,719
1995	50,962
1998	65,298
2001	66,301
2004	74,657
2007	80,216

In Scotland there are 15 prison establishments. The prison population (including pre-trial detainees/remand prisoners) was 7,953 (30/06/10), the percentage of pre-trial detainees/remand prisoners was 17.7% (25/06/10), the percentage of women prisoners was 5.3% (25/10/10) and the percentage of Juveniles / minors / young prisoners (under 18 years) was 1.9% (26/02/10). In September 2007 foreign prisoners made up 2.8% of the prison population. The prison population has been steadily rising since 1992 as can be seen in Table 3 below.[2]

[1] Figures were taken from the world prison brief accessed on 4/08/10. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=169

[2] Figures were taken from the world prison brief accessed on 4/08/10. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=169

Table 3: Prison population, Scotland, 1992–2001

Year	Prison population
1992	5,357
1995	5,657
1998	6,082
2001	6,172
2004	6,885
2007	7,412

The prison services of England and Wales have a very different organizational structure particularly for the juvenile justice system. The main focus of the literature review is England and Wales and the Scottish system will be referred to where appropriate. However, in-depth information about the Scottish Justice system will not be provided.

3.1 Ethnicity, youth and prisons in England and Wales

The prison population is made up of a variety of different groups. The Ministry of Justice figures (2009) show that there are four times more arrests of Black people per head of population than of White people, and there are five times more Black people in prison per head of population than White people. The following table (Table 4) indicates the percentage of ethnic groups at different stages of the criminal justice system compared to the general population of England and Wales. When a higher proportion of an ethnic group is shown compared to the general population then there is 'disproportionality and they are over-represented at that stage in the criminal justice process' (MOJ, 2009: *x*). The over representation of young black people in the CJS can be linked to disadvantage and lawbreaking as Hill (2007:191) argues 'young black people… leading complex lives were often on the receiving end of systematic patterns of disadvantage'.

Table4: Percentage of ethnic groups at different stages of the criminal justice process compared to the ethnic breakdown of the general population, England and Wales 2007/08

	Ethnicity						
	White	Mixed	Black	Asian	Chinese or Other	Not stated/ Unknown	Total
General population (aged 10 & over) @ 2001 Census	91.3	1.3	2.2	4.4	0.9	0.0	100
Stops and searches[1]	68.1	2.5	13.1	8.1	1.2	7.0	100
Arrests[2]	79.3	2.8	7.4	5.1	1.4	4.0	100
Cautions[2][3]	82.5		6.5	4.6	1.4	5.0	100
Youth offences	84.8	3.5	5.8	3.0	0.4	2.5	100
Tried at Crown Court[3][4]	73.5		14.0	8.0	4.4	*	100
Court ordered supervision by probation service[5]	83.6	2.5	6.3	4.6	1.2	1.8	100
Prison receptions[6]	79.1	2.9	10.6	5.9	1.2	0.2	100

Source: MoJ, 2009. Note: Figures may not add up to 100% due to rounding.

The 2009 Ministry of Justice report indicated some interesting findings regarding ethnic groups in the criminal justice system:

> *A greater proportion of White defendants (78%) were found guilty than Black (75%) or Asian (73%) defendants. However, custodial sentences were given to a greater proportion of Black offenders (67%) and those in the Other category (68%) than White (53%) or Asian offenders (57%).*
>
> *There were 3.8 times more arrests of Black people per head of population than of White people (compared with 3.6 times the previous year). The police cautioned 350,492 persons for notifiable offences in 2007. Of these, 6% were recorded as Black people, 5% Asian and 1% of other ethnic origin.*
>
> *There was a lower use of cautioning for Black offenders relative to arrests (16%) compared with White offenders (24%).*
>
> *In 2007 ethnicity was recorded in 81% of the Crown Court cases, similar to 82% in the previous year. A greater proportion of White defendants (78%) were found guilty than Black (75%) or Asian (73%) defendants. However, custodial sentences were given to a greater proportion of Black offenders (67%) and those in the Other category (68%) than White (53%) or Asian offenders (57%)(Ministry of Justice, 2009; xii -xiv).*

According to Nacro (2007), the primary cause of the over representation of young black people in the criminal justice system is social exclusion and discriminatory treatment by the youth justice system.

Policy makers in England and Wales have raised concerns that there are particular groups of offenders who are particularly vulnerable. One such group is women who have distinct needs that are often unaddressed (Fossi, 2005). In 2010, the Inspectorate of Prisons carried out a comparison of women prisoners surveyed in 2003-05 with those surveyed in 2006-08. The report argues that there has been an overall improvement in the majority of women's prisons particularly in the area of drug treatment.

Although health care and mental health care was deemed to have improved, the report expressed concern at the continuing high level and seriousness of self harm particularly in local women's prisons. Conditions in some prisons were:

> …not judged to be sufficiently safe: one had noticeably declined when increased numbers led to the use of a large number of detached duty staff, many of them men. Dormitory accommodation in women's prisons remained highly unsatisfactory, on grounds both of safety and respect. Three prisons were also not performing sufficiently well in resettlement, because services were not sufficiently aligned to the specific needs of women, or of the women who were held. Work with foreign nationals was often underdeveloped, a serious failing given the over-representation of this group within the women's prison population (HM Inspectorate of Prisons, 2010).

4.0 Mental Health in prisons and the Bradley Report (2009)

The prevalence of poor mental health among offenders is a key management issue in the UK, particular in respect of throughcare provision. Although there has been a substantial amount of work done to meet the needs of prisoners with mental health problems, more work is required. Despite the introduction of mental health in-reach

teams, prison health care is still under resourced to meet the needs of prisoners with complex mental health needs such as dual diagnosis and personality disorder. In fact, current provision often does not meet the needs of the seriously mentally ill as was originally envisaged (Steel et al, 2007). Much of the work has also questioned the appropriateness of prison for those with mental illness whose crimes were less serious and not 'goal-directed'.

A key policy document is the *Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system* (Bradley, 2009). This report highlighted the growing proportion of prisoners with mental health issues in prisons and observed that prison was the wrong environment for prisoners with mental health issues because custody could 'exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide' (Bradley, 2009: 7).

Bradley noted that despite the existence of a government-supported policy of 'diversion' for people with mental health issues and learning disabilities since 1990, there had been a lack of a nationally guided approach resulting in inconsistent implementation. Since then, policy developments in the health and criminal justice sectors have created a much more receptive background for implementing this diversion approach. For example, offenders are now recognised as part of a socially excluded population. In addition, there have been long-standing difficulties in defining learning disabilities.

However, Bradley, despite being much anticipated, has been heavily critiqued. Brooker et al. (2009) for example, argue that Lord Bradley has missed an opportunity to recommend much needed improvements inside prison as well as outside it. The poor level of prison mental health funding is not addressed by the Bradley Review – there is an imbalance in the amount spent by prisons from their total health care budget on mental health compared with the community – 11% in prison and 15% in community. According to this argument, there should be a shift from a focus on primary care to an integrated prison-wide mental health care system. The resettlement of offenders on release from prison is also a crucial issue. Specialists are required on the ground to ensure that the complex task of delivering mental health services in prisons is analysed, audited and funded properly.

Brooker et al. also argue that there needs to be an increased emphasis on staff training, an issue also identified by the Sainsbury Centre for Mental Health and Skills for Justice (2009). They argue that there is a need for a more joined-up approach to delivery of services based on a national level.

Police forces and courts are required to submit data centrally for the collection of criminal justice data. Different legal and data collection systems in England and Wales, Scotland and Northern Ireland mean that it is not possible to provide data on the outcome of drug offences on a United Kingdom basis. In England and Wales in 2006 there were 200,270 drug possession offences recorded by police and 37,913 drug trafficking offences. There were a total of 90,926 arrests for drug offences. 42 % of all stop-and-searches carried out were under suspicion of drug offences. Of these, eight % resulted in an arrest for Class A drugs (Reitox National Focal Point, UK, 2008).

5.0 Problematic drug use in prison

Scotland and England and Wales have similar figures for proportions of prisoners with problematic drug use. In Scotland, 69% of prisoners overall reported having used illegal drugs in the previous 12 months before coming into prison. 51% of prisoners claimed to have used drugs in prison at some point in the past (Scottish Prison Survey, 2007).The Scottish Prison Survey also reported that most of those who claimed to have used drugs in prison in the past said that their drug use had changed, with most (82%) reporting that their drug use in prison had decreased. In addition:

> *A small minority of prisoners (3%; n=100) reported injecting drugs in prison in the last month. Of this small minority of injecting prisoners, most (80%; n=80) stated that they had shared their "works (injecting equipment). Half of prisoners (45%) reported that their drug use was a problem for them on the outside and that they were under the influence of drugs at the time of their offence (50%). A quarter (26%) indicated that they committed their offence to get money for drugs (Scottish Prison Survey, 2007, Executive Summary).*

Approximately half of the respondents to the 2007 Scottish Prison Survey indicated that they had been assessed for problematic drug use at reception to the prison and been offered treatment; a third had actually undergone treatment during their sentence (see table 5 below). The response from the survey also highlighted the need for throughcare from prison to the community, as 30% of respondents were concerned that their drug use would be a problem when they were released (Scottish Prison Survey, 2007)

Table 5: Prisoners with Problematic Drug Use: Assessment and Treatment

Category	Percentage
Assessed for drug use at reception	51
Chance to receive treatment for their drug use	40
Received treatment during sentence	35

Source: Scottish Prison Survey, 2007

According to the National Offender Management Service (2006), there are 10,680 people in prison for specific drug offences. Drugscope (2005) reporting on women prisoners and their drug use found that:

- '40% of sentenced women in prison were for drug offences in 2002, compared to 16% of men.'
- 'Nearly two-thirds of women in prison have a drug problem according to a survey carried out in 2001. Anecdotally, in some prisons, this is considered to be about 70-80%'

- ‘Nearly two-thirds of those who commit suicide in prison have a history of drug misuse and nearly a third a history of alcohol misuse' (McSweeney et al 2008: 43).

5.1 Infectious diseases in prison

Previous research has claimed that prisoners in England and Wales are more likely to be infected with HIV than other members of the population due to high-risk behaviour, particularly injecting drug use.

One of the main issues highlighted in recent research (MacDonald, 2007; Lines, 2006) is that clean needles, which enable prisoners who are injecting drugs to protect themselves from HIV infection, are not provided in UK prisons. Access to condoms in prison is at best variable but often poor; condoms are not available at all in prisons in Northern Ireland. HIV prevalence in prisons is significantly higher than in the general population demonstrated by the last anonymous sero-survey of HIV and hepatitis C infection to establish HIV prevalence in prisons (1997). Currently, data on diagnosis and treatment or HIV/hepatitis C co-infection in prisons are not available.

Serious concerns were raised by the Prison Reform Trust (PRT) and National Aids Trust (NAT) (2005) Survey about how HIV and Hepatitis C in UK prisons were being addressed with a third of prisons surveyed having no HIV policy and one in five having no hepatitis C policy. The survey also identified that many prisoners did not have appropriate access to condoms, disinfecting tablets, clean needles or healthcare information.

5.2 Alternatives to prison for problem drug users

With a rising prison population, the ability of prisons to cope with all healthcare needs of prisoners will become more of a concern. In England and Wales, a review of the prison system suggested that as well as an expansion of prison capacity, changes are needed in existing sentencing legislation to modify the use of custody for certain types of low risk offenders and offences, reserving custody for the most serious and dangerous offenders. Following this review, the Ministry of Justice suggests that community sentences, including drug rehabilitation programmes, can be a more effective punishment than short prison sentences for drug using offenders. To this end, the probation service in England and Wales is to receive an additional €58.8 million (£40m) to pilot intensive alternatives to custody (Reitox National Focal Point, UK, 2008).

The new United Kingdom Drug Strategy seeks to increase the number of conditional cautions with a Drug Intervention Programme (DIP) condition to 2,000 by March 2009, which means doubling current usage. Drug Rehabilitation Requirements (DRRs) are also to be extended with plans for 1,000 such orders by 2009. As mentioned previously, the probation service is to receive additional funding to pilot intensive alternatives to custody. Drug Treatment and Testing Orders (DTTOs) continue to be the main community sentence imposed on drug using offenders in Scotland although, until recently, these have been used only with high tariff offenders. In June 2008, two pilots extending them to lower tariff offenders commenced. A total of 696 DTTOs were made in 2006/07, up 16 % from 599 in 2005/06 (Scottish Prison Service, 2007).

5.3 Prison health care

In Scotland, primary health care is the responsibility of the prison service either by those directly employed by the prison system or contracted with hospital care provided by the National Health System. Each prison has a devolved budget for health care under the responsibility of the prison governor and the SPS Health Care Policy group. Currently, Primary Care medical services and pharmaceutical services are provided via national contracts with outside providers. Opticians and dentists are employed directly on a contractual basis. The privately run prison at Kilmarnock has separate arrangements for the provision of health care (Scottish Prison Service Website)[3]

5.4 Measures available for drug users

Law enforcement agencies have a number of measures available to them when dealing with drug offenders. These include out-of-court disposals such as cautions in England, Wales and Northern Ireland and fiscal fines in Scotland. In addition, there are a wide range of measures that can be used after a finding of guilt by a court including custodial sentence, community sentence, fine, and confiscation order.

6.0 Organisation of existing throughcare

This section examines the literature on existing drug treatment and throughcare practices. It explores prison drug treatments available, UK strategies and provision of throughcare.

6.1 Prison drug treatment

The provision of drug treatment is a priority for both the English and Welsh and Scottish Prison Systems. The treatment available for problematic drug users in prison falls into five categories:

1. Provision of Detoxification;
2. Maintenance-prescribing;
3. Interview with the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) workers;
4. Provision of rehabilitative programmes; and
5. Voluntary testing compacts (by committing to remain drug free the prisoner receives enhanced privileges with compliance underpinned by drug tests).

The number of prisoners who are receiving the above treatment options is recorded by the prison service on a individual prison basis and the results of mandatory drug testing is recorded nationally for all prisons.

The cost of providing the above treatment in England and Wales has increased from £7 million in 1997/98 to £80 million in 2007/08. Available treatment options differ

[3] http://www.sps.gov.uk/default.aspx

between individual prisons and different regions and results in an extremely complex range of interventions.

It is important that aftercare programmes are in place to continue the benefits made by drug treatment while in prison. Aftercare programmes are key in reducing relapse and post release risk of overdose particularly during the first two weeks after release from prison (Seaman et al., 1998). According to the UNODC:

the mortality rate of prisoners under post-custody supervision is three and half times that of the general population, and one-quarter of deaths occur within the first four weeks of release. The main risk factors for overdose deaths after release are:

- injecting heroin;
- recent history of non-fatal overdose;
- longer injecting career;
- high levels of use or intoxication;
- high levels of alcohol use;
- low tolerance because of detoxification in prison;
- depression;
- a history of using combinations of drugs including benzodiazepines and/or alcohol;
- sharing injecting equipment (may be indicative of low concern about personal risk);
- premature exit from a methadone treatment programme;
- not being in a methadone or other treatment programme (UNODC, 2008: 61).

The number of deaths can be reduced when there is good liaison between drug treatment and mental health services in prison with community services and where there are clear protocols between prison and community service providers.

The effectiveness of drug treatment that has been initiated in prison can be sustained by good aftercare provision by providing post release support for those released to build on the changes that they started while in prison.

According to the 2008 UNODC Report,

> *recidivism and relapse rates for released prisoners who have participated in prison drug treatment programmes are slightly lower than for control groups that have received no treatment at all. However prisoners who complete both in-prison treatment programmes and who attend residential aftercare programmes have significantly lower rates of drug use and re-arrest (Inciardi, J.A., et al. 1997); Dolan K, Khoei EM, Brentari, C, and Stevens A 2008); (Mitchell, O; Wilson, D and MacKenzie, D 2006)*

Information on those in treatment is available for England only. The National Drug Treatment Monitoring System reports that, of those in treatment in 2006/07:

- 148,866 were problem opiate and/or crack cocaine users (either using

these as primary drug or as a secondary or tertiary drug); that is 45 per cent of the PDU estimate, this compares with 42 % in 2005/06.

- there were 140,357 opiate users, 49 % of the PDU estimate (46% in 2005/06);
- there were 46,415 crack cocaine users in treatment, 24 % of the PDU estimates (21% in 2005/06) (Reitox National Focal Point, UK, 2008 IS ALL THE

6.2 UK Drug Strategy and Throughcare

In the UK, there are a number of interventions for offenders with problematic drug use: with most drug strategies focusing more and more on the provision of treatment and support services for drug-dependent offenders as a way of reducing overall crime levels. The 2008 UK drug strategy has continued this focus emphasis. In the 2008 United Kingdom Drug Strategy, *Drugs: protecting families and communities,* policies concerning health, education, housing and social care are confined to England; those relating to policing and the criminal justice system cover England and Wales. The Scottish Government launched, *The Road to Recovery. A New Approach to Tackling Scotland's Drug Problem*. The Welsh Assembly Government launched *Working Together to Reduce Harm – the Substance Misuse Strategy for Wales 2008-2018,* a combined approach to the misuse of drugs, alcohol and other substances (Reitox National Focal Point, UK, 2008).

The UK Drug Policy Commission (UKDPC) has conducted an analysis of evidence from these initiatives and concluded they are effective in reducing drug use and reoffending (UK Drug Policy Commission, 2008). They argue that there are no published evaluations of the effectiveness of *CARAT interventions; drug-free wings; programmes based on cognitive behavioural therapy, such as short-duration programmes and ASRO (Addressing Substance Related Offending) programmes; conditional cautions; diversion from prosecution schemes; and Intervention Orders* (UK Drug Policy Commission 2008). In addition they identified that '*prison drug services frequently fall short of even minimum standards'.* They also stress that although there have been improvements in the number of prisoners who receive detoxification despite overcrowding and short sentences there is still not:

> *sufficient support and aftercare and many prisoners are not getting the help they need. This will lead to an increased risk of relapse and overdose, particularly on release into the community (UK Drug Policy Commission 2008:14).*

Current UK strategies aim to have a greater focus on recovery and a service provision that is focused on the needs of the individual, in conjunction with new approaches to drug treatment and social re-integration. Also, there is now a much stronger emphasis on preventing harm to children and young people and to the provision of support to families affected by drug misuse.

To implement the new strategies where powers are not devolved, 30 new Public Service Agreements (PSAs) set out the key priority for Government, each underpinned by a Delivery Agreement. A new National Performance Framework supports delivery in Scotland, where one indicator is "reducing the estimated number

of problem drug users in Scotland by 2011". In Wales, a new National Substance Misuse Strategy Implementation Board will oversee delivery of the strategy (Reitox National Focal Point, UK, 2008).

6.3 Provision of throughcare

Providing high quality throughcare for prisoners with problematic drug use has been identified in the literature as a challenge and provision for this group can be lacking (MacDonald, 2007; Social Exclusion Unit in 2002; Harrison 2001). Additionally, prisoners with problematic drug use can be at risk of overdose and death due to the high levels of drug use in the community after a period of limited drug use in prison. Harrison (2001) points out that what is needed are holistic aftercare services that '*attempt to address the needs of the 'whole person', not just their substance misuse'*. This need for a holistic approach is reinforced by Turnbull (2000) who points out that it is hard for prisoners with problematic drug use to manage the transition from institutional settings to the community. Many ex-prisoners:

> *have no choice but to return to the community from which they originally came. This will often be poor, deprived areas where exposure to others using drugs is likely. The resolve prisoners developed not to use drugs on their release may quickly disappear.*

Webster (2004) argues that it is difficult to provide continuing drug treatment in the community where prisoners may have embarked on drug treatment under pressure of the criminal justice system and who choose to opt out of treatment upon release. This is not to say that prison based drug treatment is wasted; rather, it needs perhaps to be seen as a first phase of treatment that may lead to accessing drug treatment in the community (Webster, 2004).

7.0 Key debates and issues in current research on prisons and throughcare

The literature reviewed identifies the following as being crucial to successful throughcare:

- Individual care plans that meet the needs of different target groups i.e. women drug users
- A nominated case worker
- Ease of access to services
- Self help groups to provide added support
- A balance between support and supervision
- High quality services that have been evaluated
- The need for co-operation between prison-based and community-based agencies and the importance of an effective case management system

One of the most important factors in providing throughcare is the establishment of collaborative partnerships with a range of relevant agencies; this is a key factor in the

success of re-settlement work. Webster advocates that these relationships should be characterised by a sense of 'shared purpose' (Webster, 2004:18).

Many prisoners, who have undertaken drug treatment whilst in prison, relapse when they are released. Often, this is because they return to their homes where their social networks were built on a culture of drug use. Continuing to remain drug free after prison can also be much harder for those with mental health problems. One way to help released prisoners is to facilitate self help groups to provide support and alternative social networks. A study by Pollack about drug users with mental health problems notes that those he interviewed found it easier to meet the self help group as the meetings were at more convenient times, sociable and nearer to where they lived (Pollack, 1998).

Webster (2004) provides a very useful checklist of critical success factors for the provision of throughcare and this will be a useful tool to help in the design of the evaluation template required from the EU Throughcare Services for Prisoners with Problematic Drug Use *(*See Appendix 1*)*

Many prisoners including those with problematic drug use are concerned that they may experience prejudice after release when they attempt to find housing and employment. At the point of release, many prisoners have problems with housing and may have no 'fixed abode'. The impact of not having a permanent address can be that throughcare arrangements are not made and adequate information about community drug services is not provided. Farrell (2000) points out that some prisoners might claim not to have a permanent address as a higher cash discharge allowance is given to prisoners who are homeless at the time of release. Ex-prisoners with drug and alcohol problems need more than access to community addiction services. They require support to manage their finances, housing, learn new skills, find employment and re-establish family relationships. Research has shown that once housing and employment have been secured, continued support is still required:

> *Our research shows that many homeless people are highly motivated to work, with financial rewards from work rarely being the primary motivation. But the route from homelessness into sustainable employment is often extremely complex and non-linear (New Economics Foundation, 2008:2).*

This process from homelessness into employment requires continued support as, other factors require attention after permanent accommodation has been secured. Help is needed with budgeting, negotiating changes in benefit payments, assistance in transferring to a different financial situation at the start of taking up employment, which can be financially difficult and often adjusting to a period of social isolation for those who have been homeless. If these needs are met and a more holistic approach adopted, then attendance at community drug services may well also improve.

If prisoners are released without adequate support to find housing, deal with finances and medical support then there is a higher risk that they may re-offend and be at increased risk of drug overdose.

7.1 Remand prisoners

Arranging throughcare is difficult in the case of those prisoners on remand who may be in prison for a relatively short time and who may not be close to the area where they come from. This is particularly acute for women prisoners who are frequently in

prison far from home. Arranging community drug treatment services for remand prisoners is highlighted in the literature. Farrell, 2000 notes that despite attempts by prison staff to make arrangements that coincide with planned release dates, this can be problematic in some instances, particularly in rural areas. In reality, sentence planning is also extremely difficult for those on short sentences leading to the same problems that agencies are faced with when arranging throughcare for remand prisoners (Baldry, 2007). Much of the literature argues that prisoners with problematic drug use who have been given short sentences should be diverted from custody and serve their sentence in the community. UNODC argues that

> *Where they (PDUs) do receive short custodial sentences, a 'fast-track' priority status for in-prison treatment and aftercare planning needs to be in place. Appropriate treatment is not always available for prisoners serving short sentences. Therefore they should be provided with information on services in the community, how to access them and where possible referral to them (UNODC, 2008:59).*

The services available for arranging throughcare for prisoners may be very different in different regional areas resulting in different outcomes. Farrell, for example, notes that in some regions:

> *arrangements were successfully made for prisoners to access services on the first day of release, or at least within the first week, while in other areas waiting lists of several months were in operation. Some prison staff observed that community providers were reluctant to make appointments for released prisoners due to experience of high non-attendance from this group. Where appointments could not be secured, the alternative was to provide prisoners with details of drop-in sessions, although it was felt that this was less likely to encourage attendance than a definite appointment (Farrell, 2000).*

Despite the commitment of prison CARAT workers and health care staff to providing adequate throughcare, this could still be problematic especially for remand prisoners with problematic drug use being released after court appearances. Key barriers cited by those in Farrell's study (ibid) were the availability of community drug treatment services and housing services. As noted above, the impact for prisoners with no 'fixed abode' could be that no throughcare arrangements were made. However, Farrell found that information about community services relating to the area that homeless prisoners said they would be likely to return to was provided . Housing was also identified as a problem area when prisoners indicated that they did not wish to return to their previous home address and friendship groups as these were based on drug using; this could increase their likelihood of starting to use drugs again.

The Sainsbury Centre for Mental Health (2008) argues that providing throughcare for released prisoners with mental health problems is particularly critical, particularly as many prisoners have complex mental health needs that are often not recognised:

> *despite a wide awareness of the risks, continuity of care between the community and prison is lacking. Birmingham (2004) reported that prisoners with mental health problems often do not receive treatment or care in the community because their needs are not properly identified in prison. Melzer et al. (2002) identified 140 prisoners who had experienced psychosis during their initial prison sentence. When they followed this group up, only 53% had received help for mental health, substance abuse or emotional problems since their initial interview, even though some of these were still in prison. Of those who had been released only 23% had an appointment with a mental health professional (Sainsbury Centre for Mental Health 2008:10).*

One response to the throughcare needs of those with mental health problems is the Diversion and the 'All-Stages model' developed by the Sainsbury Centre for Mental health. The model covers seven stages of the criminal justice system (CJS):

- Prevention;
- Pre-arrest;
- Point of arrest;
- Arrest pre court;
- Bail, remand, sentence;
- Custody and detention;
- Community.

The model can be helpful in identifying those with mental health problems and divert them from the different stages of the CJS. A key finding of the report was that information about treatment a prisoner had been receiving in the community was often not passed on to the prison:

> *many of the prisoners we spoke to had been receiving a range of services in the community, for example, mental health and substance misuse treatment and support. However, information about the support they were receiving is often not passed on to the prison service. Therefore our findings would recommend that continuity into prison needs to be improved to ensure prisoners receive a seamless provision of care into and out of prison (Sainsbury Centre for Mental Health 2008:58).*

7.2 Throughcare for hard to reach groups

Arranging throughcare for women and Black and Minority Ethnic groups is often problematic. The reasons for the lack of engagement of these two groups in co-operating with prison staff in arranging throughcare is often the lack of specialist services in the community and, in the case of women prisoners with children, a fear that involvement with social services and throughcare agencies will lead to their children being taken into care (Fox, A. et al, 2005). Social workers were identified as holding negative attitudes towards drug users and those on methadone programmes by former drug users as in a study by MacDonald (2009). The lack of understanding that some social workers had was considered to be responsible for some young women not wanting to register for a methadone programme after release from prison:

> *Social work is a key issue for women drug users. Social workers often don't understand drug use and many women fear that they will lose their children if they go onto a methadone programme. "What the hell do social workers know about people with addictions? So these women will sit at home and suffer rather than get help to stop using drugs (MacDonald, 2009: Users Focus Group).*
>
> *The minute I told the social worker I had a drug problem the …. hit the fan, that was it. Even their faces changed and I have been clean now for over a year and the doctor at the methadone programme was also saying we were two of the most motivated parents but this was also ignored. I don't know what more I*

could possibly do I go to parenting classes every week but I can't put a foot wrong (MacDonald, 2009: Users Focus Group).

Once a junkie always a junkie and they consider me to be living a chaotic life and I can't get on with my current social worker. (MacDonald, 2009, Users Focus Group)

The organiser of a drug user Involvement Group reinforced the point that the attitude of some social workers to women with problematic drug use who have children could be very negative:

What I have witnessed is the attitude towards parents. Where people are sorting themselves out and this is not getting recognised which is to a certain extent understandable but still needs to be recognition as well. They also need to understand the motivation that getting their child back can really have but the parent are not getting listened to or receiving any support. There should be support for the parents. Some social workers do recognise that drug using parents can be good gatekeepers of their own paraphernalia and that their kids are highly protected and the social worker won't take their kid away but there are others who are blinkered and take extreme action. There is almost an expectation for those (PDUs) in recovery to fail. If there was more support for those in recovery then there would be less people failing (Interview, Inverness, 2008).

Fox (2005) identified some promising practice that encouraged greater engagement with hard to reach groups that included:

- raising the profile of drug services for Asian prisoners in Brixton Prison via specialist drug projects for Asian Users in Tower Hamlets;
- Having a staff group from diverse backgrounds was considered to have helped to attract clients from several ethnic origins (this was not thought to have resulted in an increase in BME referrals by other aftercare teams);
- Holding meetings with local BME community groups
- Community link workers undertaking prison visits and gate pickups to encourage female prisoners to engage with the services offered.

Young offenders, those from the BME community and those with mental health disorders and/or intellectual disabilities are often the groups that have the least specialist throughcare provision at the time of release back into the community.

7.3 Evaluation and Monitoring of Throughcare

Evaluation of both the processes involved in the arrangement of throughcare and of individual service providers are crucial to be able to provide accountability, feedback and identification of areas of best practice. It is also essential to understand what does and doesn't work, and why so that successful practice can be replicated and areas of concern identified. In order to evaluate effectively, a clear model or approach needs to be used that includes clear aims and expected outcomes. Key areas that need to be included in the evaluation should be identified. These could be:

- Implementation: including service and policy development, the service model, implementation plans, criteria for participation; programme components, treatment length, staff competence and training;

- Process: including assessment and admission; programme access (including access by minority groups); completion rates; reasons for discharge; drug testing results; prisoner disciplinary records; level of service delivery (including whether delivered at level/frequency intended) and operational constraints on service delivery;

- Outcome: analysis of outcomes in relation to drug use, criminal activity, social adjustment, health risk behaviours and cost.

Methodology should include pre and post test comparison, including long term follow up (UNODC, 2008:86).

Evaluation and monitoring of throughcare provision is identified in the literature as often missing, resulting in the lack of an evidence base about what interventions are successful and those which are not. Fox (2005) identified that many agencies wanted to evaluate how their services functioned but felt that they lacked the time and staff resources to follow up clients after they had left programmes. Farrell (2000) found that some CARAT teams met with problems of client confidentiality and reluctance to provide information when they attempted to follow up whether referrals made in prison had been used by prisoners after release by contacting community agencies.

Many agencies involved in the provision of throughcare do not use systematic and objective methods of assessing the short and long term impact of their services.(Baldry, 2007). The lack of monitoring and evaluation of service provision can result in problems attracting future funding and a lack of sustainability. Staff interviewed in the study by Fox (2005) felt that there was not an existing tool for outcome monitoring that was appropriate for use in resettlement work with substance misusers.

The key aim of the *Throughcare Services for Prisoners with Problematic Drug Use* project is to develop an evaluation tool that can be used for service providers. Some of the key issues that will need to be considered are how to measure the effectiveness of the provision, should it be longitudinal in nature, should it use qualitative or quantitative measures, analysis of Recidivism and reconviction rates and so on. In the development of such a tool, it is important to remember that problematic drug use is a chronic and relapsing condition and that:

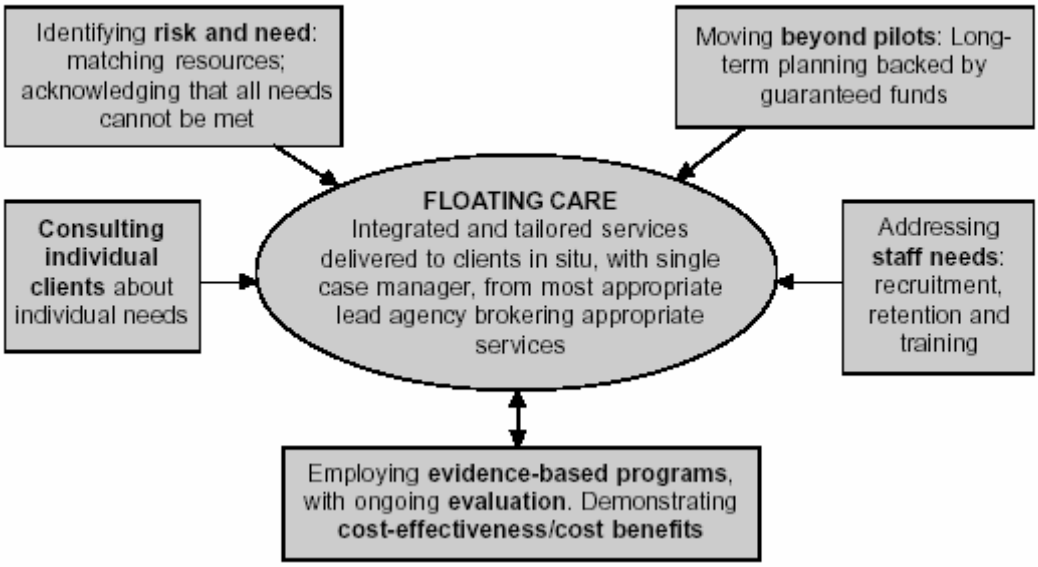
> *recovery from dependent drug use and desistance from offending need to be viewed as processes or journeys, rather than single events that can be orchestrated easily. Therefore, it is likely that most drug-dependent offenders will go through multiple treatment and other interventions before they end their offending and drug-using careers (UK Drug Policy Commission, 2008).*

8.0 Conclusion

There is consensus amongst authors that throughcare is a key factor for prisoners with problematic drug use and one that encourages them to either remain drug free or to build on the drug treatment they received whilst in prison. The most effective throughcare is that which is delivered in partnership with all the relevant agencies, both in prison and in the community, to provide individual care packages. An approach that takes an holistic view of the needs of ex-prisoners, which includes

support with finding housing, skill development, employment, finances and re-building family relationships will have a higher probability of success. A useful throughcare model is Borzycke (cited in Webster, 2004) (see below Figure 1).

Figure 1: *A model of throughcare service delivery to ex-prisoners*



However, even if such model is adopted there are still major problems to overcome in the provision of throughcare for prisoners. These include a fragmented criminal justice system subject to continual policy changes and an ever increasing prison population stemming from an ideology that prison works in reducing re-offending. This is contrary to the evidence as Baldry (2007) argues, “even if these programs were mainstreamed across the whole post-release population…. this would not resolve the matter”. Indeed, as the UK Drug Commission has noted, ‘There is no single intervention, or magic bullet, that will solve their dependency and change their behaviours or overcome the problems underpinning their drug use. A one-size intervention will not fit all (UK Drug Policy Commission, 2008).

The work done by the Sainsbury Centre for Mental Health has produced a wide ranging model that encompasses the entire criminal Justice system and clearly identifies the need for throughcare provision for all who come into contact with it.

Appendix 1: Checklist of critical success factors

(From Webster, 2000: 18-19)

In a study of the aftercare needs of dual diagnosis patients, Pollack reports on his cohort's views of what is important in aftercare for them, grouped under three headings: attitude of staff; information; and service. This list has been added to from the review of the literature, and an extended version is presented below in the hope that it will serve as a useful checklist against which to measure any new aftercare service.

Staff Attitude

- Available outside office hours
- Supportive and caring
- Service users feel able to ask questions and talk freely
- Actively sets out to engage service user and build motivation
- Honest about what aftercare services are, and are not, available
- Ex-drug using prisoners involved in service design and delivery

Information

- Education on particular substances and disorders
- Information about range of services and how to access them
- Encourage attendance at self-help meetings
- Information provided in an easily accessible, portable form

Service

- Continuity from in-prison treatment
- Fast access
- Wide range of services with a holistic approach
- Secure housing
- Fast access to employment, training and education
- Transportation
- Individualised packages of care
- Outreach service and check up calls and appointment reminders

- Regular monitoring of drug use and attendance in treatment
- Services for affected others
- Women only provision

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