



An tSeirbhís Phromhaidh
The Probation Service



Review of Drug and Alcohol Treatment Services for Adult Offenders in Prison and in the Community



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Eustace Patterson Limited

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Executive Summary

(i) Introduction

In 2015, the Probation Service and Irish Prisons Service (IPS) sought an independent review of alcohol and drug treatment services for adult offenders in the community and in prison.

The review explores current provision and provides recommendations based on the evidence collected. It sets out a **model of effective practice** for the treatment of adult offenders which facilitates a continuum of care from prison to the community.

A multi-method approach was used to meet the terms of reference. This included a literature review, consultations with key personnel in the Probation Service, IPS, service providers, the National Drugs Rehabilitation Implementation Committee (NDRIC), and the Health Service Executive (HSE), as well as site visits to Cork and Mountjoy Prisons, five community-based organisations and five Local Drugs and Alcohol Task Force projects (LDATFs).

(ii) Model of Effective Practice

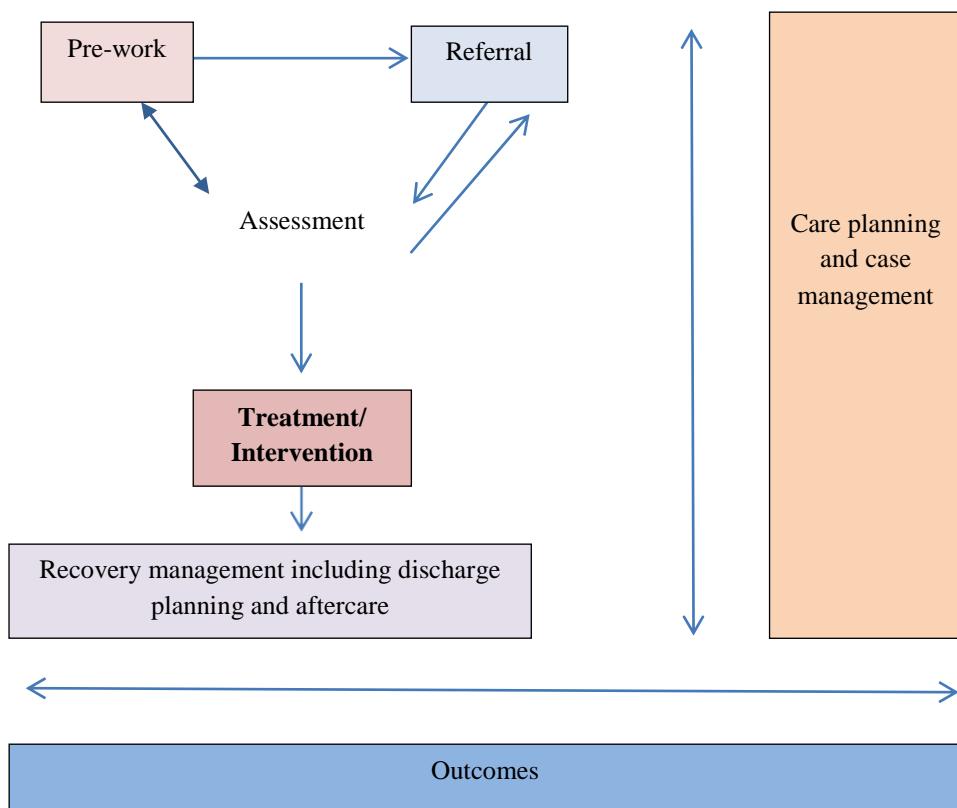
The model of effective practice is presented in the main report. This is based on a review of international literature, the NDRIC framework, consultations with community-based organisations¹ and prison-based health teams and addiction counsellors. It recognises that recovery from addiction is a long-term process that frequently requires multiple episodes of treatment and/or interventions. It acknowledges that no one treatment option fits all individuals and a broad range of options is required. It highlights the importance of good communication and co-ordination both within systems (e.g. prison) and between systems (e.g. prison and community).

The principles underpinning the model include equity of access, choice, person centred provision that uses evidenced-based treatment and intervention options, co-ordinated approaches with clear treatment pathways into and out of different settings, using time in prison as an opportunity to address addiction and having a focus on outcomes.

The core components of the model are interlinked rather than linear. These components are pre-work and preparation, referral, assessment, care planning, case management, treatment and recovery management. The model will work in both the community setting and prison setting. The model is summarised in Figure 1.

¹ Whenever this document refers to Community Based Organisations (CBOs) it refers to a community based organisation (CBO) funded either fully or partly by the Probation Service, the Irish Prison Service or both.

Figure 1: Summary of Effective Practice Model



(iii) Strengths of the Current System of Provision

Addiction is a major contributory factor in criminality. The Probation Service's Drugs and Alcohol Survey (2011) found that the majority of alcohol and drug misusing offenders had their misuse linked to their offending. Martyn (2012) found that 89% of adult offenders on probation supervision had misused drugs or alcohol and Freeman and Allen (2015) found that 60% of prisoners in Cork prison had a documented history of substance abuse and addiction.

Both the Probation Service and the IPS recognise the role drugs and alcohol play in criminality and recidivism and both have invested heavily in developing a system of provision to address drug and alcohol addictions.

The prison environment provides a unique opportunity to support individuals to address addiction and it is appropriate that a range of treatment and intervention options is provided in the prison estate.

Excluding direct staff and GP costs, the IPS and Probation Service have combined expenditure of €3.33m on the provision of addiction services for adult offenders. Expenditure by the Probation Service has remained stable in recent years, while spending by the IPS has reduced in line with the decline in prisoner numbers. However, those in prison are now more likely to be the most challenging and chaotic. This includes those with a dual diagnosis of addiction and mental health issues.

Health teams are present in every prison and some staff have specialist qualifications in the treatment of addiction. Clinicians have an interest in addiction and are familiar with the care pathways within the prison estate, thus increasing their effectiveness.

The development of joint strategies between the Probation Service and the IPS has supported the development of a more integrated and co-ordinated approach to dealing with offenders, including those with addictions.

The current model of provision is a mixed methods layered approach incorporating residential treatment provided in the community using a number of treatment regimes. This includes detoxification within prison, methadone treatment, one to one and group addiction counselling, specialist treatment methodologies (e.g. Cognitive Behaviour Therapy, Therapeutic Communities, 12 Step Programmes), harm reduction and relapse prevention. This mixed methods way of working fits with international best practice and is appropriate.

The NDRIC framework is an important national development that the Probation Service and the IPS have aligned with. There are opportunities to further strengthen this alignment with NDRIC, most notably in the areas of care planning, enhanced communication and protocols with the HSE, better internal and external co-ordination.

While small in number and primarily Dublin-based, community prison link workers are a valuable resource which provides a link for offenders between prison and the community.

Greater integration of these workers in the system of provision, including links with the work of Probation Officers and Integrated Sentence Managers (ISMs), would be supported by the development of a formal joint Service Level Agreement between the Probation Service and the IPS and organisations providing community prison link workers.

From the limited outcomes data that is available, positive outcomes are evident. Overall we can expect between 70% and 100% of those who enter a detox programme to complete it, and between 60% and 80% of those who commence treatment to complete it. Of those who complete treatment we can expect around half to return to training, education or employment. Around one-third will achieve total recovery, another one-third will manage their addiction safely and around one-third will relapse.

(iv) Gaps in Provision

The system of provision is evolving to address needs as they arise. Areas that pose particular challenges at present and that require attention and further development are:

- Treatment services for women offenders. Women, especially women with children, have specific needs that a comprehensive system of provision should cater for. While women with addiction are catered for within prison and within the community, the options available are relatively limited. The Probation Service and the IPS are aiming to address these challenges through a joint strategy for women offenders.
- There is a strong focus on drug addiction within the current system of provision. However, alcohol abuse is just as important a contributor to criminality as is drug addiction and abuse. Because of the non-availability of alcohol within the prison estate, prisoners with an alcohol addiction effectively have no choice other than to detox, with or without medication. Programmes that place more attention on the underlying reasons for alcohol addiction and how to prevent these triggers in the future as well as harm reduction strategies require further development across the prison estate.
- Within drug addiction, many of the treatment regimes are focused on opiate based drugs. However, in recent years the trends in usage have been away from opiates towards other drugs such as benzodiazepines and novel psychoactive substances, which are more difficult to detect. Treatment regimes are playing catch up to these developments, both in the community and within the prison estate.
- There are a growing number of offenders presenting with co-morbidities, e.g. alcohol and/or drug abuse combined with mental health issues. Best practice advocates a system of integrated dual treatment and many of the existing suites of community-based service providers and the system of provision within the prison estate does not adequately cater for co-morbidities.

- The absence of a peer-led positive drugs free environment, within the prison estate, for offenders who have come off drugs or alcohol needs to be addressed.

(v) Development Needs

In terms of actual work on the ground, certain aspects of the **model of effective practice** (see Figure 1 above for a summary and chapter five of the main report for the full model) require further development as follows:

NDRIC is an important national framework that the Probation Service and the IPS should align further with wherever possible. This will help ensure continuity of care between different settings and optimal use of resources.

As highlighted above, a more broadly based system of provision that caters for the specific needs of women offenders, treatments and interventions for alcohol abuse, treatments and interventions that accommodate the changing nature of drug abuse and co-morbidities is desirable. Within the prison estate, more focus on the development of alcohol treatment programmes would be beneficial as well as relevant screening and treatment regimes for non-opiate based drug addiction. This latter point also requires development within the community setting. With regard to co-morbidities, commissioning of service providers with expertise in mental health and treatment of addiction is one option. Another possibility is to develop protocols with the HSE on access to psychiatric and psychological services.

Equity of access and treatment irrespective of location is a key principle that underpins the service provision model. This means that the current system of a broad base of community based organisations should be continued. However, as noted above, this could be strengthened by having more specialist services for women, services capable of addressing co-morbidities and services willing and able to deal with sex offenders or those with a history of violence. Within the prison estate, a minimum standard of provision should be present in every prison, with specialist programmes developed in Mountjoy. This is with a view to disseminating these throughout the prison estate once proven – in other words a hub and spoke model rather than a centralised model.

Care planning the whole way through, from an offender being in the community (e.g. receiving treatment in the community through the HSE) to being in prison (where they might receive addiction counselling or participate in detox or continue with methadone maintenance) to discharge from prison back into the community, is an area that requires further work. Use of common assessment, screening tools and care plan templates can support a more co-ordinated care planning process. Currently, when an offender moves from the community into prison, there is a break in the care planning process. Similar breaks can occur on discharge, although the Integrated Sentence Management process has gone a considerable way to minimising this. Within the prison estate, clear responsibility for case management should be assigned and known.

Information sharing, communication and co-ordination are requirements for effective through-care planning. At present, care plans do not follow the offender from one setting to another and at each stage the prison health staff, prison-based addiction counsellors, community-based treatment staff, Probation Officers, ISMs and community prison link workers are relying on the offender to inform them of what treatment or interventions they have engaged in before. Working with NDRIC, to develop a basic care plan that can be shared electronically, will support better co-ordination and effective provision of services.

National protocols around referral, drop-out from treatment/interventions and information sharing require development to ensure a co-ordinated collaborative approach that supports effective case management and care planning between and within different settings.

Better preparation of offenders who are moving to a residential treatment centre is an important success determinant in reducing drop-out rates, particularly in respect of offenders coming from a prison setting.

Within the prison estate, a system of waiting time recording and management is a necessary step in order to support effective deployment of resources and efficient management of demand for services, particularly for addiction counselling.

Harm reduction is an important component of the treatment toolkit (e.g. providing information and education on the risks of taking different types of drugs). Not every offender in treatment will successfully detox or remain drugs or alcohol free. Within the prison estate, a harm reduction programme should be developed and incorporated into the treatment regime.

The Mountjoy Medical Unit operates the Drugs Treatment Programme (DTP). This could be improved through the development of a universal curriculum, better co-ordination of the service providers contracted to deliver different aspects of the curriculum and tracking of outcomes achieved. It has potential to be disseminated to other prisons once its effectiveness has been proven.

For offenders remaining in prison, who have successfully detoxed, access to a peer-led positive drugs free environment will support their recovery. However, it must be remembered that within a community setting, drugs are readily available. This suggests that the primary focus should be on supporting offenders to build their own internal resilience and capacity to resist a return to addictive behaviours and be supported to build an alternative set of behaviours that support their good health and well-being.

Considerable progress has been made in the management of release planning from prisons, e.g. the introduction of ISMs. However, there are still a number of areas where release of offenders with an addiction can be problematic, e.g. those who are homeless, or who are still chaotic drug users, or who are on remand, or who are released on bail by the courts, or who are on temporary release or post custody supervision. Managing these complex cases jointly

and developing shared protocols would support more effective communication and co-ordination of such cases.

The IPS needs to develop a national system of clinical governance for treatment within the prison estate that ensures consistency across prisons in the approach to treating offenders with addictions.

Service Level Agreements (SLAs) are a fundamental tool in the overall governance (both financial and operational) of external service providers/CBOs contracted to provide addiction related services either in the community or within prisons. The SLAs that currently are in place have too much variability in their requirements for each service provider and there are inconsistencies between those of the Probation Service and the IPS. A standardised SLA template should be used by the Probation Service and the IPS for contracting of CBOs.

One group of workers who currently provide services within the prison system have no SLA or oversight by either the Probation Service or the IPS, i.e. community prison link workers. This needs to be addressed, given that funding for their work is channelled through the Department of Justice and Equality.

All Service Level Agreements should incorporate an agreed set of outcomes. For treatment services we would recommend a small number of performance indicators that focus on participation and treatment outcomes. These indicators should apply to community based services *and* treatment programmes within the prison estate.

Joint training between community based organisations, the Probation Service and the IPS would facilitate useful networking and sharing of good practice and learning. This would also support working across the silos that are within the control of the Probation Service and the IPS.

Finally, funding levels by the Probation Service should be maintained while those of the IPS should be restored to 2011 levels in order to address the gaps identified above. Multi-annual SLAs (covering up to a three-year period) should be considered for all service providers.

Detailed recommendations are provided in chapter fifteen.

Chapter One

Introduction

The Probation Service and Irish Prisons Service sought an independent review of alcohol and drug treatment services for adult offenders in the community and in prison.

1.1 Terms of Reference

The terms of reference for the review were as follows:

- A review of the current provision of alcohol and drug treatment services to adult offenders in prison and in the community.
- A review of the governance of funding and management of Prison Links Workers employed through the Local Drugs and Alcohol Task Forces having regard to the roles of the Probation and Prisons Services with funding provided by the Department of Health's Drugs Initiative.
- An assessment of the outputs, outcomes, relevancy and co-ordination of services, achieved by Community Based Organisations (CBOs) funded by the Probation Service and Irish Prison Service.
- Provide recommendations, based on evidence collected, to include establishment of a model of best practice for adult offenders which facilitates a continuum of care from prison to the community.

These requirements were to be considered in the context of:

- On-going developments in relation to provision of drug and alcohol treatment services to adult offenders in prison and in the community with particular reference to NDRIC and the National Drugs Rehabilitation Framework 2010.
- Consultation with HSE with particular reference to adult offenders in prison and in the community given, the major role of the HSE in the delivery of drug and alcohol treatment services and support for inter-agency work, based on care planning.

1.2 Methodology

A multi-method approach was used to meet the terms of reference. This included the following:

- Initial consultation with the Steering Group established to oversee the review (see Appendix A for membership of the Steering Group) followed by two workshops with the Steering Group to review and discuss key findings and recommendations.
- One to one consultations with members of the Steering Group.
- Review of the Probation Service CBO database.
- Scan of national policy and international literature.
- Review of Service Level Agreements (SLAs) and business plans of funded community based organisations (CBOs).
- Site visits to two prisons – Cork and Mountjoy, incorporating interviews with medical staff and healthcare teams.
- Telephone interview with healthcare staff in the Dochas Centre.
- Face to face consultations with six CBOs funded by the Probation Service and the Irish Prison Service. These were Merchants Quay Ireland (MQI), Aiseiri, Fusion CPL, Tabor Lodge, Fellowship House and Coolmine Therapeutic Community (TC)
- Telephone interviews with Cuan Mhuire.
- E-consultation template administered to services not visited.
- E and telephone consultations with HSE regional community addiction managers.
- Face to face consultation with the chairperson of the National Drugs Rehabilitation Implementation Committee (NDRIC) and with the Health Service Executive (HSE) Social Inclusion Manager.
- Face to face consultations with four Dublin-based Local Drugs and Alcohol Task Forces (LADTFs) who have community prison link workers.
- Focus groups with Senior Probation Officers and Probation Officers working in the community and in prisons.
- Consultations with eight offenders attending or who had completed treatment.
- Consultation with the Department of Justice and Equality.
- Consultation with the Director General of the Irish Prison Service.

Given the methodology undertaken, there may be individual opinions detailed within this report which may not necessarily reflect fully the overall practice of the organisations referred to.

1.3 Structure of Report

This introduction is followed by an overview of the context in which addiction treatment for offenders operates and the current system of provision. This is followed by a summary of what the international literature tells us about addiction treatment. A model of effective practice in the treatment of offenders is then proposed. The reality of practice on the ground is then discussed. Finally, the report concludes with the main findings and recommendations.

Chapter Two

National Context

This chapter summarises the roles and responsibilities of the Irish Prison Service and the Probation Service in respect of the management of offenders and the national policy context related to drugs and alcohol abuse.

2.1 Roles and Responsibilities

The Probation Service and the Irish Prison Service (IPS) are responsible for managing offenders in the community and in prison, respectively. Both organisations have as their primary goal the maintenance of public safety through the reduction in offending of those in their care. The Probation Service and the IPS recognise that substance abuse and addiction is a contributing factor to offending behaviour and they are committed to working in close partnership and co-operation with other services involved in the delivery of addiction treatment/interventions, in ensuring access to these services for offenders.

The Probation Service and the IPS Joint Strategic Plan 2015-2017 aims to ensure better co-ordination. Its primary objective is '*to have a multi-agency approach to offender management and rehabilitation from pre to post imprisonment in order to reduce re-offending and improve prisoner outcomes*'. The aim is to focus on the offender, rather than offences, by developing approaches that tackle complex needs, rather than focusing on a single need in isolation. Within the context of this strategy, a joint strategy has also been developed to address women offenders².

The Health Services Executive (HSE) has statutory responsibility for providing public health and social care services in Ireland and is the lead agency for developing integrated drug and alcohol treatment and rehabilitation. It is recognised that the HSE has a central role in the delivery of drug and alcohol services and support for interagency work based on care planning.

Within the prison system a range of drug rehabilitation programmes seek to reduce the demand for drugs through education, treatment and rehabilitation services for drug addicted prisoners. The delivery of these services is in partnership with Community Based Organisations (CBOs) with a value of €1.14m per annum.

The Probation Service engages with offenders who have addiction problems, to ensure the offender has access to required supports. Addiction services are delivered in partnership with 18 CBOs with a value of €1.59m per annum.

² Joint Probation Service Irish Prison Service Strategy 2014-2016, An Effective Response to Women who Offend.

Annual funding of approximately €0.22m is provided by the Department of Health through its drug initiative fund to a number of Local Drug and Alcohol Task Forces (LDATFs) to employ community prison links workers.

2.2 National Addiction Policy

In 2009, the government introduced the National Drugs Strategy 2009-2016 and it also decided to include alcohol in a national Substance Misuse Strategy. A steering group was established to advise the Minister on a new strategy. In 2012 it produced the Substance Misuse Strategy, which focuses on alcohol misuse. Taken in conjunction with the National Drugs Strategy these two documents form the overall National Substance Misuse Strategy until the end of 2016, after which a unified national strategy document will be developed. The primary aim is to promote healthier lifestyle choices through measures on the supply side, prevention, treatment and rehabilitation and research and information.

2.3 National Drugs Rehabilitation Implementation Committee (NDRIC)

A range of statutory, community and voluntary agencies are involved in alcohol and drug treatment in Ireland. These include the HSE, Local Drugs and Alcohol Task Forces (formerly Local Drugs Task Forces), local general practitioners (GPs) and pharmacists, community and voluntary groups and prisons. A co-ordinated and integrated approach is a necessary step towards an effective and efficient treatment system.

The National Drugs Rehabilitation Implementation Committee (NDRIC) was set up to oversee and monitor implementation of recommendations from the Report of the Working Group on Drugs Rehabilitation (2007); to develop agreed protocols and Service Level Agreements (SLAs); to develop quality standards, building on existing standards; to oversee case management and care planning processes, and to identify core competencies and training needs and ensure these needs are met. Both the IPS and the Probation Service are represented on NDRIC.

NDRIC developed a framework for work in the area of drug rehabilitation. The framework arose out of recommendations made by the Working Group on Drugs Rehabilitation³.

The NDRIC framework aims to assist service providers to plan and implement a range of different approaches in order to provide an Integrated Care Pathway for former and current drug users. The framework recognises that drug users have many and varied needs, not all of which can be met by any one service provider. Services that are well co-ordinated make navigating the system for the client easier, minimise the risk of clients ‘falling between the

³ Report of the Working Group on Drugs Rehabilitation, May 2007, HSE.

cracks', reduce delays, lessens the need for clients to provide the same information repeatedly to multiple sources thereby reducing anxiety, frustration, inconvenience and trauma.

NDRIC describes a Rehabilitation Pathway in the context of four tiers of service provision. The first tier includes interventions whose primary focus is not drug treatment (e.g. social care, family support, employment support, education, housing support, etc.). The second tier is drug related interventions, e.g. pharmacies, primary care, community-based services, specialist addiction services, etc. The third tier is specialist drug related interventions in prison, community or hospital settings. The fourth tier is specialist dedicated inpatient or residential units and wards. Tiers two and three are the most relevant to this review.

The framework also outlines the key activities that are required to provide an integrated seamless pathway for clients. These include preliminary screening, initial assessment, referral, comprehensive assessment, key working, care planning, appropriate interventions, advocacy, case management, case review, exit planning, service transfer, aftercare, relapse and identification and taking action to address gaps and blocks.

Quality standards should underpin all work. At national level the Report of the Working Group Examining Quality and Standards in Addiction Services was adopted as national policy by the HSE in 2009. NDRIC recommended the use of Quality in Alcohol and Drug Services (QuADS) or an equivalent such as the Healthcare Accreditation and Quality Unit (HAQU) to support clinical and organisational governance standards. The Working Group Examining Quality and Standards also recommended the introduction of an agreed accreditation/training process for all staff employed in addiction services such as Drugs and Alcohol National Occupational Standards (DANOS).

NDRIC describes a prescribed reporting structure for handling Gaps & Blocks. The first step is follow-up by the local case manager. The next step, if the issue remains unresolved, is for the manager to report it to the area Rehabilitation Co-ordinator using a Gaps & Blocks form. The area Rehabilitation Co-ordinator may raise the issue at the next Drugs Task Force Treatment and Rehabilitation sub-group meeting, if appropriate and if the matter remains unresolved. Finally, if the issue remains unresolved the Gaps & Blocks form can be referred by the area Rehabilitation Co-ordinator to the National Senior Rehabilitation Co-ordinator who chairs NDRIC.

Guidelines have been agreed for the NDRIC framework and implementation is underway, including the development of a Common Assessment Tool.

2.4 Summary

Ireland has a national framework in which the work of the Probation Service and the IPS in respect of substance misusing offenders is recognised. The implementation of the NDRIC

framework is at an early stage of development and there are opportunities for the Probation Service and the IPS to further align their work with the framework.

The next chapter describes the current system of provision in respect of the treatment of offenders for drugs and alcohol abuse.

Chapter Three

System of Provision for Treatment of Offenders

Both the Irish Prison Service and the Probation Service have developed a range of policies and programmes to address the issue of addiction in offenders. For example, the Probation Service's *Principles of Probation Practice in Working with Substance Misusers* and the Irish Prison Service's *Keeping Drugs out of Prisons Drugs Policy and Strategy*. They both also fund community-based services to provide treatment services and the IPS funds internal health teams with addiction specialisms.

This section summarises the range of addiction treatment services for offenders in prison and in the community that are funded by the Probation Service and the IPS. It also sets out the issues in the wider environment that influence the effectiveness of service provision.

3.1 Range of Addiction Services Funded by the Probation Service and the IPS

The Probation Service currently commissions 18 community based service providers (CBOs): Aftercare Recovery, Aiseiri in two locations and Ceim Eile (part of the Aiseiri group), Ballymun Youth Action, Clarecare Bushypark, Coolmine TC (which has three services: one for women, one for men and a day service), Crinan Youth Project, Cuan Mhuire in four locations, Fellowship House and Tabor Lodge (both part of the same group), Fusion CPL, Merchants Quay Ireland - MQI (St. Francis Farm, High Park and Aftercare programme) and Matt Talbot Community Trust. A range of services are provided including residential treatment programmes for drug and alcohol addictions, harm reduction counselling and support, recovery and aftercare programmes, community education, therapeutic advice and family support.

Six organisations are funded to provide services in the prison system: MQI (funded under two separate contracts from the IPS and the Probation Service), Coolmine TC, Ana Liffey, Ballymun Youth Project, Fusion CPL and Matt Talbot Community Trust (all funded by the Probation Service to carry out work both in the community and in prison). The Harmony project is funded by the IPS to provide a module of the Drug Treatment Programme in Mountjoy prison.

As well as addiction counselling, substitution treatment and detox are the main treatment modalities offered within the prison estate. In addition, Mountjoy offers an eight week programme, the Drug Treatment Programme (DTP), delivered by the addiction health team and external CBOs (which are funded by the Probation Service). There are also other community based organisations which are not part of this review which provide one-to-one interventions, e.g. PALLS (Probation and Linkage in Limerick Scheme), Cork Alliance, etc.

Table 3.1: Summary of Treatment in Prison Estate 2014

Prison	Detox	Maintenance	Stabilisation
Castlerea	7	29	0
Cloverhill	305	385	0
Cork	69	64	0
Dochas	96	183	1
Limerick	85	132	1
Midlands	107	146	0
Mountjoy Main	77	320	0
Mountjoy Medical Unit	1	5	0
Portlaoise	19	30	0
St. Patrick's	2	2	0
Wheatfield	46	195	0
Total	814	1,491	2

(Source: HSE National Drug Treatment Centre Central Treatment List. Note: Methadone is not available in Shelton Abbey)

3.2 Links with HSE Funded Services

There are other community-based services, funded by the HSE, which are not co-funded by the Probation Service or the IPS that Probation Officers refer offenders to for treatment.

Probation Officers also make referrals to HSE addiction counsellors. These referrals are accompanied by a GP referral and the HSE seeks the offender's consent to liaise with the Probation Officer.

Some Local Drugs and Alcohol Task Forces (LDTAFs), most notably in five areas in Dublin, provide funding for community prison link workers to work with offenders in the community and while in prison. This service is described in more detail in chapter thirteen.

3.3 Expenditure

Overall expenditure by the Probation Service in funding the 18 CBOs that form part of this review has remained stable over the past four years.

Table 3.2: Probation Service Expenditure on Addiction Services

2012	2013	2014	2015 Budget
1,596,300	1,595,200	1,595,200	1,595,200

(Source: Probation Service)

Each prison has a health team. All prisons have nursing staff, some of whom have an addiction specialism. All prisons have a visiting GP and links to local pharmacies. All prisons also have in-reach psychiatry provided by the Central Mental Hospital Dundrum and all have psychologists on their staff. Mountjoy has a specialist addiction team comprising a GP addiction specialist, addiction nurses, addiction counsellors and pharmacist.

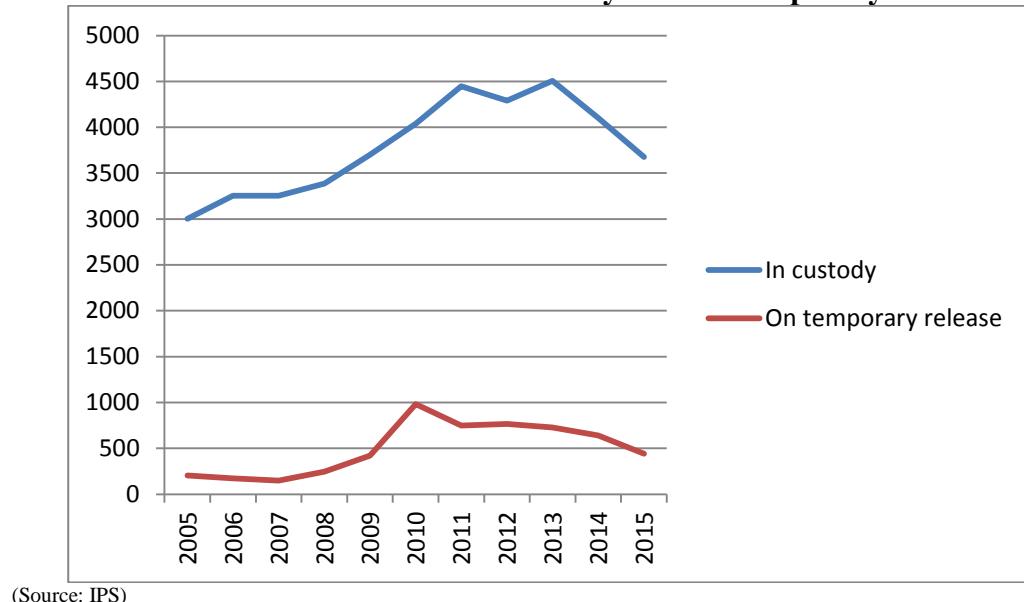
The trend in overall health spending in the prison estate in recent years has been downwards. The trend in spending on addiction services has also been downwards. It should be noted that the table below showing the trends in respect of addiction costs excludes staff costs, e.g. addiction nurses, GPs, psychiatrists, psychologists, etc. Since the review of addiction services in prisons in 2005 by Farrell and Marsden, more staff with addiction specialisms have been hired throughout the prison estate.

Table 3.3: Irish Prison Service Expenditure on Health and Addiction Services

	2011	2012	2014
Total health spend	c.9,600,00	c. 9,200,00	c.8,800,00
<i>Of which:</i>			
Drug treatment pharmacy services	743,678	781,709	512,325
Addiction counselling services	1,178,520	1,225,039	1,142,384
Methadone	67,012	78,076	80,169
Total addiction spend	1,989,210	2,084,824	1,734,878
Addiction spend as a % of total health spend	17%	18%	16%

The reduction in overall health spending mirrors a fall in the number of prisoners held in the prison estate as more initiatives such as community return have been introduced. However, those who are within the prison system now tend to be the more challenging, high risk and chaotic whose criminality and addictions are more entrenched and it can be argued that more resourcing is required to address this difficult group.

Figure 3.1: Trend in Prison Numbers in Custody and on Temporary Release 2005-2015



(Source: IPS)

During the review, concerns were expressed about the level of disinvestment in health in the prison estate and pointed to the absence of a Clinical Director or Health Director at senior management levels as deficits within the overall suite of provision.

The reduction in expenditure on addiction counselling has not only impacted on the number of addiction counsellors provided by MQI, with some prisons having only part-time access, but also on the type of work MQI engages in and waiting times for access by prisoners to addiction counsellors.

Addiction treatment is an important component of healthcare within a prison system and addiction is also a serious contributory factor in offending behaviour and the risk of recidivism. It is thus also an important justice issue and as such requires adequate investment.

3.4 Governance

All of the organisations funded by the Probation Service and the IPS have Service Level Agreements (SLAs). However, the community prison link workers funded through interim funding do not have specific SLAs⁴.

SLAs between the Probation Service and CBOs operate for a year. The SLA between the IPS and MQI operates for three years.

A number of CBOs are funded by the Probation Service to provide services within the prison system. While these services have SLAs with the Probation Service, they do not have SLAs with the IPS. There are opportunities to streamline the SLA template by taking the best of the Probation Service and IPS contracts and creating one SLA that both organisations apply.

Currently the outputs/outcomes detailed in SLAs vary considerably from one service provider to another and are based on what each CBO puts forward in its business plans. A minimum data set should be required of all CBOs and be specified in SLAs with a primary focus on participation and treatment.

3.5 Emergent Issues in the Environment

Consultations with service providers, the Probation Service, the IPS and the HSE all highlighted a number of recent changes that were impacting capacity to treat offenders with addictions:

⁴ Apart from Fusion CPL which, as a CBO, does have an SLA with the Probation Service and this includes the work of the CPLW.

- The trends in drug addiction in Ireland and the challenges this poses for treatment. Respondents noted a decline in opiate based addiction and an increase in benzodiazepine, novel psychoactive substances (e.g. ‘head-shop’, ‘snow-blow’, etc.), opiate-based analgesics and other narcotics usage as well as poly-substance abuse. Alcohol and drug use combined ranged from 7% to 94% of referrals made to services by the Probation Service depending on the CBO involved, while poly-drug use ranged from 47% to 80% of referrals.
- The strong link between alcohol abuse and crime, notably public order offences and crimes against the person. The 2011 Probation Service survey indicated that in 71% of cases involving alcohol there was a direct link between alcohol abuse and crimes committed. It also found a similarly strong link between crime and drug misuse, particularly for offenders aged 44 or under.
- Increasing numbers of offenders presenting with co-morbidities, most notably mental illness combined with drug and/or alcohol addiction. Respondent CBOs indicated this ranged from 6% to 60% of offenders referred to them (this was estimated at 90% + for offenders worked with by community prison link workers).
- Despite implementation of new policies to address access to drugs in the prison estate, (e.g. introduction of sniffer dogs, random searches, etc.), the ready availability of drugs within the prison system (for personal use or as currency) continues to be a serious issue in effectively treating addictions in the prison setting.
- The housing crisis and access to long term accommodation, particularly with the focus of policy on accommodation for families. It was felt that there is a danger that accommodation for single men, which was always challenging, will become even more pronounced.
- Younger people with complex needs, e.g. drug addiction combined with chaotic personal lifestyles, homelessness, mental health issues, poor literacy and communication skills deficits.
- The development of the Dark Net and the ready and anonymous access this provides to drugs through the internet.
- The possibility of decriminalisation of possession for own use or expunging of convictions for possession. Many practitioners welcome this potential legislative move as they believe that fear of criminalisation, especially amongst young people, inhibits access to treatment.
- A cohort of offenders with substance abuse issues continue to move in and out of the criminal system repeatedly. This means that the prison setting presents an opportunity to work with this cohort and seek to treat the addictions. However, the prevailing

belief is that this repeat offending and movement in and out of prison poses significant challenges to effective treatment. In particular, the view is that female offenders in prison are more likely to be chaotic substance mis-users than their male counter parts. This results in particular challenges when treating their addictions.

3.6 Summary

The IPS and the Probation Service have combined annual expenditure of drug and alcohol treatment interventions of €3.33m. This funding enables a mix of treatment options to be provided including detox, methadone maintenance, residential treatment, addiction counselling, therapeutic advice, aftercare, education and awareness raising and family support. There are a number of significant challenges posed for treatment by changes in the external environment including trends in choice of drug, increased cases with complex needs and co-morbidities, accessibility of drugs in prison and in the community and the ongoing impact of the shortage of housing.

The next chapter examines what the international literature tells us about effective treatment regimes.

Chapter Four

What the International Literature tells us about Treatment of Addictions

The following highlights are drawn from a scan of the international literature. They explore substance misuse and offending, engagement in treatment, effective treatment, the prison setting and outcomes.

4.1 Substance Misuse and Offending

Substance misuse is a known risk factor for offending behaviour and recidivism (Bennett and Holloway 2004, Budd et al 2005, Connolly 2006).

In Ireland, the Probation Service's Drugs and Alcohol Survey (2011) found that the majority of alcohol and drug misusing offenders had their misuse linked to their offending.

A study by the Health Research Board (2012) found that 85% of respondents believe the current level of alcohol consumption in Ireland is too high and 73% believe that Irish society tolerated high levels of alcohol consumption. Seventy-five percent of those who consumed alcohol engaged in binge-drinking, a factor in public order offences, and 54% of participants were classified as harmful drinkers. The research estimated that 7% of participants were dependant on alcohol equating to 176,000 dependent drinkers nationally.

Martyn (2012) found that 89% of adult offenders on probation supervision had misused drugs or alcohol. Strong links between drug and alcohol misuse and current index offences were evident. Alcohol was the most common substance misused, followed by cannabis. Although opiates were not in high use, their use amongst offenders was much higher than for the Irish population as a whole. Alcohol related offences centred mainly on crimes against the person and public order, while offences for those using drugs related mainly to drug offences (e.g. possession, supply, etc.) or acquisitive offences (e.g. theft). The survey also highlighted other factors associated with offending behaviour including anger, mental health, mild learning difficulties, disrupted family background, lack of parental control, low educational attainment, child abuse and domestic violence.

Freeman and Allen (2015) found that 60% of prisoners in Cork prison had a documented history of substance abuse and addiction, comprised of 40% with a history of benzodiazepine misuse, 10% with alcohol misuse, 1% with cannabis abuse, 1% with cocaine abuse and 1% with gambling addictions. Seventy-six percent of survey participants had or were seeing an addiction counsellor in the prison system.

The prevalence of psychiatric co-morbidity among drug and alcohol users in Ireland is unknown (National Drugs Strategy 2009-2016) but Probation Officers named mental health issues as a factor in offending behaviour (Martyn 2012). Research in Sweden (Chang et al 2015) indicates that the risk of violent reoffending increases for prisoners with severe mental illness and comorbid substance use disorders and suggested that treatment should focus on co-morbidity and multi-morbidity rather than on one disorder as at present.

Substance misusers in prison or on probation are not a homogenous group. Different levels of addiction are involved, as are different types of substances including mono drug use, mono alcohol use, as well as poly drug use and multiple substance abuse (alcohol combined with drugs). Substance misusers may want to come off drugs or alcohol, may have tried and failed, or may have no inclination to change. Some may already be stabilised on methadone maintenance.

4.2 Engagement

Individuals who engage in their treatment, who form a strong therapeutic alliance and who have greater satisfaction with their care stay in treatment longer. Frequency of contact by an individual with a service is a good indicator of engagement (Power et al 2005). These features of engagement are also good predictors of successful treatment.

Longer stays in treatment (3 months plus) lead to better outcomes. Long term retention is a strong predictor of positive outcomes. Engagement can be increased through periodic phone calls, patient outreach services and treatment follow-up (Power et al 2005, Hubbard et al 1989, Grella et al 1995, NIDA 2000, UNODC 2003).

Treatment does not have to be voluntary to be effective (ATTC 2003, NIDA 1999 and 2000).

4.3 Effective Treatment

Certain treatments, interventions or approaches on their own are considered to be ineffective. These include stand-alone acupuncture, relaxation therapy, didactic group education or biological monitoring of substance abuse; stand-alone detoxification; individual psychodynamic therapy; unstructured group therapy; confrontation as a principal treatment approach and discharge from treatment in response to relapse (Power et al 2005).

Treatments that are considered effective include cognitive behaviour therapy, community reinforcement, motivational interviewing, motivational enhancement therapy, 12-step facilitation, contingency management, pharmacological therapies, systems treatment, behavioural contracting, social skills training and brief intervention (Miller et al 1995; Power et al 2005).

While participation in self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have been found to increase the likelihood of abstinence, improved social functioning and greater self-efficacy, they are most effective when viewed as a form of continuing care rather than a substitute for treatment services. AA combined with professional treatment has been found to be superior to AA on its own (Pelletier 2004).

Medical detoxification on its own does little to change long-term drug use and should be viewed as a potential first step in a treatment programme (NIDA 2000).

Abstinence is not the only effective approach – other approaches are effective in managing drug addiction, e.g. Opiate Substitution Treatment combined with addiction counselling (Chisholm et al 2006).

Mixed methods are more effective than stand-alone methods (ATTC 2003, Pelletier 2004).

Prescribing practice needs to be integrated with psychological, medical and social interventions. One of these interventions on its own is not considered sufficient for an effective treatment programme (Amato et al 2004).

Effective treatment programmes match the individual with the level of care required by means of standardized criteria (Pelletier 2004).

Effective treatments address multiple needs of the individual, not just drug or alcohol use (ATTC 2003).

Relapse prevention is considered a critical component of effective treatment programmes (Pelletier 2004).

Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment (ATTC 2003).

Best practice for those with dual diagnosis (e.g. mental health combined with substance abuse) incorporates integrated dual disorders treatment (IDDT). Key components of effective IDDT include multi-disciplinary team approach, integrated substance abuse specialisms, stage-wise interventions, access to comprehensive and time unlimited services, outreach, motivational interventions, substance abuse counselling, group dual diagnosis treatment, psychoeducation of families about dual diagnosis, participation in self-help groups, pharmacological treatment as appropriate, interventions to promote health and secondary interventions for non-responders to substance abuse treatment (Pelletier 2004).

Different forms of therapeutic communities (TCs) are in use in prisons in the USA, UK and Europe, with mixed results. European prisons mainly operate democratic TCs or modified

forms of democratic TCs, sometimes called empowerment TCs, while in the USA the hierarchical form of TC applies (this is the form used by Coolmine). In-prison TCs in the UK tend to have no specialised aftercare and those offenders not transferred back into the main population are released into the community. By contrast, in the USA prison TCs are often linked to similar organisations in the community and prisoners who have taken part in a prison TC often go straight to one of these community TCs on release, thereby enhancing reintegration into society. Germany also has much greater provision for aftercare and rehabilitation in its TCs (Rawlings 1998).

4.4 Prison Setting

Clinicians who are familiar with integrated care pathways, within the prisons they serve, are more effective in their treatment work with patients. Clinical supervision from a clinician with experience of working in a prison environment is also important as a means of overseeing the work of others on an addiction team. Such supervision also provides necessary support which builds confidence when working in a prison setting (UK Clinical Guidelines 2007).

As with other settings, the literature highlights the prison setting as an opportunity to reduce substance abuse, treat substance abuse and address wider health issues associated with addiction, such as Hepatitis, through harm reduction and treatment interventions. There are a number of features of a prison setting, however, which require additional attention by clinicians in drug treatment. The table below summarises these issues:

Figure 4.1: Features of Prison Setting in Context of Addiction Treatment

Unique Features of Prison Setting	Risks
Lower availability of drugs and alcohol	Intermittent intoxication and unanticipated withdrawal episodes Higher risk of suicide during first week in prison linked to drug withdrawal
Less injecting behaviour	Potentially more risky behaviours, where injecting does occur, due to the scarcity of injecting equipment, e.g. sharing of equipment Increased risk of blood-borne viruses
High volume and frequency of movement of patients	Inconsistent treatment or breaks in treatment
Diminished opioid tolerance on release	Higher risk of overdose, particularly within the two week period post release
High value of drugs relative to a prisoner's income	Higher risk of violence or attempts to gain access to drugs
Security and control	Limited continuous access for clinicians to prisoners and difficulty in monitoring treatment
Prisoners on short sentences	Access to meaningful treatment
Poly-drug use which may be combined with alcohol	Treatment regimes that do not take into consideration co-dependency – more than one regime and phasing of detox for different drugs may be required

(Source: Based on UK Clinical Guidelines 2007, Shaw et al 2003, Farrell and Marsden 2005, Bird and Hutchinson 2003)

4.5 Outcomes

Engagement with certain treatment services (methadone, residential rehabilitation, therapeutic communities, etc.) can lead to a reduction in offending behaviour and recidivism (McSweeney et al 2008). Irish research also has found reduced offending behaviour for those engaging in drug treatment services that were maintained over a three year period (NACD ROSIE study 2011).

A variety of factors influence outcomes. These include treatment efficacy; characteristics of those receiving treatment, particularly motivation, commitment and readiness for change; competence and experience of staff and organisations delivering interventions, and the broader context in which interventions are delivered, etc. (UKDPC 2008). This suggests that an approach which deals only with one aspect of a person (e.g. treating addiction) will probably fail to achieve sustainable long term outcomes. An approach which also adopts ‘one size fits all’ is also likely to fail as a key factor in effectiveness is tailoring interventions to the person’s level of motivation and readiness, their abilities and capacity and learning style.

The National Institute of Drug Abuse (2012) compared relapse after treatment amongst drug users and patients with chronic illness that have a behavioural as well as a physiological component such as patients with type 1 diabetes, hypertension and asthma. They found that typical relapse rates after treatment for those addicted to drugs were not dissimilar (ranging from 40% to 60%, compared to 30% to 50% relapse for those with type 1 diabetes, 50% to 70% for those with hypertension and 50% to 70% for those with asthma), and made a strong case for drug treatment efficacy, recognising that relapse was part of the cycle and not necessarily an indicator of treatment failure.

Martyn (2012) recorded treatment outcomes for those engaged in alcohol treatment in different settings. Of those engaged in community alcohol treatment programmes, 50% were engaged in controlled drinking compared to 19% of those on residential programmes and 36% of those in self-help. Twenty-eight percent of community treatment participants were engaged in abstinence (i.e. assessed by a professional as not having engaged in alcohol misuse for three months or longer) compared to 48% of those in residential treatment and 40% of those in self-help. Finally, 14% of community participants had relapsed compared to 26% of those in residential treatment and 19% of those in self-help. While many factors can impact on treatment outcomes, these results suggest that residential alcohol treatment programmes are more likely to result in abstinence or relapse when compared to community treatment programmes or self-help and less likely to result in controlled drinking.

It is uncertain whether or not recidivism is a good indicator of treatment success as positive change regarding addiction may not translate into changed offending behaviour. There is

some research evidence indicating that offending rates for persistent offenders have been found to slow down for people in their 30s and 40s regardless of treatment (Cormier 1975).

There are significant parallels between desistance trajectories for offenders and those suffering from addiction (whether offenders or not). Narrative plays a key role in understanding desistance from crime and recovery from addiction and both groups who desist have been found to develop new ‘life scripts’ that explain how they got to where they are and what needs to change for the future (Vaughan 2007, Marsh 2011).

4.6 Summary

Strong therapeutic alliances lead to better engagement in treatment and better engagement results in improved outcomes. Treatment can result in a sustained reduction in criminal behaviour as a high proportion of crimes committed by substance misusing offenders are directly linked to their addiction. However, relapse is part of the cycle of recovery and multiple episodes of treatment may be necessary before a successful treatment outcome is achieved. Some treatments, interventions and approaches are considered to be effective, while others are not. Thus, having a strong evidence base of efficacy is important in any treatment regime. Prison settings provide a unique opportunity to address addiction and support desistance. However, they also pose unique challenges that the treatment regime must be cognisant of.

The next chapter uses the findings from the scan of international literature, along with consultations with key stakeholders for the review, to develop a practice model for the treatment of addiction in offenders in prisons and in the community.

Chapter Five

Model of Effective Treatment Practice

A model for effective treatment of offenders with an addiction, in prisons and in the community, is presented below.

This model is based on the results of the review including evidence from the international literature, NDRIC, consultations with service providers, probation staff, prison staff, HSE staff, LDATFs and community prison link workers.

The model outlines the principles that will underpin practice and the features of effective practice for each part of the treatment process. It also sets out the measures to support on-going development of good practice.

5.1 Principles

The proposed principles to underpin effective practice in the treatment of offenders, in the community and in prison, are as follows:

Figure 5.1: Proposed Principles for Effective Practice

- **Equity of access:** to a range of services, whether in the community or prison, and in a timely manner.
- **Choice:** a sufficient, multi-faceted approach is more effective than a single/sole intervention as individuals differ in their capacity to engage with different treatment models.
- **Person centred:** care planning is an on-going process that is holistic, tailored and takes into account all of the individual's needs as these impact on recovery.
- **Outcomes:** primarily focussed on acceptable individual-identified outcomes.
- **Evidence based:** treatment approaches based on scientific evidence of efficacy.
- **Co-ordinated** approaches: within and across systems (especially justice and health) and between different settings in order to ensure continuity of care.
- **Time:** seeking to make best use of time in prison to address addiction, including harm reduction.
- **Pathways:** clear treatment pathways into and out of different settings.

5.2 Core Constituents of Effective Practice

Safe, un-cramped and equipped facilities are important constituents of the environment in which effective practice operates.

Staffing is another key constituent that impacts on effective practice. This includes the right skills mix, competence and adequate staffing levels, continuous professional development and staff retention.

Good communication, on a daily basis, is a critical success determinant. Good communication also facilitates other key constituents, in particular, the effective use of a multi-disciplinary team approach and co-ordination of services and supports.

5.3 Core Components of Effective Practice

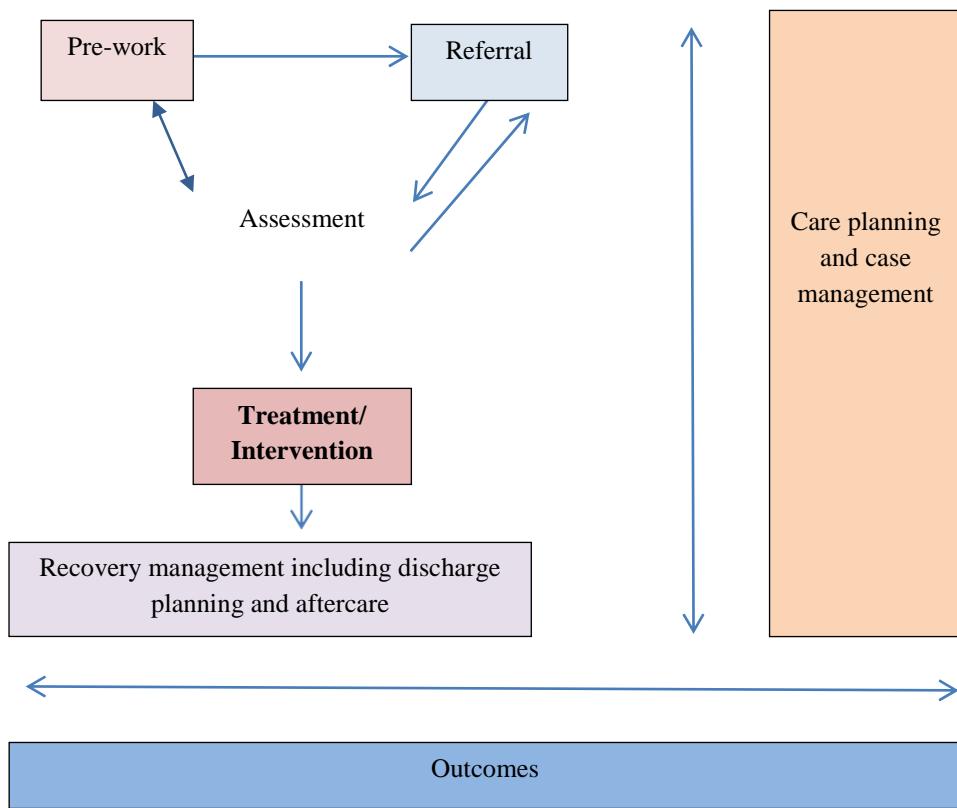
The practice model is built around the following core practice components:

- Pre-work
- Referral
- Assessment
- Care planning
- Case management
- Treatment
- Recovery management

The model applies to both a prison setting and a community setting. However, it acknowledges that there are particular minimum requirements that need to be put in place in the prison estate, and these are dealt with separately.

The figure below summarises the model. While *outcomes* are not a component of practice, they are included in the diagram to illustrate that all stages lead to the achievement of an outcome(s). Chapter fourteen explores outcomes in more detail.

Figure 5.2: Summary of the Model of Effective Practice



5.3.1 Features of effective pre-work

Pre-work involves working with an offender to assess their motivation to change and to prepare, encourage and activate their motivation to make good choices and decisions about their addiction. It can be carried out by Probation Officers, community prison link workers, Integrated Sentence Management officers (ISM), addiction counsellors or healthcare professionals working in the community or in prisons. The key features of effective practice are:

- Identifying offender attributes, in particular their motivation, psychological functioning and the severity of the addiction, prior to referral. The use of psychometrics can support this process.
- Preparing offenders for the transition to treatment and/or interventions.
- Making sure the offender is fully aware of their options and what is involved in different services and treatment options so that they can make an informed choice.
- Screening of offenders, using screening tools to identify substance misuse as early as possible, particularly alcohol abuse⁵.
- Providing those determined (by screening) as having an addiction with an initial brief intervention.
- Brief interventions (e.g. the SAOR model) include assessment, information provision, referral to specialist services in the community or in prison and systematic monitoring. These may be carried out by a range of people including GPs, community addiction teams, Probation Officers, Prison Officers and healthcare teams in prison and in the community.
- Referral into Probation Service programmes, e.g. Alcohol Awareness and Alcohol and Offending.
- Preparing the offender, through information provision and briefings and, if appropriate, site visits, about different treatment and intervention programmes and what each involves. This includes preparation for working in groups as all of the treatment programmes funded by the Probation Service and the IPS rely primarily on group-based therapies. Inadequate preparation of offenders is a contributory factor to high drop-out rates, most notably for those being referred from a prison setting.

⁵The National Quality Forum in the USA (2005) noted that while effective evidence-based screening methods have been developed for alcohol abuse and while it is believed that screening could be similarly effective for drug abuse, the evidence to support routine drug screening is less extensive.

5.3.2 *Features of effective referral*

Referral is the process of making contact with appropriate services in order to secure a treatment option for an offender. Referral can be made by Probation Officers, community prison link workers, ISM officers, addiction counsellors or healthcare professionals working in the community or in prisons. The key features of effective referral practice are:

- Awareness and understanding by referral agents of the programmes and treatments on offer in different services, e.g. meeting with services is an effective way to support the development of a good level of understanding so that the referral agent is well informed prior to engaging with an offender.
- Clear pathways of referral are in place.
- Needs of the offender are clearly identified and explored.
- Achieving clarity of the precise purpose in making a referral.
- Initial assessment by referring agent (e.g. the Probation Service, ISM, prison health team) to assess suitability and to match needs to service availability, including risk assessment and if necessary, psychological assessment.
- Encouraging the offender to make direct contact with the service. Willingness to do so is an indicator of motivation and a direct conversation between the offender and service provider enables the service provider to assess motivation. Formal engagement between the offender, the CBO and the Probation Officer, e.g. by way of three-way meetings early in the referral process, ensures the referral is appropriate and establishes a shared understanding of the service to be provided to the offender.
- All relevant information, including medical reports, which should accompany referral forms, is gathered through open communication between the referring agent (e.g. the IPS or the Probation Service) and referral destination (e.g. a CBO) with comprehensive hand-over from the referring agent, including contact details of Probation Officers assigned and court cases pending (some services will not accept referrals until pending court cases are dealt with first), and relevant information about previous care planning and/or treatment and/or interventions that the offender has already engaged in while with the referring agent.
- Selection and early discharge criteria are clearly communicated to referring agencies.
- Reasons for refusal are provided to the referring agent and the offender.
- Offenders referred from prison to CBOs who are on medication have their medication dispensed prior to release if release is on a Friday.
- Adequate preparation of the offender prior to transition to treatment.

- Waiting times are actively managed and communicated to offenders, the Probation Service and the IPS. Waiting times are minimised. This may require provision of additional resourcing in some settings, most notably access to addiction counselling in a prison setting.
- Full appreciation of the roles, expertise and responsibilities of each stakeholder, i.e. Probation Officers, ISM teams, CBOs, MQI prison-based addiction counsellors, prison-based addiction or healthcare workers, community prison links workers, etc.
- Consideration of confidentiality and need to share information.
- Ongoing review of referral processes.

5.3.3 *Features of effective assessment*

Assessment is the process of exploring the nature and extent of a person's addiction and other needs that impact on this, their motivation to engage in treatment and rehabilitation and immediate risk factors. Assessment is a continuous process that can take place in a number of different settings and in a number of different forms.

The features of effective assessment practice are:

- Person centred approach.
- Conducting initial assessments soon after admittance to a treatment centre or prison or by Probation Officers on referral from court in advance of release from custody and as part of a supervision order.
- Adequate time is given to initial assessments conducted in prison.
- Identifying offender attributes, in particular their motivation, psychological functioning and the severity of the addiction, on intake to a treatment programme or prison in order to determine the offender's readiness, capacity and willingness to change.
- Assessment process gathers as much relevant and accurate information as possible. Assessment includes clinical and psychosocial needs using evidence-based assessment tools in order to match the offender with the most appropriate service. Many of the community-based services have developed their own assessment tools based on the proposed Common Assessment Tool being developed by NDRIC.
- Risks to self and others are incorporated into the assessment.
- The assessment takes into account the particular needs of women, especially those who are pregnant and/or who have children.

- The referral agent is notified when, based on the results of assessment, a person is deemed unsuitable for treatment in a particular service so that alternatives can be sought.
- Setting realistic expectations during the assessment process.
- Conducting on-going assessment during treatment.
- Good communication, including communication between the CBO and Probation Officers, regarding particular challenges the offender might face in treatment and subsequently, and contingency planning around these challenges.
- On-going review of assessment processes.

5.3.4 Features of effective care planning

Care planning is a holistic on-going process that addresses addiction and wider physical and mental health, family, financial, housing, legal, education and employment needs that are relevant to each offender and that could impact on their ability to engage in treatment and subsequent recovery.

The features of effective care planning are:

- Care planning obtains offender buy-in and incorporates detailed needs assessment and reassessment, goal setting, joint planning, agreeing and assigning roles and responsibilities, information management, feedback and review loops and tracking and follow-up.
- Good communication with other stakeholders, including relevant information-sharing between services, with the offender's consent, to ensure continuity of care plan goals and appropriate change when necessary.
- Cultivating a relationship of trust with the offender.
- Checking with the offender what care planning they have engaged in before and their goals.
- Irrespective of setting, care planning is a multi-disciplinary activity that integrates the holistic needs of the individual, not just their substance abuse.
- The care plan is a written statement of goals and actions to be undertaken towards achieving goals that is reviewed and updated regularly.
- Establishing realistic expectations, goals and identifiable outcomes and meaningful timeframes for their achievement.

- Engaging and empowering the offender to actively take part in the care planning process.
- Follow-through on goal achievement.
- Integrating detox, treatment and aftercare within the care plan.
- Obtaining input from the referral agent, including visits by Probation Officers while the person is in treatment.
- Exploring post treatment options and supports at an early stage, e.g. secondary treatment, GP, fellowship meetings, counselling, etc.
- In a prison setting, care planning commences on committal and clear responsibility for co-ordinating care planning for the prisoner is assigned. Care planning should incorporate plans for reintegration into the community upon release.
- The prison setting should be used as an opportunity to assess and if necessary treat, for HIV/AIDS, tuberculosis (TB), Hepatitis B and C, and to support offenders to modify at-risk behaviours.
- On-going review of care planning processes.

5.3.5 Features of effective case management

Case management is a process by which services are provided to an individual offender on a co-ordinated basis across multiple service providers/agencies through the use of a care plan that reflects the offender's needs. Features of effective practice are:

- There are clear criteria and methods for selecting and prioritising cases for the case management process as not all cases need to be case managed.
- Key-work counsellor is assigned to the offender on admission to a service or the prison setting with overall responsibility for managing the case throughout treatment.
- External support agencies and referral agents are linked into the care planning and care management process. Care service plan negotiation takes place to address the needs of the offender and agree the roles and responsibilities of the various service providers that will be involved in a particular case, both within and external to the community or prison setting.
- Services and agencies work together to support the offender while they are in treatment and in aftercare and necessary services are actively involved in aftercare and recovery management.
- Interagency case conferencing takes place.

- Consistent use of appropriate tools and information technology within and across settings.
- Issues arising from care plan implementation are addressed including effective communication, information sharing, inter-agency liaison and co-ordination and managing of blockages.
- Prison addiction teams are made aware of external supports provided by CBOs or other agencies such as LDATFs that could support the progression of prisoners, e.g. the work of community prison links workers, availability of CE schemes, community based programmes, etc.
- On-going review of case management processes.

5.3.6 Features of effective treatment

The term treatment in this instance refers to the process of medical and psychotherapeutic intervention to alleviate dependency on alcohol, illicit drugs or prescription drugs and provision of other services that support recovery.

Key features of effective treatment are:

- Treatment interventions and approaches, in whatever setting(s), are evidence-based and valid.
- A range of treatment options are catered for within the system of overall provision, e.g. abstinence, maintenance, substitution, etc.
- There is continuity in treatment provision. In a prison setting this means that systems must be in place to ensure access to prisoners by external agencies contracted to provide services. Prison clearance for CBOs linking in with prisoners is provided in a timely manner.
- Good communication between treatment centres or prison treatment programmes with prison teams, addiction nurses, addiction counsellors, Probation Officers, etc., to support selection onto appropriate treatment interventions, to provide supportive networks for offenders experiencing specific difficulties compounded by their addiction and to keep referring agents up to date.
- The risks associated with treatment are communicated to the person seeking treatment.
- Detox, whether for alcohol or drugs, is supervised. In a prison setting this includes supervision of those prisoners who choose self-directed detox or to go ‘cold turkey’ and not to use substitution medication while coming off drugs or alcohol.

- Detox programmes in the community or prison encompass non-opiate based substances wherever possible.
- Person centred approach that establishes quality relationships with the offender and clear treatment goals.
- Preparing the offender for the transition to residential treatment, e.g. through pre-entry groups in the community and small group work in treatment.
- Observation, for first week after committal to prison, for signs of emerging acute physical or psychological problems.
- Commencing with an orientation or induction period to familiarise the offender with new surroundings, structures and people. During this phase, behavioural contracting may be used to inform the offender about expectations of them and also what they can expect from the service.
- The offender is supported to engage. Programme participation and engagement is built around the development of strong therapeutic relationships and enhanced addiction counselling. Programmes focus on encouraging engagement for a sufficient period of time.
- Use of mixed methods in the treatment programme rather than reliance on one. Inclusion of evidence-based psychosocial interventions for all treatment referrals. For example, motivational interviewing, motivational enhancement therapy, cognitive behavioural therapy (CBT), structured family and couples therapy, contingency management/motivational incentives, community reinforcement therapy and 12-step facilitation therapy.
- Treatment regimes for women take into consideration childcare, pregnancy and the impact of past physical or sexual abuse.
- Appropriate alternatives are sought for offenders who are not capable of coping with group therapies, e.g. one-to-one addiction counselling, community detox, working in partnership with the person's GP.
- Co-morbidities are addressed using an integrated approach that incorporates multi-disciplinary teams (these might be drawn from internal staff or a combination of partnership working between internal and external specialists). Co-operation from relevant HSE psychological and psychiatric services for those with a dual diagnosis of substance addiction and mental health. This is necessary in order to provide adequate treatment and continuum of care during and after addiction treatment, whether in a community or prison setting. This may necessitate the development of Memorandums of Understanding or Service Level Agreements between the Probation Service, the Irish Prison Service and the HSE. These will ensure timely and appropriate access to

services for offenders who have an addiction combined with mental health issues, whether in a community based treatment programme operated by a CBO or in a prison.

- Prescriptions are verified with community prescribers, where relevant, and the appropriateness of dosage is monitored and reviewed.
- Where appropriate and if prescribed, provision of addiction-focussed pharmacotherapy in conjunction with psychosocial interventions, e.g. Librium for alcohol detoxification, methadone for opiate detoxification. Pharmacotherapy is not appropriate for all offenders, however, and appropriate assessment should precede prescription and treatment should be medically supervised. Pharmacotherapy must be used in conjunction with other therapies, as appropriate, and its efficacy evaluated for each offender.
- Provision for one-to-one addiction counselling options, even when group therapy is the primary methodology.
- Inclusion of workshops on offending behaviour and the links to addiction.
- Inclusion of social skills training.
- Relapse prevention is built into the treatment programme including identification of trigger behaviours or events and coping skills.
- Engaging family members or concerned others in the treatment programme if possible and appropriate. This is an important component of early recovery and reinforcing behavioural and psycho-social change.
- Urine toxicology screening is used to support treatment compliance.
- Breaks in treatment are minimised. Treatment in a prison setting is not discontinued as a punitive measure.
- Continuity of care in the prison setting is prioritised.
- Provision of ‘move-on’ options in a prison setting for prisoners who have successfully completed treatment programmes.
- Service providers employ strategies that support retention. Early discharge due to relapse is considered in the international literature to be punitive and counter-productive. While acknowledging that there are very good reasons why a person who has relapsed may have to leave a group, this should not mean that they have to leave a service. There are currently only a few services in the ecosystem of provision for offenders that cater for those who relapse.

- Within the prison setting, when relapse occurs it is discussed with the prisoner and treatment options are explored.
- Where early discharge is warranted, early discharge protocols are in place and are clearly communicated to offenders and to key stakeholder organisations, e.g. the Probation Service and the IPS. The Probation Service or the IPS, whichever is relevant, should be notified immediately about offenders who are on probation supervision (irrespective of whether or not they are a direct referral) or who have been referred by the IPS who drop-out of treatment programmes or who are discharged early because of inappropriate behaviour or relapse.
- There is clinical governance and oversight of therapeutic interventions. Effective clinical governance incorporates:
 - clear policies and procedures,
 - effective team work,
 - effective reporting structures,
 - adequate staffing levels,
 - effective staff management,
 - effective recording, management and use of information,
 - relevant staff competencies,
 - access to continuous professional development for staff,
 - risk identification and management,
 - assessments/ evaluations of clinical effectiveness, and
 - access to internal and/or external clinical expertise and supervision.
- On-going review of effectiveness of treatment.

5.3.7 *Features of effective recovery management*

Recovery management encompasses care planning, discharge planning from a service, aftercare and linking an offender into appropriate supports and services post treatment.

Care planning:

- Care planning continues into the recovery phase.
- Explicit strategies are employed to engage offenders in self-management as part of recovery. This includes offenders being supported to engage in their long-term care planning.
- Discharge planning is integrated into the care planning process.

Discharge/exit planning:

- The process of planned discharge commences a number of weeks prior to the date of discharge, whether in a prison or community setting. Support agencies and services are contacted at least three weeks in advance of discharge to ensure relevant supports are in place.
- Factors such as access to accommodation, reconnecting with family, engaging in meaningful activities and linking into appropriate supports (e.g. self-help groups) are addressed as part of the discharge planning process.
- The relevant Probation Officer or the IPS is kept informed of discharge planning from community services and final date of exit from the service. CBOs contact the Probation Service prior to a planned discharge to plan for the offender's exit from the service.
- Emergency discharge plans are put in place for offenders who drop-out or who are asked to leave a service.
- CBOs notify the Probation Service or the IPS of unplanned discharges or drop-outs from treatment in a timely manner.
- Discharge planning includes preparing the offender for transition from the treatment service back to the community or prison.
- Discharge planning incorporates assessment of risk of relapse in a community setting where drugs and alcohol are readily available.
- Discharge planning, whether from a community or prison setting, includes strategies to minimise the risk of overdose as a result of relapse after discharge, e.g. information about overdose risks, prescription of Naloxone.
- Discharge planning ensures the offender has meaningful activity to engage in prior to exiting a service on completion of treatment.
- In the prison system, ISM officers and healthcare teams are fully aware of the suite of services that can support a prisoner on release and appropriate links or referrals are made with these services as part of discharge planning, e.g. Probation Officers, community-based services, HSE services, community prison links workers.
- Discharge on Friday from prisons is eliminated.
- Discharge planning from a prison setting adheres to the protocol agreed with the HSE regarding those commenced on methadone treatment.

- Discharge planning from a prison setting is compliant with the national quality standards for homeless services which state that '*Local authorities and the IPS work together to ensure there is adequate planning for discharge from custody for service users who do not have an accommodation option*'⁶.

Aftercare:

- Aftercare is an integrated part of the treatment programme and is offered as an option for those completing treatment.
- The offender and the Probation Service are made aware of aftercare provision where the person is subject to probation supervision/engagement.
- Offenders are encouraged and empowered to attend a minimum number of aftercare sessions.
- Aftercare provides continuing support and a safe space for offenders to attend.
- Probation Officers are informed of aftercare plans. The service maintains records of attendance at aftercare and where participation in aftercare is a requirement of a probation supervision order, the service reports on attendance to the relevant Probation Officer.
- Telephone support is offered to offenders experiencing difficulties post treatment.

Community integration:

- Every effort is made to link prisoners into appropriate community services prior to release.
- Offenders are supported to link into primary care providers, self-help groups such as AA or NA, addiction workers, prison link workers, etc., that can support their recovery when they leave a service or after completion of treatment in and discharge from a prison setting.
- Longer term engagement strategies post aftercare are employed by CBOs, e.g. occasional telephone calls to check in with the offender, celebration events, participation in research tracking exercises, etc.

5.4 Supporting On-going Development of Effective Practice

Effective practice requires on-going support and development to become embedded within any system. Core elements of an effective support structure include:

⁶National Quality Standards Framework for Homeless Services in Ireland, draft, standard 2.1 (5), DRHE

- Cross training between services and agencies, e.g. Probation Officers, ISMs, CBOs, addiction counsellors and nurses, community prison link workers, etc.
- Regular continuous professional development (CPD) for health and addiction teams, Probation Officers, ISMs and Prison Officers.
- Structured provision of opportunities for reflective practice, e.g. through themed workshops, clinical supervision, team meetings, peer support, etc.
- Evaluation and review of performance and outcomes.
- Implementation of quality standards and quality assurance methodologies.

5.5 Summary

The figure on page 46 summarises the model of effective practice. The following chapters explore the work on the ground based on the results of the research conducted during the review process using the components of the model.

Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community.
A Clarke and A Eustace, Eustace Patterson Ltd. March 2016

- Pre Work**
- Identify attributes and motivation
 - Preparation for transition
 - Fully inform about options
 - Screening
 - Initial brief intervention

- Assessment**
- Client focussed
 - Timely initial assessment
 - Identify attributes, motivation, functioning, severity of addiction and readiness to change
 - Assess clinical and psychosocial needs using evidence-based tools
 - Risk assess
 - Gather information
 - Set realistic expectations
 - Good communication
 - Reassess during treatment
 - Contingency planning

- Recovery Management**
- Discharge planning – planned discharge and emergency discharge
 - Self-management strategies
 - Risk assess including risk of overdose
 - Good communication
 - Preparation for transition
 - Ensure meaningful activities in place post treatment
 - Aftercare as an integrated option
 - Empower to attend
 - Engagement strategies post treatment
 - Links to appropriate community services

Referral

- Identify and explore needs
- Aware of services available
- Clarity in purpose of referral
- Initial assessment
- Risk assessment
- Encourage direct contact with service
- Clear referral pathway
- Information sharing
- Comprehensive hand-over
- Clear communication
- Preparation for transition
- Management of waiting times
- Appreciation of roles and responsibilities
- Confidentiality and consent
- Review of process

Treatment and Intervention

- Evidence-based mixed methods approaches
- Client centred
- Range of options
- Selection for appropriate treatment
- Continuity of provision – breaks minimised
- Screening
- Verify prescriptions
- Induction and behavioural contracting
- Observation on intake
- Detox supervised
- Support engagement
- Engage family and concerned others
- Relapse prevention and management
- Early discharge protocols
- Good communication
- Preparation for transition
- Clinical oversight

Care Planning and Case Management

- Holistic and on-going care planning
- Achieve buy-in
- Assess and reassess
- Awareness of possible range of supports
- Set goals
- Joint planning
- Agree roles and responsibilities
- Manage information, feedback and review loops
- Track and follow-up on goal achievement
- Good communication
- Information sharing with consent
- Empower active participation
- Input from relevant agencies/ organisations and links to care planning
- Explain post treatment options early
- Planning for post treatment
- On-going review
- Clear criteria for selecting and prioritising for case management
- Assign case manager
- Negotiate care service plan when necessary
- Collaborate to support client
- Address issues in care plan
- Manage blockages
- Good communication and information sharing
- Interagency co-ordination and liaison

Chapter Six

The Work on the Ground: Pre-Work

Pre-work involves working with an offender to assess their motivation to change and to prepare, encourage and activate their motivation to make good choices and decisions about treating their addiction.

6.1 Community Based Organisations

Pre-work prior to formal referral to a residential facility can take place at a number of levels within the justice system: Probation Officers, ISMs, addiction counsellors and community prison link workers all play a role in preparing and motivating offenders to seek treatment.

Some CBO residential facilities have pre-entry groups or induction weeks to support the transition into a residential treatment setting. Participants are facilitated to understand what will be involved in residential treatment, to prepare them for working in group therapy and, if necessary, to ask offenders to reduce their intake of substances such as benzodiazepine or to make other changes necessary for participation in residential treatment. Probation Officers also engage in pre-work to encourage, motivate and support offenders to make informed choices.

6.2 Probation Service

Probation Officers complete one-to-one work with their offenders and this may not necessarily result in a referral to a treatment or counselling service. Such work includes assessment, specific interventions in respect of addiction/substance misuse, offence focussed work, motivational interviewing, pre-release planning, preparatory work for transitions, links into community based services, mental health services and HSE community drugs workers. Probation Officers might also refer an offender to internal Probation Service interventions such as the Alcohol Awareness Programme or the Alcohol and Offending Programme.

6.3 Irish Prison Service

Within the prison estate, MQI addiction counsellors run preparation groups within prisons to prepare offenders for the intensive group work they will face in a residential setting. Site visits can also support preparation and some examples were provided of Probation Officers who had brought offenders to visit residential treatment centres prior to referrals being made. Preparation is known to contribute towards higher retention in treatment programmes. In addition, many CBOs prefer if offenders, referred from a prison setting, are close to their release date so that they can then engage in aftercare services post treatment.

For those unable to cope with a group setting, one-to-one addiction counselling can be offered, as well as detox. ISMs also engage in pre-work. An example of good practice is the

ISM in Dochas who has visited services in advance of a prisoner being referred to discuss the offender's needs and prepare the offender for the transition. In some instances, the offenders have been brought to the CBO by the ISM so the offender could learn more about the service and what is involved in its treatment programme.

6.2 Summary

The results highlight the importance of the care planning process and its co-ordination, particularly within the prison system. This is achieved by having a care plan manager who is aware of the treatment options and supports available both within the community and prison, the supports that the offender has used in the past which they could be linked into again, and the range of in-reach services that can support an offender in their transition back into the community. It also highlights the role that Probation Officers and ISMs can play in pre-release planning and inputting to pre-entry/preparation groups for offenders being referred to residential treatment.

Referral is an important first step in the continuum of care and it is examined in the next chapter.

Chapter Seven

The Work on the Ground: Referral

Referral is the process of making contact with appropriate services in order to secure a treatment option for an offender.

7.1 Process of Referral

Probation Officers commented on the importance of choice and a good geographic spread of effective and appropriate services to refer offenders to. The 18 CBOs funded by the Probation Service include national, local and target-specific services located around Ireland, although the west and north-west are under-represented.

The HSE has recently standardised its referral pathways into its addiction services. This means that all referrals to these services must now come via a GP or consultant psychiatrist. This can be a challenge for offenders who do not have a medical card. Probation Officers might encourage an offender in prison or the community to attend a HSE clinic or HSE addiction counsellor for example, but they can no longer make a direct referral to such services. The HSE also obtains the offender's consent to make contact with their Probation Officer.

Referral protocols are in place between the HSE and the IPS to ensure that prisoners are linked into methadone clinics on release and that the timing/sequencing of detox programmes is maximised. For example, those detox programmes that cannot be completed while an offender is in prison are not commenced prior to release.

7.2 Management of Referrals

Referrals to CBOs can come from many sources: family, GPs, addiction services, Probation Officers, prison ISM, prison governors, etc. Many of the CBOs commented that a high proportion of their referrals were 'self-referrals'. Consultations with offenders and Probation Officers indicated that often the offender is encouraged to contact the CBO by the Probation Officer, MQI addiction counsellors in prisons or ISM prison teams.

Some services have a policy of insisting that the offender makes contact directly with them, as this is an indicator of motivation to change. Others accept direct referrals from a Probation Officer or MQI addiction counsellor based in a prison. Yet others will only accept referrals through a 12-step primary addiction treatment centre or offenders who have completed a 12-step primary addiction treatment programme. Table 7.1 sets out some examples of how CBOs manage inward referrals to their services.

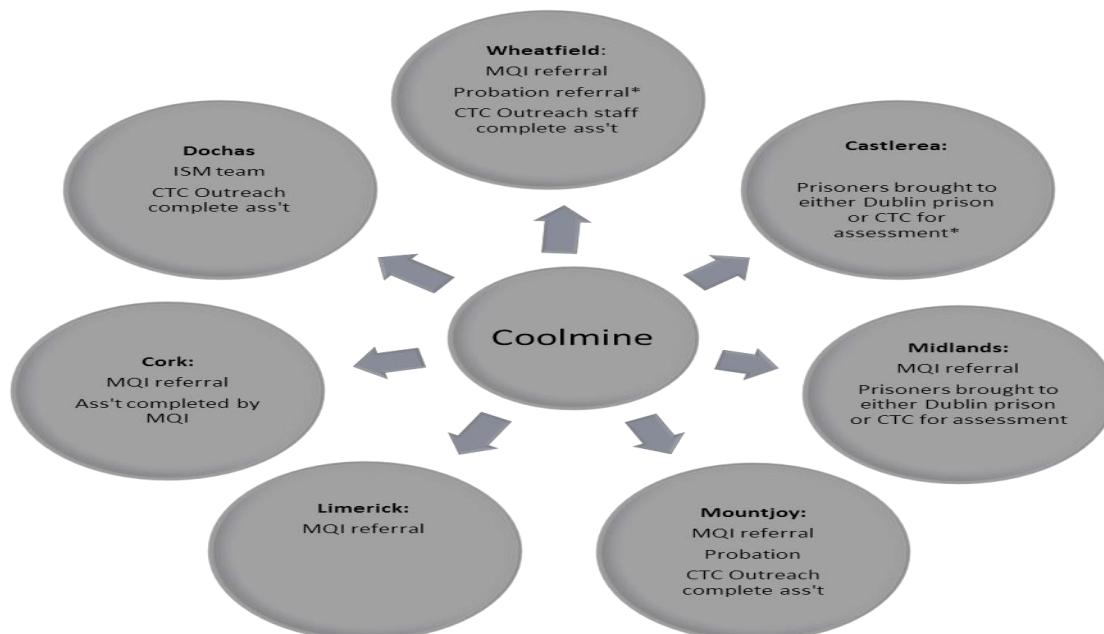
Table 7.1: Examples of Management of Inward Referrals

CBO	Internal Responsibility for Referrals
Coolmine TC	Outreach Co-ordinator, Clinical Nurse Manager Weekly prison outreach meeting to conduct admission planning and waiting list management
Ballymun Youth Action	Client Services Coordinator who allocates offenders to individual workers. Direct referrals by a Probation Officer normally result in a three-way meeting between the offender, BYAP and the Probation Officer to initiate engagement.
Ceim Eile	Referral form completed by primary addiction treatment centre. Team Lead and senior addiction counsellor are responsible for managing referrals and arranging assessments.
Aftercare Recovery	Email/telephone contact made by Probation Officer who is sent a referral form to complete. Offender's needs discussed with the Probation Officer. Urinary analysis used to establish drug/alcohol-free status.
Cuan Mhuire	Irrespective of where the referral is coming from, the offender is asked to make contact directly with the service and is taken through a series of questions. Offenders on probation supervision are requested to obtain a letter from their Probation Officer setting out what they are on probation for.
Aiseiri	Team leader will accept telephone referrals made by Probation Officers or Probation Officers can forward completed referral form. Offender is then contacted to set up an appointment.

7.3 Referral Pathways from Prison

Referral methods vary from one prison setting to another. An example is set out in the Figure 7.2 from Coolmine TC, which is the largest CBO funded by the Probation Service. While not directly funded by the IPS, Coolmine has a high proportion of offenders referred from prison.

Figure 7.2: Example of Referral Pathways from Prisons



(Source: Coolmine TC)

Within the prison estate, referral pathways into Mountjoy Medical Unit have been developed and communicated to all prisons, including Chief Nurse Officers in each prison. Referral to MQI can happen at any time during a person's sentence by Probation Officers, ISMs, self-referral, prison staff, pharmacists, or community prison links workers. MQI's focus in terms of the provision of addiction counselling is mainly on those prisoners nearing the end of their sentence.

7.4 Selection

Management of sex offenders and those with a history of violence or psychiatric illness is particularly challenging. All of the CBOs consulted have selection criteria and most have exclusion criteria. For example, most CBOs will not accept sex offenders or arsonists for residential services, although some will accept them for day services. Most services will not accept offenders with a history of serious assault or violent behaviour. The small number of CBOs that provide medically supervised detox do not take offenders on methadone over 40mls, indicating that a hospital setting is more appropriate for this type of detox. Some CBOs will not take offenders who have court cases pending, although they will accept these referrals once court matters have been dealt with. A small number of CBOs operate from a philosophy of total inclusion. This means that, at intake assessment, they take into consideration previous behaviour that could impact on others or the service and put in place contingency plans around the individual. A goal setting approach is used rather than refusal, with the possible exception of offenders with very serious psychiatric issues.

Offenders with serious psychiatric or mental health issues are also a challenge with many CBOs not accepting such referrals if such conditions are known in advance. In some cases such conditions are masked by the addiction and only become evident as treatment progresses.

Most of the CBOs' information systems do not gather data about the number of offenders with mental health issues. Of those that did provide data for this research, one CBO indicated that addiction combined with mental health accounted for 35% of offenders. Another indicated that 20% to 40% of offenders referred come in on psychiatric medication but during or after full assessments and treatment this rises to 60%. Another indicated that addiction combined with mental health affected around 5% of offenders.

CBOs aim to admit referrals as quickly as possible, e.g. within 3 to 4 days or within 3 to 4 weeks, but waiting lists were in operation in some services. Waiting times for access to addiction counselling in prison can be from three months onwards.

7.5 Communication

Positive working relationships with local Probation Officers in the community or Probation Officers attached to different prisons were named by CBOs as a positive strength of the current system. CBOs indicated that Probation Officers had a good understanding of their services and thus referrals made by the Probation Service were appropriate. There were some calls for more sharing of information by Probation Officers with CBOs about offenders' court cases, convictions and offending history. An example of good practice is one CBO which holds a three-way meeting involving the offender, Probation Officer and CBO when a direct referral from the Probation Service was made.

Another example of good practice is a Probation Officer making contact with a CBO while the offender was still in prison. The Probation Officer and the CBO discussed the offender's needs and suitability for the service. The CBO sent a referral form to the Probation Officer who completed it with the offender. The completed referral form was forwarded by the Probation Officer to the CBO. The CBO conducted an assessment in prison, with a follow on assessment conducted in the CBO's service once the offender was transferred. A start date was established prior to transfer and a care plan was put in place.

Another example is the Dochas Centre where the Probation Officers meet weekly with the healthcare team. Similarly in Cork prison, the Probation Officers meet the healthcare team weekly and monthly.

Some challenges were noted in respect of communication and these are discussed in the next section.

7.6 Communication Challenges

It had been noted that on occasion there are breakdowns in the communication structures in advance and during treatment between CBOs, Probation Officers and the IPS. This is partly linked to the different systems of referrals within each prison and sharing of information across systems as well as resourcing issues. Engagement with Probation Officers prior to referrals being made from a prison setting or during the assessment phase is an important part of good practice.

Other challenges noted by CBOs included some offenders referred with an assessment but without an accompanying medical report or without their medication which should have been dispensed in prison prior to release.

Offenders admitted to CBOs on post custody supervision without the Probation Officer being made aware that this had happened was also identified as a challenge by both CBOs and Probation Officers. Probation Officers expressed concerns about offenders on post custody supervision leaving treatment prior to or on their release date without having completed the

full treatment programme and without the Probation Officer being notified. Generally, prisoners are released to a treatment centre in advance of their Earliest Date of Release (EDR) and with post custody supervision, with post custody supervision only commencing when EDR passes. If a prisoner leaves treatment in advance of the EDR and post custody supervision and does not return to prison, then they are unlawfully at large in the community without supervision. If they leave at the EDR then the post custody supervision commences and it is then the Probation Officer's responsibility to re-engage the prisoner in supervision.

Not all referrals to CBOs, made by addiction counsellors operating in prisons, were considered appropriate by CBOs, with motivation of offenders a key issue. Offenders need to know in advance what to expect and what will be expected of them so as to make an informed choice. Motivation to change is an important success determinant and it is important that this is displayed.

Occasional referrals and resulting transfers at very short notice from prisons to CBOs resulting in rushed admittance procedures was another challenge identified by CBOs.

The system of prison clearance can present a challenge for outreach/in-reach workers. Local clearance might be granted by the governor of a prison while central clearance was being processed. Delays experienced in obtaining the latter (12 weeks in once instance) means that assessments could not be undertaken and this creates backlogs and waiting times.

Research suggests that women do best in specialist services that can meet their needs. However, the number of specialist services for women is limited in Ireland and only one receives funding from the Probation Service. The IPS and the Probation Service are currently addressing this issue as part of the joint strategy for women offenders.

A challenge right across the prison estate is that any one prisoner might have referral links made to different services or the same services by any number of people they come in contact while in prison, e.g. Probation Officers, community prison link workers, addiction nurses, MQI addiction counsellors, etc. This can lead to duplication and confusion. There were calls for the development of clear referral pathways, link in and transfer for offenders from prisons to CBOs. CBOs suggested that they should be able to check in with both the IPS and the Probation Service regarding the appropriateness of referrals from prisons (irrespective of who made the referral) to check for eligibility before the person is transferred to the CBO and an assessment is completed. It was suggested that formal sign off by the Probation Service might address this situation.

7.7 Summary

The findings highlight the need to improve communication and to develop a more collaborative and co-ordinated approach to referral between all stakeholders, with clear

referral pathways within the prison system and from prison to community based services. On-going communication between CBOs and referring agents, particularly Probation Officers, once an offender is referred to treatment is also good practice.

The importance of making the offender aware of their treatment choices and what each will involve was also highlighted, along with checking motivation and willingness to change. This would result in consistently ensuring appropriate referrals and would more likely lead to better outcomes in terms of retention in treatment.

Chapter Eight

The Work on the Ground: Assessment

Assessment is the process of exploring the nature and extent of a person's addiction and other needs that impact on this, their motivation to engage in treatment and rehabilitation and immediate risk factors.

8.1 Assessment Process

Probation Officers conduct initial assessments prior to making referrals to CBOs or HSE addiction services or internal interventions including Probation Service programmes. This contributes to appropriate and effective referral to CBOs.

Apart from Coolmine TC and MQI, no other CBO consulted for this review indicated that they conducted outreach to prisons for the purpose of initial assessment, relying instead on input from Probation Officers. However, there are a range of in-reach services around the country from a range of CBOs outside of the 18 funded by the Probation Service, some of which engage in initial assessment.

Each CBO has developed its own standardized assessment form. The main areas covered are referral sources and notes (if available), presenting issues, demographics, previous treatment and involvement in other treatment services, current active care plan and areas of risk, supports sought in the short and medium term. Some services complete the NDTRS⁷ reporting form. Some use standardized tools in their assessment process, e.g. SASSI⁸, MAST,⁹ AUDIT.DUDIT/CUDIT-R. Many services have built their initial and comprehensive assessment processes around the basic requirements as set out in the NDRIC model and guidance framework. The table below presents examples of how assessment is conducted in some CBOs.

Table 8.1: Examples of Assessment Practice

Coolmine	The Outreach Co-ordinator is responsible for assessments.
Ballymun Youth Action	Key details are identified at referral stage. Offenders are allocated to a designated staff member by the Client Services Coordinator. This staff member conducts the initial assessment and, where appropriate (e.g. complex cases) a comprehensive assessment.
Ceim Eile	Assessment conducted by Team Lead, senior addiction counsellor, with offender while they are still in primary treatment. The assessment report and referral form are discussed by the clinical team.
Aftercare Recovery	Assessment conducted in prison or the community as appropriate by the assigned project worker/counsellor.
Cuan Mhuire	Assessment conducted by the nurse or addiction counsellor on duty or both together.
Aiseiri	Assessment conducted by team leader.

⁷ National Drug Treatment Reporting System.

⁸ Substance Abuse Screening Inventory

⁹ Michigan Alcoholism Screening Test

The length of time it takes to complete assessments varied from CBO to CBO, ranging from one hour to a number of weeks. Most CBOs conduct an assessment as a once-off activity at intake, while others view it as an on-going process. Assessments are generally conducted within one to two days of an offender being admitted, unless they are taking part in a detox programme, in which case assessment might not happen until two to three weeks into the detox programme when the offender is more capable of engaging in the assessment process.

Different approaches to assessment apply in different prisons for referrals being made to CBOs. In most prisons, the MQI addiction counsellors conduct the initial assessment. In others, Coolmine TC's outreach team conduct initial assessments in prison for offenders being referred to its services and in some prisons (e.g. Castlerea), Coolmine TC has trained MQI addiction counsellors to conduct Coolmine TC assessments. However, if the person doing the assessment cannot make an appointment then the prison-based MQI addiction counsellor might have to conduct the assessment with consequent knock-on impacts on internal caseloads. There were calls for better communication between service providers and streamlining of assessment processes and tools.

8.2 Communication

Where an assessment result deems an offender unsuitable for a service, then, in general and if the offender is under Probation supervision, the CBO informs the relevant Probation Officer so that an alternative may be sought.

CBOs that take referrals only from primary treatment centres refer any unsuitable referrals back to the primary treatment centre.

Concerns raised by Probation Officers covered insufficient communication between CBOs and Probation Officers and the IPS (e.g. with ISMs) regarding the outcomes of assessments. Probation Officers felt that there should be some link between them, the IPS where relevant and the CBO during the assessment so that wider issues, e.g. security, risk of offending, etc., can be taken into consideration. These concerns regarding insufficient communication, for example with ISMs, are also relevant to offenders who are not subject to probation supervision.

8.3 Waiting Lists

There is a waiting list for access to MQI addiction counsellors in most prisons. There appears to be no central recording of waiting lists and waiting times and such a system would facilitate waiting time management.

The waiting list for the Medical Unit in Mountjoy is managed by the addiction nurses who also conduct assessments. These assessments are reviewed each week by the clinical addiction team who then assigns each prisoner to a suitable programme, e.g. continuance on

methadone, or 21 day detox which can then be followed by self-directed detox under the supervision of the pharmacy team, or taking part in the Drug Treatment Programme (eight week structured programme), or medically supervised slow detox or stabilisation (e.g. for those with HIV, Hepatitis C or mental health issues).

8.4 Summary

The results highlight the need for improved communication between CBOs and Probation Officers and relevant staff in the IPS at all stages from assessment, to treatment to completion or drop-out in order to ensure that wider security and risks are taken into consideration at each stage. The overall system of managing waiting times for access to services within the prison estate could be improved by the development of a centralised data recording system accessible to addiction counsellors, Probation Officers, health teams and ISMs.

The next chapter examines how care planning operates in a community and prison setting.

Chapter Nine

The Work on the Ground: Care Planning

Care planning is a holistic on-going process that addresses addiction and wider physical and mental health needs. It also includes family, financial, housing, legal, education and employment needs that are relevant to each offender and that could impact on their ability to engage in treatment and subsequent recovery.

9.1 Process of Care Planning

Probation Officers play an important role in care planning given their on-going engagement and intervention and role in the case management of offenders under probation supervision.

CBOs have internal systems of care planning. Some use existing models such as the Outcomes Star or variants on it, others have developed their own systems, some of which have external accreditation. Care plans are holistic covering all aspects of a person's life, not just their addiction. For example, one CBO's care plan covers spiritual, emotional, behavioural, social and vocational needs including individualised learning plans to address training and education needs. Another CBO's care plan covers detox plan, family, social services, budgeting, legal matters, probation supervision, housing, mental health and physical health and aftercare plan. Some CBOs felt that financial support provided by the Probation Service was insufficient to cover all of the needs of some offenders, e.g. literacy issues, anger management issues, long term housing needs, training and educational needs.

Some examples of interagency care planning were named, where a dedicated case manager was appointed. In some instances this was the Probation Officer and in others a LDATF case worker. However, many CBOs commented that the majority of offenders referred to them do not come with a pre-existing care plan or if such a care plan exists it is not available to the CBO. One CBO held the view that often pre-existing care plans are already in place and it is incumbent on the CBO to do sufficient 'homework' by making contact with the offender's support network and previous service providers to find out what is already in place. This is necessary to ensure continuity of care planning where appropriate and to build on the care plan.

An example of good practice is an offender who was in prison and was referred to a CBO by the Probation Service. The CBO outreach team, local Gardaí and Probation Officers, both in the prison and the community, worked closely together prior to release from prison to the treatment centre. The offender was involved early on in their care planning and this eased the transfer process and ensured the offender was engaged, motivated and empowered. Another example was a CBO that engages with the Probation Officer prior to formal referral in order to identify clear and realisable care plan objectives for the offender.

Responsibility for care planning in a prison setting in general is unclear. Informal care planning does occur through discussion with prisoners, but often time and resources limit the amount of information that can be gathered and there is no structured care plan process or format within the prison system.

An example of care planning within the prison system is Cork prison. Here, the LDATF provides funding through the prison school for a link worker. The link worker care plans with the prisoners in respect of housing, education, social welfare entitlements, health needs in the community (e.g. medical cards), etc. Other services come in to provide supports, such as the Citizens Information Service, Money Advice and Budgeting Service and social welfare. Focus Ireland and Sophia Housing provide life skills programmes as well as referrals to addiction services in the community.

9.2 Care Plans

Care plans from other services do not generally transfer into the prison estate, although some CBOs, e.g. Ana Liffey, engage in prison in-reach visits to check with their clients who are in prison regarding their care plan which had been developed while they were with the CBO. It is often only by ringing previous service providers that the GP or nurse can ascertain what treatment the prisoner had before. This is reliant on the prisoner naming the services they have attended in the community. Similarly, care plans developed within prison do not always transfer to community settings.

9.3 Summary

The results show that within different settings, care planning is conducted, but that this process is more developed in the community than in the prison estate. In addition, when an offender moves from one setting to another, breaks in the care planning process can occur, notably when an offender moves from the community into prison.

The results underline the importance of inter-agency working and communication in care planning in order to ensure continuity from one setting to another and to build on the work that has been previously done with an offender rather than starting from scratch or duplicating. Ideally, the goals of the care plan should follow the offender from one service or setting to another and basic information sharing protocols, with the individual's permission, should be put in place to support this process. This would ensure alignment with the NDRIC framework irrespective of which setting the offender is in. The use of information technology, e.g. cloud computing, might facilitate the transfer of key care plan goals across settings and is an issue that the IPS and the Probation Service should bring up at NDRIC.

The next chapter looks at case management in a community and prison setting.

Chapter Ten

The Work on the Ground: Case Management

Case management is a process by which services are provided to an individual offender on a co-ordinated basis across multiple service providers/agencies through the use of a care plan that reflects the offender's needs.

10.1 Process of Case Management

CBOs have internal systems to case manage individuals within their service, e.g. weekly team meetings to review cases. The CBOs make contact with previous services or referral agencies, where they are aware of these, and might invite these services or agencies to attend some internal case meetings. Due to time and resource constraints, most of these services input to the case management meetings via telephone, email or letter. CBOs indicated that Probation Officers were most likely to attend in person. CBOs also indicated that often because of internal time constraints and resourcing they were not always able to attend external inter-agency case conferences and would input via telephone, email or letter. Some CBOs have a strict policy of not allowing individuals to leave their centre once treatment commences. This means that individual offenders cannot attend inter-agency case conferences.

Most CBOs consider themselves as providers of services rather than case managers of integrated care pathways across services and systems. CBOs indicated that their experience of cross-service case conferences under the NDRIC framework were very 'hit and miss' and might never occur for some individuals attending treatment, partly because of timing issues. At the same time they are aware of the challenges transitions pose for offenders and many actively promote more integrated transitions into the community and work with external stakeholders such as the Probation Service, social services, the HSE, LDATFs, etc.

MQI, as part of the assessment process in prisons, identify if a person has been attending psychiatric services. If this is the case, often the case manager will be the community psychiatric manager and MQI's role in case management is to ensure the offender remains linked into community services.

CBOs and community prison link workers who conduct prison in-reach for offenders whom they dealt with in the community prior to prison do their best to case manage these offenders, while in and out of prison, but this process is heavily reliant on self-referral and requests for visits being made by the offender.

10.2 Challenges

In the context of the NDRIC framework, even when CBOs consulted for this review use the eCASS¹⁰ information system, they tend to use it for internal purposes rather than cross-agency information sharing and their experience of other statutory and non-statutory services is of similar usage.

Some of the CBOs consulted commented that at regional level they had experienced disagreements over who was a case manager and who was a key worker and that this needed to be clarified in the context of the implementation of NDRIC. Some services are linked into local interagency networks around NDRIC protocols and commented that they felt these structures have yet to bed down sufficiently. The regional focus can also be problematic for CBOs that operate a national service.

Case management across systems (e.g. from health to justice) requires improvement. It is often blurred with care planning. The ideal is the appointment of one individual who acts as case manager for the offender in whatever setting the offender is based in order to ensure continuity of care. However, once a person enters prison, there needs to be hand-over of the case management role to a person working within the prison setting and this case manager in turn ensures a smooth hand-over to an external case manager once the offender leaves prison. With the exception of Mountjoy Medical Unit, where a multi-disciplinary approach is used to case manage prisoners attending the Medical Unit or DTP, responsibility for case management within prisons is unclear.

10.3 Summary

The results indicate that case management across settings under the NDRIC framework has yet to bed down fully. Within the prison estate, the case management function requires further development including clarification over responsibility for it.

The next chapter explores addiction treatment within the community and prison settings.

¹⁰ Electronic Consolidated Automated Support System

Chapter Eleven

The Work on the Ground: Treatment and Intervention

Two prisons, Cork and Mountjoy, were visited as part of the review and a telephone interview was conducted with a member of the health team in the Dochas Centre. Five CBOs were visited, a telephone interview was held with another and a number also made written submissions. Treatment regimes are described below along with challenges highlighted in respect of treating offenders.

11.1 Treatment and Intervention Options

The suite of treatment and intervention options covered by the cohort of service providers (CBOs) funded by the IPS and the Probation Service includes the following. Not all of these options are available in all of the services but each service uses more than one option:

Figure 11.1: Range of Treatment and Intervention Options

- Detoxification
- One to one counselling
- Key working
- Group therapy
- Minnesota Model (12 Step Programme)
- Motivational Interviewing (MI)
- Motivational Enhancement Therapy
- Disclosure Groups
- Cognitive Behaviour Therapy (CBT)
- Rogerian Approach
- Rewards system
- Crisis Intervention
- Community Reinforcement Approach (CRA)
- Brief Solution Therapy
- Rational Emotive Behaviour Therapy (REBT)
- Harm reduction
- Relapse prevention
- Information and awareness raising about substance misuse
- Workshops about re-offending behaviour
- Psych-educational groups
- Gender groups
- Mindfulness
- Meditation
- Diversion workshops
- Prison visits
- Linkage to training, education and employment opportunities
- Support with housing, financial or other needs
- Access to Community Employment
- Complementary therapies

- Holistic therapies
- The Probation Service's Alcohol Awareness and Alcohol and Offending Programmes

The majority of CBOs require individuals to attend treatment drug and alcohol-free but a small number provide medically supervised detox.

The treatment options offered by CBOs are underpinned by different philosophies. The majority of services are based on a total abstinence model (e.g. Cuan Mhuire, Aiseiri, Fellowship House, Tabor Lodge, etc.). A small number are based on a recovery model that recognises that relapse does occur and is catered for within the suite of services offered (e.g. MQI). Coolmine TC operates on the basis of a hierarchical therapeutic community, with abstinence as a core component. It has the only residential facility that takes women and their children. Some CBOs incorporate a harm reduction approach within an abstinence and relapse prevention model (e.g. Ballymun Youth Action). A small number of services offer specialist supports (e.g. Fusion CPL integrates prison link work and family support into its suite of services).

Some CBOs recognise that group work can be daunting or inappropriate for some individuals and they operate pre-entry groups. This might be followed by participation in a part-time group prior to participation in a full group.

Programme length was typically around three months, although some CBOs had shorter programmes lasting four weeks, or longer programmes lasting six months.

Given that abstinence is a core value in the majority of the services consulted with, these CBOs require an individual, who has relapsed, to leave the treatment centre immediately, particularly if relapse arises in-house and drugs or alcohol are found on the treatment centre's premises. A small number of CBOs will continue to work with individuals who relapse.

CBOs believe that offenders benefit from meetings with their Probation Officers during treatment in the treatment centre as this maintains connections with a key support network for the offender and reinforces partnership working between the CBO and the Probation Service. A number of CBOs feel that there are fewer opportunities for this to happen in the current arrangements. Probation Officers noted that some CBOs were good at regular communication with them regarding an offender's progress while in treatment, while others were not and there were calls for a regular feedback mechanism to be developed.

There are a range of interventions incorporating substance misuse as part of a broader engagement by the Probation Service with offenders. The Probation Service has also developed Alcohol Awareness and Alcohol and Offending Programmes under its programme strategy. While these programmes are primarily delivered by Probation Officers,

as appropriate they are being delivered in partnership with a number of CBOs, thereby providing a consistent approach nationwide.

A number of the CBOs involved in delivering the Drugs Treatment Programme in Mountjoy (DTP) already include offending behaviour in their modules and there may be further opportunities to share this learning with other services as well as learning from the Probation Service interventions and programmes.

Within the prison estate, opiate substitution treatment (e.g. methadone) is still the primary treatment provided in prison. However, an increasing number of prisoners are seeking detox. This appears to be due to a number of factors including a desire to obtain bail and influence court decisions and fears about the long-term health impacts of opiate use. Detoxification options are currently centred on opiates. Given the prevalence of other drugs, particularly benzodiazepines, other detox programmes need to be considered for inclusion in prison treatment programmes.

Two main types of detox programmes are available within prison. Detox off opiates using methadone is an eight week programme for prisoners who are already stable on 20mls or less of methadone. Attendance at one-to-one addiction counselling and education programmes (e.g. DTP) is a requirement. The second option is a slow detox programme which operates over six months and those participating are required to attend one-to-one sessions with an addiction counsellor or psychologist.

The IPS and the HSE have developed a protocol whereby a prisoner is started on methadone treatment only when the HSE guarantees a treatment place on release. This arrangement appears to work well in Dublin as there are a large number of HSE clinics, but can be problematic in some counties.

Detox for alcohol is supported by prescription of Librium. Many of those consulted believe that protocols and standard operating procedures around alcohol detox within prisons require strengthening and specific programmes need to be developed to address underlying issues resulting in alcohol addiction.

The Mountjoy Campus has contracted in pharmacy services. The pharmacists are based within the prison and see prisoners on a daily basis. This can be an invaluable extra support and helps to cultivate trust. The pharmacists can make referrals to appropriate services and they can follow-through and ensure continuity of care. In all other prisons, methadone is stored on site in prison surgeries and dispensed by nursing staff and all other prescribed medication is provided by local pharmacies on a needs basis. In some prisons, having a centralised dispensing service could pose challenges to the operational management of the prison.

Addiction counselling and in-reach is provided in prisons by a number of CBOs. For example, MQI provides one-to-one addiction counselling for prisoners across the prison estate. It also conducts assessments and makes referrals to CBOs. There is a waiting list for addiction counselling of up to three months in some prisons, e.g. Mountjoy, so the addiction counselling teams prioritise those prisoners nearing the end of their sentence. Another example is Ballymun Youth Action, which provides one to one addiction counselling in prison that involves a continuation of work that has been done while the prisoner was in the community. Ballymun Youth Action is involved in pre-release preparation work for some prisoners. It also runs a module in the DTP in Mountjoy.

Some CBOs engage in prison in-reach in different prisons. For example, Ana Liffey provides prison in-reach in a number of prisons to offenders it has dealt with in the community either on request from a prisoner or checking in regarding care plans or for case conferences. It also runs modules in the DTP and open group facilitation in Mountjoy.

Concerns were raised about the absence of suitable tools/mechanisms to support harm reduction interventions in prisons for prisoners who are using drugs, e.g. access to clean injecting paraphernalia rather than make-shift or reused syringes, informing prisoners of the risks associated with sharing equipment or using make-shift equipment, etc.

11.2 Mountjoy Prison

The clinical team in Mountjoy comprises an addiction specialist doctor, two addiction nurses, two pharmacists and two MQI addiction counsellors and the chief nurse. It meets weekly to review cases and the governor of the prison also attends to address any operational matters.

On committal, prisoners entering Mountjoy are seen by a nurse who conducts an initial assessment. This establishes if the person is already on methadone and the amount being used and the nurse confirms this. If the person is already on methadone they will be seen by the doctor the following day and the prescription regime will be continued. Once it is established that the person is stable while on methadone, they can opt for full detox. If on committal the person is not on methadone and discloses they have used heroin and require an immediate detox, they are referred to the doctor who prescribes 21 day detox using methadone. If on committal the clinical presentation suggests the person should be on methadone, the person will only be started on methadone if a place in a community clinic upon release can be secured. This must be confirmed in writing. If a clinic place cannot be guaranteed, the person is offered a 21 day detox.

The Medical Unit in Mountjoy takes prisoners for treatment from other prisons as well as from Mountjoy and there is always a waiting list. In mid-2015, the Clinical Addiction Team took on the role of managing the waiting list for entry to the Medical Unit. Protocols were put in place to streamline the referral and assessment processes and to address operational issues

that had arisen. The prison governor attends the clinical meeting each week and this provides a link between the clinical and operational functions.

Since 2008, Mountjoy has contracted in a drug treatment pharmacy service to provide pharmacy services within the prison on a daily basis, particularly to ensure safe and efficient dispensing of methadone. Not all prisoners wishing to detox want to do so under a prescribed and fixed regime and since 2010 the pharmacists have been involved in supervising and managing self-directed detoxification (SDD). SDD allows prisoners to detox at times when they feel ready for change. It provides an empowering and flexible approach to prescribed detox. SDD is offered in 12 locations within the prison and prisoners wishing to avail of SDD must notify the pharmacists 24 hours in advance of commencing. This provides time to ensure the prisoner is not making hasty decisions and facilitates assessing the clinical appropriateness of SDD for each individual. The parameters within which SDD will operate are communicated to the addiction specialist doctor who prescribes reductions in methadone and also medication to alleviate withdrawal symptoms if required. The pharmacists supervise the prisoner daily and make interventions as appropriate. A list of those taking part in SDD is communicated to the weekly clinical team meeting. Research suggests that this is an effective and safe approach to SDD within a prison.

Offenders are at high risk of overdose within the first three weeks of release and Mountjoy has agreed to take part in the Naloxone project operated by the HSE. Naloxone is a medicine (an ‘opioid antidote’) commonly used by healthcare professionals and ambulance services to reverse the effects of an opioid overdose and bring the person back to consciousness. It is suitable for lay use to manage an overdose situation whilst waiting for full medical support to arrive. The clinical teams plan to introduce its use in the Medical Unit for the DTP during 2016.

11.3 Drug Treatment Programme (DTP)

The DTP is operated in the Mountjoy Medical Unit. It is an eight-week programme operating five days a week delivered by the Mountjoy health team and various CBOs (Ana Liffey, Coolmine TC, MQI, Harmony and Ballymun Youth Action). Each CBO is responsible for developing and delivering its own modules. There are nine places available on the F5 landing and another nine available on the F6 landing. It is planned that over the course of a full year there will be five cycles of the DTP on each landing (a total of 90 participants per annum). The latest cycle commenced in November 2015.

Prisoners interested in taking part in the DTP must be free of drugs. Those expressing an interest are referred to an addiction nurse or addiction counsellor who conducts an assessment for suitability for the programme. The clinical team meets weekly to review names put forward for the DTP and these are checked for operational issues – behaviour report, local governor report, discipline report and, if relevant, psychological report. The clinical and

operational teams in Mountjoy meet with the Operations Directorate of the IPS to select nine names for each DTP. Prisoners who are successful are informed of their selection but there is scope to improve feedback to those who are unsuccessful.

A number of CBOs are involved in delivering the DTP (see figure below for summary of provision). If an offender drops out of any of these modules then the clinical team in Mountjoy is notified and the person is linked back to an addiction counsellor. DTP participants who relapse are removed from the programme immediately, their case is discussed at the clinical team meeting and they are linked back to an addiction counsellor. Some CBOs, while acknowledging that decisions to remove prisoners from DTP groups due to behaviour rests with the IPS, would like to be consulted more regarding a prisoner's engagement and progress prior to decisions to remove a prisoner from the DTP.

Figure 11.2: Components of DTP Modules

Ana Liffey	Pre-set programme incorporating harm reduction, educational approach to substance dependency and recovery. Open group facilitation once a week.
Ballymun Youth Action	Experiential group work intervention exploring the relationship between participants, drugs and addiction, examining the effects of drugs and addiction and the process of addiction within a person's life, what is involved in moving on and recovery, change, blockages and supports and strengths..
Coolmine	Focus is on interpersonal skills and relapse prevention using CRA. Covers behavioural chain, managing urges to drink/take drugs, refusal skills, functional analysis, interpersonal skills, problem solving, anger management, managing negative thinking, decision-making, and relapse prevention. Uses a combination of presentations, handouts, role play, assignments, group pressure and support.
Harmony	Music therapy to address denial, underlying root causes and stigma using music, CBT, meditation, exercise and skills development including preventative strategies.
MQI	Focus is on reflection, learning objectives and goal setting. Group work supported by one-to-one counselling if required. Relapse prevention groups.
Prison Medical Team	Health promotion, nursing care plans
VEC through prison school	Arts and crafts, yoga

Early experience in implementing the DTP resulted in the development of clear selection criteria for those wishing to participate. Readiness for change is an important selection criterion and CBOs involved in delivering the DTP commented that selection on the basis of readiness currently applies.

The DTP does not currently have a universal curriculum and this is contributing to some duplication and overlap in provision between different service providers. It is unclear whether or not all the approaches being employed are evidence-based. There is also an absence of a clear co-ordination strategy and on-going oversight for the programme. In the past, this was provided by the Probation Service. MQI, along with the clinical team, have a meeting once during each programme cycle to review the dynamics of the group, but there is lack of clarity over who is responsible for co-ordinating the DTP. While there is participant

feedback on individual modules of the DTP, the programme does not have an overarching evaluation framework. After sufficient time (e.g. within the next three to five years) the DTP will be assessed for short, medium and long term outcomes.

11.4 Cork Prison

Considerable progress has been made in Cork prison in the treatment regime since the last review by Farrell and Marsden in 2010. A visiting GP has been appointed who is based in the prison and this has improved continuity of care and working relationships with the prison health team.

Interventions in Cork prison are based on the SAOR model (Support, Ask, Assess, Offer assistance and Refer). On committal all prisoners meet a nurse/medic for a brief assessment (medical, psychiatric and addiction history). If addiction is present an addiction assessment is conducted using the DUDIT/AUDIT framework. All data is recorded electronically on the Prisoner Health Management System (PHMS). Prisoners can then be referred to general medical services, addiction nurses, addiction counsellors, psychology, psychiatry, Probation Officers (especially for prisoners close to release) and Cork Alliance which runs AA and NA meetings. Only one prisoner has recently requested a transfer to the DTP in Mountjoy and the view was expressed by the healthcare team that most prisoners want to be treated in Cork (the majority are from Cork city) rather than transferring to another prison.

Prisoners presenting with an opiate addiction may be offered opiate replacement therapy such as methadone detox, stabilisation or maintenance. If a prisoner is already on methadone their prescription is continued while in prison once the dosage is confirmed. Those committed with alcohol addiction can be offered a detox with Librium to ease withdrawal symptoms. Prisoners with benzodiazepine dependence may be offered an Epilim detox for up to 21 days to prevent seizures that can arise from benzodiazepine withdrawal. Prisoners are seen every day by a nurse and once a week by the addiction nurse or GP. An ‘alert’ system is used to watch prisoners for the first week after committal for signs of withdrawal symptoms.

A particular challenge noted by the GP was the prevalence of opiate-based analgesic usage amongst the prison population. The GP expressed the view that a Standard Operating Procedure was required to address this issue, with a strong preference for banning their use.

The GP was also of the view that there should be a policy regarding those on long-term methadone treatment, e.g. proactively encouraging detox, or at least requiring that they regularly see an addiction counsellor.

Addiction counselling is provided by two MQI addiction counsellors, who facilitate one-to-one counselling and group sessions, and there is also a counsellor funded by the Probation Service. The addiction counsellors liaise with external service providers such as homeless

services, addiction services and LDATFs. Approximately 10% of prisoners who engage with MQI addiction counsellors are referred to MQI residential facilities or Coolmine TC. The active case load is c.55 prisoners at any one time with up to 50 others on a waiting list.

The LDATF, which is not part of this review, has provided funding through the prison school for a worker who works with prisoners in advance of their release to help them in securing accommodation.

Some CBOs also engage in pre-release planning, for example, Cork Alliance, which is not part of this review. It provides assistance upon release with accommodation, social welfare, training and education, employment, family relationships and linking into addiction services. However, the prison GP commented that he has no input to pre-release planning and feels this should be addressed in order to ensure that health and addiction goals established in prison are followed through into the community.

Three drug free landings are in operation in the prison. Transfer to these landings is controlled by operational management and behaviour appears to be a key determinant. As a result, there are some prisoners on these landings who are on methadone.

11.5 Dochas Centre

The Dochas Centre is the main prison for women in Ireland. Thus women committed to it can range from those on remand to those on a life sentence.

On committal a healthcare nurse (there are no specialist addiction nurses in the Dochas Centre) will conduct an initial assessment. The prison GP prescribes methadone or offers symptomatic drug detox tailored to each individual's needs. A Librium detox is offered to those with an alcohol addiction. There is a lower threshold for commencement on methadone than elsewhere and while every effort is made to ensure detox is completed prior to release, sometimes this may not happen.

A senior nurse is responsible for links with community clinics including making contact with clinics prisoners were in before committal and setting up referrals for those on methadone prior to release.

An inter-disciplinary team approach is employed to care planning and case management. This team is comprised of the health team, Probation Officers, ISM, MQI addiction counsellors, general management in the prison and Central Mental Hospital in-reach team. This has proven be an effective approach. This team meets once a week to discuss cases, including women who are coming up for temporary release or nearing the end of their sentence. The prison currently does not have a psychologist but plans are in progress to appoint one.

Referrals to community-based residential treatment are handled by the MQI addiction counsellors. Referrals to community clinics are handled by the senior nurse and referrals to day programmes (e.g. relapse prevention) are handled by the Probation Officers or ISM.

A resettlement officer handles referrals to homeless services or accommodation providers.

This integrated approach, multi-disciplinary team and the development of strong links with community clinics through a dedicated member of staff are strengths of the current system in the Dochas Centre. This requires regular on-going communication, building good personal relationships and sharing of information (primarily by email).

11.6 Equity of Access

Equity of access is a core component of the model of effective practice outlined in chapter five. This raises questions as to whether centralising treatment in one centre is a good way to go for the future. Prisoners may not wish to transfer to a central unit and there is a strong risk that centralisation will result in services in other prisons being left behind. Building on what is already present in each prison and disseminating learning gained from the Medical Unit in Mountjoy may be a more effective approach, particularly in the short to medium term. For example, the DTP, or elements of it, has potential to be replicated in other prisons.

If equity of access and treatment is to be provided to prisoners irrespective of location, then a minimum standard of provision should be present in every prison in Ireland. This should encompass assessment, assisted and supervised detox, substitution treatment and addiction counselling. Addiction counselling combined with substitution treatment is a cost effective approach to treatment within a prison setting. Each prison should have a dedicated addiction nurse or nurses who can work with prisoners on a consistent basis and ensure continuity of care within the prison system, a visiting GP or psychiatrist with an interest in addiction who can provide continuity of care (locums should be minimised), access to a pharmacy/dispensing service and access to regular addiction counselling services. Treatment for addiction should be viewed as part of healthcare treatment that employs a multi-disciplinary approach.

Remand settings pose particular challenges in treating addiction. A ‘best can do’ approach may be the most realistic option and a good starting point. For example, an approach that incorporates assessment, screening, referral to treatment on release, assisted withdrawal that enables a prisoner to manage the transition to lower or no use of drugs on release, access to one-to-one addiction counselling and harm reduction strategies.

11.7 Dual Diagnosis

All of the CBOs commented on the number of offenders with dual diagnosis of addiction and mental health, but the majority of CBOs consulted indicated that they are not equipped to provide integrated treatment. CBOs highlighted the importance of finding out during assessment if a person is already linked into psychiatric services and ensuring these links were maintained. Most CBOs have developed good working relationships with local psychiatric units and mental health services.

Some others have had a poor experience of referring individuals to mental health or psychiatric services or getting in-patient access to hospital. Examples were given of healthcare psychiatric teams refusing to accept individuals from addiction services, the argument being that the mental health issue was linked to the addiction and the addiction needed to be addressed first or requiring that a person be four, six or twelve months drug or alcohol free before they would accept a referral. However, services have noted that often addiction masks an underlying mental health issue (and substance abuse may have been used as a coping mechanism) that only becomes evident as the person detoxes and in order to support their recovery the person needs mental health services.

A small number of CBOs have developed in-house capability in response to the prevalence of dual diagnosis cases. For example, one CBO has trained staff in mental health issues in order to provide some level of integrated treatment in-house. It also has a visiting GP with links to local psychiatric services. Another has up-skilled its team to deal with low level mental health issues such as depression and anxiety, as well as recognising the signs and symptoms of more serious illness. Good working relationships and appropriate referrals with GPs and psychiatric teams ensure access to mental health services when required. Another CBO has 24/7 nursing and GP care and can accommodate individuals with dual diagnosis unless a person is extremely ill in which case they are referred to a psychiatric unit. Another CBO has a multi-disciplinary team that includes a psychiatrist.

Within the prison estate, dual diagnosis also poses challenges in terms of treatment. While visiting GPs or psychiatrists are available within all of the prisons, not all prisons have access to a senior clinician.

11.8 Drugs-Free Environments

While continued efforts are required to enforce a drugs-free policy within the prison estate, it is acknowledged that achieving a totally drugs-free regime is a major long-term challenge.

Given that drugs are readily available in the community into which prisoners are released, addiction treatment in prisons must acknowledge that it works in an environment in which drugs are available.

Strategies that support a person to remain drug-free after treatment, albeit in an environment where drugs are available, help to strengthen and prepare a person for returning into the community. Strategies that encourage and reinforce positive behaviour seem to work well, e.g. enhanced privileges. The results also suggest that some individuals benefit from a period in a drug-free environment post treatment in order to sustain their recovery. This is acknowledged in the community setting through the provision of aftercare and step-down facilities. In a prison context, drug-free options include relapse prevention group counselling and drug-free landings.

Drug-free landings have been tried in the past. They were unsuccessful primarily because they were viewed as an operational asset rather than a clinical tool. Selection criteria were inadequate and inappropriate and inadequate monitoring was in place.

Another drug-free option that is under consideration is the introduction of a therapeutic community (TC) within the prison estate, e.g. within a prison such as Mountjoy or in a separate facility such as St. Patrick's Institution.

Both hierarchical and democratic or modified empowerment models of TC have been applied in prison estates in the USA, UK and Europe with mixed results. The prison setting itself and security requirements limits the ways in which a TC can operate, e.g. a key component, work tasks, is often a challenge to overcome where cleaning, cooking and laundry duties (core tasks used in some TC models) are outsourced to service providers. Another is establishing a suitable mix of peers. A third is the length of time a person can remain in a TC and where they go to afterwards. Prison management and staff must buy-in to the concept if it is to be successful, even if they are not directly involved in delivery of the TC programme. Adequate on-going funding is required to resource the TC with experienced facilitators, some of whom in some TC models are ex-drug users. This is perceived by some as a security risk.

11.9 Other Challenges in Treating Offenders

There are a limited number of residential detox places available both in prison and in the community. For example, MQI indicated that it made 350 referrals of prisoners due for release to its St. Francis Farm, a facility with only 40 places, resulting in waiting times of between three and six months. MQI has encouraged prisoners to take part in pre-entry groups in the meantime, but uptake is low. It was suggested that more dedicated detox facilities available to prisoners while they were in prison pre-release would help to reduce waiting times.

Another challenge noted by CBOs in providing treatment or assessment within a prison setting that impacts on the continuity of care was access by CBOs to prisoners. This challenge is most notable when lock-down occurs, when Prison Officers are not available to accompany CBO staff or when central clearance is delayed or refused. In-reach visits being

classified as ‘welfare’ visits rather than addiction assessment or treatment can also mean that a prisoner does not know who is visiting and the real purpose of the visit and this may result in the prisoner refusing the visit.

Within the community setting, some offenders need to move away from their original community on completing treatment if their recovery is to be sustained, e.g. due to fractured family relationships, anti-social networks and friendships, memories and links to poor patterns of behaviour. Accessing suitable accommodation is a real challenge faced by those moving away from their home environment. A small number of offenders who complete treatment in the community may be returning to prison and they return to the general population which may not be conducive to recovery sustainment.

This latter point is a challenge for all treatment programmes within the prison estate, i.e. where to progress those prisoners who have completed detox programmes. Most go back to the main prison population but other options need to be considered, e.g. peer led positive drug-free environments within the prison estate, moves to approved open centres or transitions to community-based rehabilitation programmes. Clear pathways for onward movement out of prison detox programmes need to be developed for each prison.

Other challenges relating to treatment in a prison setting include operational management of protection prisoners requiring detox. Currently protection prisoners cannot be accommodated in the Mountjoy Medical Unit (16 have requested transfer to it) until operational matters are addressed.

Managing transitions for prisoners who are released by the courts is another challenge as it can be difficult to put supports or prescriptions in place without advance notice.

CBOs commented on the importance of extending the period of care for a person recovering from addiction. Limitations in current service provision were noted in respect of the number of secondary treatment facilities available in Ireland. CBOs that have had offenders referred on to secondary treatment facilities noted the positive outcomes achieved. Other methods of extending care include aftercare programmes. Attendance at day services by offenders can be affected by conditions of probation supervision orders. CBOs noted that where there was good communication with the Probation Officer and the Probation Officer was willing to be flexible, these challenges could be overcome.

Particular challenges were noted in respect of offenders who have been and who remain chaotic drug or alcohol users. Prisoners who are on methadone in prison and who are maintained on it are linked into methadone clinics in the community prior to release and this is an effective safety net. However, there are limited safety nets available for chaotic drug users after they leave prison, especially as the risk of homelessness is high and access to

medical services can be low. This is particularly pronounced when the relevant paperwork that facilitates access is absent.

Finally, how funds are attached to each patient by CBOs can give rise to challenges. For example, some services allocate a ‘bed-night’ rate or ‘fee’ to each individual referred by the Probation Service or the IPS. Probation Service SLAs specify the number of referrals that each service is obliged to take. In some services this quota is reached early in the year and as funds are attached to each person, no further referrals are taken once the Probation Service allocation is used. Other services are more flexible in their approach and have taken higher numbers of referrals (direct or indirect).

11.10 Challenges Specific to Women Prisoners

A number of specific challenges with respect to treating women prisoners were highlighted. The Dochas Centre is the main prison for women within the State and as such it has a mix of women on remand and those who are sentenced within the prison. Many of the women coming to the Dochas Centre have chaotic lives. It is estimated that 85% of the women prisoners have addiction issues. They have been in and out of prison on multiple occasions and have been engaged in substance abuse for a long time. Court orders may require that they receive addiction counselling, psychological assessment, treatment or rehabilitation, but if they are on remand there are limited opportunities to provide any of these interventions.

Like their male counterparts, the spectrum of addiction includes alcohol, opiates, tablets (illicit and prescribed), head shop drugs, benzodiazepines, snow blow and alcohol. Community clinics and treatment services are still focussed on opiates and do not appear to have caught up with the trend towards increased use of tablets, benzodiazepines and novel psychoactive drugs.

Many of the women have personality disorders which limit their capacity to engage meaningfully with addiction counselling unless these personality disorders are addressed first. The absence of a psychologist within the Dochas Centre, to date, means that there is a waiting list for addiction counselling¹¹.

Sourcing community clinics for some women can be difficult, particularly if they have a combination of behavioural issues and a history of engagement and disengagement in a clinic or have never been linked into a community clinic before. It appears that the Central Treatment List is unable to provide specific guidance regarding geographical designation of addresses and their corresponding clinic.

¹¹ A psychologist is due to be appointed.

11.11 Clinical Governance

Based on consultations with service providers, CBOs appear to have adequate clinical governance structures in place, with some stronger than others. A number of CBOs indicated that the services they provide do not require clinical governance, even though these services included addiction counselling. Examples of clinical governance practice within CBOs included written policies and procedures; weekly or fortnightly clinical supervision team meetings; monthly individual or group supervision of staff; external clinical governance advisory committees; access to addiction-related CPD for staff; accreditation, e.g. CHKS accreditation, and QuADS.

The review indicates that clinical governance within the prison estate could be strengthened. At senior management level there is no longer a Medical Director or Clinical Director post and in its absence, responsibility for clinical governance at local level falls to either the nursing staff or visiting GP. While Mountjoy has access to clinical supervision by an experienced clinician who has worked in the prison system and there are regular team meetings, this is not the case in all prisons in Ireland. If a coherent policy with a co-ordinated approach is to be developed with regard to clinical governance throughout the prison estate then either a clinical governance advisory group or senior management post needs to be developed.

While there is a manual of Standard Operating Procedures, quality standards for addiction treatment across the prison estate are absent and there is no formal quality assurance mechanism for treatment programmes.

11.12 Summary

The strengths of the current system of provision include the range of addiction interventions that are available in the community and within the prison estate and working relationships between Probation Officers and CBOs providing such interventions. This results in access to relevant information about an offender's progress which can inform the type of group or one-to-one work CBOs do as part of in-reach visits or prison programmes.

A number of challenges were also highlighted. These include the changing profile of drug use and treatment options available, accessing treatment for offenders with dual diagnosis, treating those who are on remand and access to drug-free environments within the prison estate.

The next chapter examines recovery management including discharge planning, managing drop-out from services and relapse and aftercare provision.

Chapter Twelve

The Work on the Ground: Recovery Management

Recovery management encompasses discharge and exit planning, aftercare and supporting transitions into the community, post treatment.

12.1 Planned Discharge and Exit Planning

Examples of planned discharge approaches by CBOs include the use of discharge groups, one-to-one discharge planning meetings, development of aftercare plans and linking offenders into services for support post treatment.

A number of CBOs, as part of care planning, develop progression pathways for individuals prior to completion of treatment, e.g. to employment or education, mainly by working in partnership with other service providers, and in some CBOs, individuals may not leave until meaningful structured activities are in place.

Access to housing is a common need for Probation Service or IPS referrals and most services have developed working relationships with housing/accommodation service providers. The absence of a fixed address can have serious repercussions for an offender in terms of access to medical cards, GP, social welfare, training and employment opportunities, etc.

There were calls, from some of those interviewed, for more day care options post treatment that offenders who have completed treatment in a primary or secondary treatment service could avail of. Some of the HSE regional managers consulted for this review indicated that there is scope for greater use of HSE funded services to support prisoners on release. Some had initiated awareness-raising with ISM officers, particularly where there had been recent changes in prison staff. More inter-agency sharing of information about service availability to support exit planning and aftercare would be beneficial.

In the prison estate, MQI and Probation Officers engage in shared working where possible to engage and prepare an offender for transition to the community, including to CBOs. MQI engages with some, but not all prisoners on post custody supervision and the level of engagement varies from prison to prison depending on local operational management. A standardised, formal process of exit planning between MQI, Probation Officers and ISM for post custody supervision and others was suggested.

If a prisoner does not have probation supervision on release, they might be linked into residential treatment centres, community prison link workers or other supports in the community. Some CBOs also engage in prison in-reach visits that include preparation for pre-release planning.

Procedures around discharge planning from prison, particularly in terms of ensuring linkage with community clinics and services, have been strengthened in recent years. For example, in Cork prison contact is made with the HSE pharmacy liaison to ensure a prescriber in the community is identified two weeks in advance of release. The HSE Central Treatment List (CTL) is notified by phone. Local services are phoned to make arrangements, e.g. Arbour House, for referral on release so that the prisoner can attend a clinic immediately and skip any waiting lists. Methadone is given prior to release and the prisoner is informed of their appointment time with the community clinic and pharmacy for prescriptions. The CTL form is completed and returned to the CTL.

However, within the prison estate discharge late on a Friday evening does still occur on occasion and the aggravation and sense of chaos this causes still means there is a perception in some quarters that many prisoners are released in this way. This is a particular challenge for a remand prison such as Clover Hill. It is also an issue in the Dochas Centre. Prisoners can be released on bail immediately after a court appearance and can then turn up in a community addiction clinic without the clinic having been notified by the prison.

Even when clear post release plans are in place, some CBOs working with prisoners commented that matching prisoners to appropriate and prompt provision of community services on release remains a challenge.

Other challenges, in some parts of the country, can be linking prisoners into a community prescriber on release, sourcing accommodation for those with a dual diagnosis, sourcing accommodation for non-nationals who are not entitled to social welfare, and access to a medical card immediately on release now that the application process is centralised.

12.2 Exit Planning for Drop-out from Services

It is estimated that around one-third of referrals to CBOs will not complete the treatment programmes. CBOs noted that referrals from prison were more likely to drop-out than those coming from the community. Factors involved include lack of previous engagement in group work, inadequate preparation and not realising what is involved and thus feeling overwhelmed. Other factors include poor motivation or feeling that treatment would be an ‘easy’ option, inability to cope with the environment and structure of treatment programmes and pre intention to abscond (often linked to family circumstances).

There are different approaches to dealing with drop-out and how drop-out from a service is communicated to the IPS and the Probation Service is an issue.

For example, in respect of referrals from prison, when a person drops-out of a service one CBO informs the IPS general office immediately with telephone and email follow-up, the Probation Officer and the local Gardaí. Another CBO informs the Probation Officer.

Another CBO reports absences of those referred from prison immediately but might, in the case of those referred by Probation Officers in the community, give the person 24 hours before reporting their absence to the Probation Officer as often (but not always) the offender realises they have made a mistake and requests a return to the service. Another CBO endeavours to talk to the individual first to determine why they are dropping out and to address issues to support their retention. If a formal referral had been made by the Probation Service or IPS, this CBO informs the Probation Officer or the IPS if the offender decides to leave the service. Another CBO has a formal protocol with prisons in respect of offenders on temporary release. A weekly report is provided on attendance for those on Temporary Release (TR) and post custody supervision in the CBO and any drop-out is reported by telephone first to the prison and then to the Probation Officer. In the meantime, contact is made with family, partners or friends involved in the care plan.

Regular stakeholder meetings and reviews between CBOs, the IPS, the Probation Service, MQI (as the lead provider of addiction counselling in prisons) and ISMs facilitates safe practice in early discharge planning and risk management. A standardised process for early discharge from treatment for offenders on post custody supervision or Temporary Release needs to be developed.

12.3 Relapse Management

Most services require a person to leave immediately if they relapse and will inform family and the IPS or the Probation Service. A small number of services will offer detox again to individuals who relapse while in treatment or will offer a referral to another sister service. Others offer appointments with an addiction counsellor to discuss why the person relapsed. If the person is homeless, referrals are made to homeless services. How this referral is made also varied ranging from direct contact being made on the person's behalf and linking them in directly to a homeless services team, to giving the person a list of numbers to ring.

Prisoners who have detoxed successfully while in prison can attend relapse prevention groups run by MQI. For those who do relapse while still in prison, MQI addiction counsellors try to keep the person engaged with a view to building on progress made and getting them back into treatment.

Probation Officers expressed concerns about timely access to methadone clinics for offenders who have come off methadone and who relapse in a community setting.

12.4 Aftercare

Many of the CBOs offer aftercare ranging in length from six months to two years to indefinite ongoing support provided by project workers/counsellors. Thus, individuals who avail of the full suite of services available in some CBOs could potentially be receiving support for two years or more. Examples of longer-term supports include a CBO which has a

number of informal opportunities to keep individuals engaged for as long as they like, e.g. annual telephone check-ins. Another CBO provides ongoing access to addiction counselling for a person's life and another has a lifelong peer support programme. Yet another has a dedicated continuing care co-ordinator who meets individuals every month as part of the aftercare programme.

The types of aftercare provided range from step down and transitional housing facilities followed by weekly structured group meetings, to contact with aftercare teams or individual addiction counsellors, to regular structured group meetings.

Referral to and advocacy with other services is also considered aftercare by some CBOs, e.g. housing, employment or education supports. A small number of CBOs provide CE schemes in partnership with other organisations for individuals who have successfully completed treatment. However, persons in receipt of Disability Allowance (i.e. many of those with mental health issues) can be reluctant to take part in CE as they will lose their entitlement.

Not all offenders offered aftercare avail of it or complete it. The international literature suggests that to be effective, aftercare must be fully integrated into the model of treatment rather than seen as an optional extra/adjunct. An example of good practice is a CBO that develops aftercare plans with the offender and their concerned other and this plan is forwarded to the Probation Officer.

Reporting on attendance at aftercare varies by CBO. Some have developed structured reporting templates that record attendance and have developed local reporting protocols with Probation Officers. Others indicated that no such protocols operated in their area.

The HSE and LDATFs fund, separately and jointly, services in the community such as outreach, family support, harm reduction and rehabilitation and aftercare. For example, HSE Midlands region and LDAFT co-fund Ana Liffey and MQI to provide these services in the Midlands. Consultations with HSE managers indicated that not all ISM officers in prisons were fully aware of the suite of services funded by the HSE that could support a prisoner on release (especially newly appointed ISM officers). Some managers have made contact with prison ISM teams to make them aware of the services that are available and that could be used to ensure continuity of care post release that goes beyond linking a prisoner into a HSE methadone clinic.

A continuum of care should include links to the primary care system for recovery management post treatment, e.g. GPs making appropriate referrals to relapse prevention services. The results indicate that currently geography appears to be playing a larger role than commitment to equity of access, with variation amongst GPs in providing support to those with addictions. The variation in commitment to a social inclusion model of medical care

seems to be determined by personal ethos, resources, familiarity with and capacity to work with the target group.

12.5 Summary

The results highlight variation across the range of services in discharge planning and managing drop-out from treatment and relapse. Communication with the IPS and the Probation Service with regard to any of these eventualities as well as attendance at aftercare requires improvement.

Chapter Thirteen

The Work on the Ground: Community Prison Link Work

A number of services are funded by the Probation Service to provide in-reach to prisons – some of these services have been described in previous chapters. The main focus of this chapter is community prison link workers who are funded by Local Drugs and Alcohol Task Forces (LDATFs). This is not a national service and the number of community prison link workers available varies from community to community. The researchers met with one CBO (Fusion CPL) that is funded by the Probation Service to do prison in-reach and the five services in Dublin that are funded by LDATFs to do community prison link work. They also conducted a telephone interview with the link worker in Cork prison who is funded by the LDATF.

13.1 Community Prison Link Work

Five community prison link workers operate in four of the Dublin LDATF areas¹². They are based within community addiction services or teams that have been operating since the late 1990s.

Community prison link workers are interested in generational impact and positive outcomes within their communities. The primary purpose of community prison link work is to address the impact of addiction on the offender's life and to explore opportunities for change, both within the prison system and on release and return to the community. Their work spans all stages of the addiction cycle, by supporting service users to access supports such as methadone treatment, residential treatment programmes, addiction counselling, group work, parenting support, accommodation, education, training and employment.

They work on a one to one basis with offenders with an average active case load of 35 offenders at any one time. They work to agreed standards and endeavour to sequence their visits to map onto priority points during an offender's sentence. They provide a range of services to support offenders from the locality who are awaiting sentence, in prison, on remand and post-release. They visit offenders in prison and work with them to encourage and support them in making the best out of their time in prison and also prepare them to return to the community post release. They also work with families of prisoners. The range of services provided includes links to statutory and community services, health services, family and parenting support, addiction counselling, group facilitation, group/peer led support post release (e.g. EPIC¹³), access to education, training, Community Employment (CE), restorative justice and social enterprise.

¹² Rialto Community Drug Team, Inchicore Bluebell Community Addiction Team, Bray Community Addiction Team (BCAT), Clondalkin Addiction Support Programme (CASP), Fusion CPL.

¹³ Ex Prisoners Integration and Change Group, organised by Rialto Community Drug Team.

Community prison link workers visit offenders in prison, develop care plans and encourage prisoners to access treatment and support during their sentence. They also work with prisoners to prepare and plan for further appropriate support post release. Preparatory work and the number of prison visits intensifies in the time leading up to release including one on one work post release mindful of the transition from prison back to community. They continue to meet the offenders they have in their case load on a one to one basis in the community, usually within the community based addiction team, in the period immediately after release. The purpose is to continue to sustain progress made during their time in prison and to support re-integration through care planning, one to one support and group support.

Given that they are embedded with community addiction teams they have a surrounding, support and supervision structure that positions them well to support offenders they deal with in their locality post release, e.g. through group support, addiction counselling, complementary therapy, referral to residential treatment, etc.

13.2 Governance

Community prison link workers operate within community based addiction teams. The community addiction teams are organisations, each constituted as a Company Limited by Guarantee with charitable status. They receive funding from a range of sources including the LDATFs and the HSE in the main.

A range of local management and governance protocols and structures are used to monitor and track the work of community prison link workers, e.g. local boards of management, monthly reports to local boards, reports to direct managers, the network of community prison link managers, the LDATFs, the DATF I Forms¹⁴. They maintain their case load of approximately 35 offenders at any given time. Some have case management systems and all report monthly on offenders' status in terms of prison visits, care plans, progression, referral on, etc. However, with the exception of Fusion CPL which is funded by the Probation Service under a Service Level Agreement, there is currently no Service Level Agreement or reporting structure for their work to either the Probation Service or the IPS.

13.3 Summary

Given that community prison link work is a very specific and individual role and that the present job incumbents are small in numbers, reside within the community based addiction teams and in the case of Fusion CPL, within a CBO, they are subject to quite intense monitoring, supervision and reporting. Their work is well monitored and tracked through a range of local management and governance protocols and structures, but this is not co-

¹⁴ The DATF 1 form is a detailed document outlining the project to be funded as part of the action plan of the LDATF. This form is submitted annually to the Drugs Policy Unit within the Department of Justice prior to securing funding.

ordinated within the prison system nor is the monitoring of their work linked into reporting structures within the Probation Service or the IPS.

The next chapter explores outcomes for offenders who have received treatment for addition.

Chapter Fourteen

Outcomes

This section explores outcomes of addiction treatment services provided to adult offenders in the community and prison settings. The tracking and measurement of outcomes is at an early stage of development across the addiction treatment services.

14.1 Challenges in Outcomes Measurement

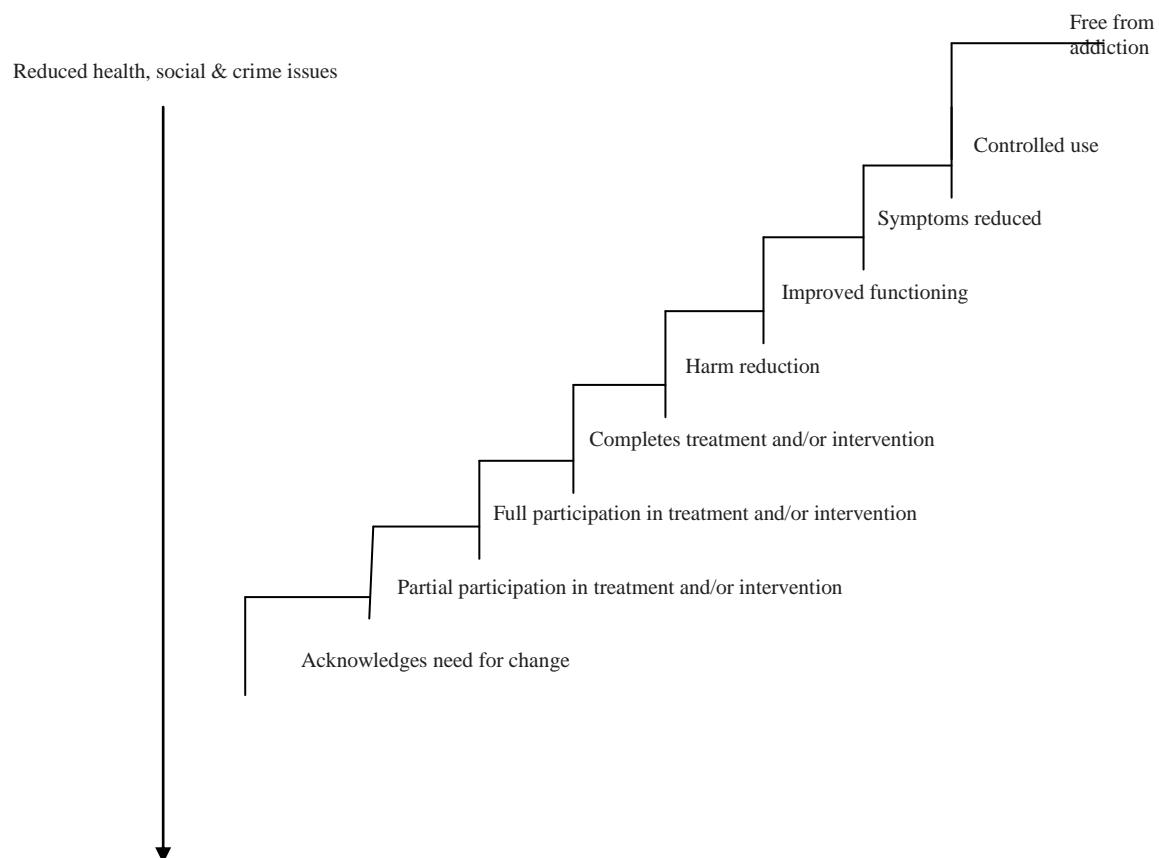
The results of this research indicate that some CBOs are making good progress towards developing outcomes models and yet there is still considerable development work to be completed.

One significant challenge to the successful tracking and capturing of outcomes is the definition of what constitutes success in terms of difference made as a direct result of a course of treatment. Outcomes for treatment can be viewed as black and white, e.g. total abstinence, or as a ladder of improved well-being and living with an addiction. Offenders may step onto or off this ladder at any point in time depending on a range of factors or triggers (see Figure 14.1), some well documented and others yet to be known.

The research indicates that this outcome ladder may include the following, all of which require careful and bounded definition:

- Participation (partial or full) in treatment and/or intervention programmes.
- Completion of treatment and/or intervention programmes.
- Harm reduction or minimisation.
- Improved functioning, e.g. behaviour and psychological.
- Symptom reduction.
- Controlled, non-dependent or non-problematic drug or alcohol use.
- Total abstinence.
- Reducing health, social, crime and other problems directly related to drug and/or alcohol misuse.

Figure 14.1: Summary of Possible Outcomes for Offenders Receiving Addiction Treatment



A second significant challenge is clearly distinguishing between outputs and outcomes. Current SLAs between the Probation Service and CBOs make no distinction between these two types of indicator¹⁵.

A third challenge is recording and measuring outcomes, especially when a range of services and client groups are involved and very different levels of change are being sought by individual service users. Most of the CBOs are engaged in establishing outcomes

¹⁵ **Outputs** are the immediate tangible quantitative things arising directly from an intervention, e.g. the number who participated in an addiction treatment programme.

Outcomes are observable and measurable changes arising from an intervention. They are linked to the original objectives of the intervention, e.g. did people attending an addiction treatment programme become free of their addiction and was it as expected (i.e. what the treatment programme aimed to do) or unexpected.

measurement systems. The range of tools being used includes eCASS¹⁶ to provide on-going monitoring data, tracking systems and attendance records, longitudinal studies, NDTRS¹⁷ data patterns, assessing attainment of care plan objectives (e.g. using STAR¹⁸), course evaluations or other specific evaluations.

14.2 Outcomes Measurement by CBOs

While the majority of CBOs employ abstinence models, they also recognise that for many individuals the goal of total abstinence may not be achievable and other positive outcomes are thus considered valid. The figure below provides examples of the varied definitions of success named by CBOs.

Figure 14.2: Some Examples of CBO Definitions of Success

- Completing treatment and achieving the goals relevant to the treatment.
- Living a life free from the implications of addiction and moving towards full potential – emotionally, psychologically, spiritually and physically.
- Long term sobriety, enhanced quality of life, improved social skills and behavioural change.
- Person achieves goals they set out in their care plan or achieves a more fundamental change in drug or alcohol use (e.g. significant harm reduction, signification use reduction, maintained controlled use, abstinence, sustained abstinence).
- Addiction free and hence crime free, social reintegration, family reunification, return to education, return to work, in secure accommodation, improved physical and mental health, sense of purpose and direction and feeling included.
- Person remains sober or drugs free while in treatment and completes programme, does not re-offend, has improved quality of life.

A number of CBOs have either commissioned longitudinal research or are working in partnership with universities to complete specific research pieces over the coming years. The findings from research into outcomes for clients, completed or commissioned by CBOs, is summarised in the figure below:

¹⁶ Electronic Consolidated Automated Support System

¹⁷ National Drug Treatment Reporting System

¹⁸ Outcome STAR is a set of tools to support and measure change across a range of variables when working with people

Figure 14.3: Summary of Longitudinal Research by CBOs

- Longitudinal study of 144 clients (offenders and non-offenders) using the Treatment Outcomes Profile by Coolmine TC found that 36% completed the entire programme of which 85% were drugs-free two years after completion¹. The range of clients completing detox varied from 80% to 100%.
- Research conducted by Aiseiri indicates that between 30% and 40% achieve recovery, around one-third relapse and around one-third manage their addiction. Of those who complete treatment and aftercare, 98% achieve full recovery.
- Research by Cuan Mhuire Bruree indicates that 86% of those who commence detox complete it and of these, 76% go on to complete the treatment programme.

Some CBOs also provided data in respect of the achievement of specific outputs and outcomes named in their Probation Service SLAs. For these CBOs it demonstrates that, with the exception of aftercare (an issue that has been addressed in the previous section), the targets set have been met or exceeded.

Figure 14.4: Achievement of SLA Targets

- Ceim Eile 2014: 17 offenders from the Probation Service admitted and treated (target was 11). 10 completed treatment, 59% (target was 60%). 9 attended aftercare, 52% (target was 50%). In addition, 4 are in receipt of ongoing support from Ceim Eile. 9 return to training, education or employment, 52% (target was 50%).
- Ceim Eile 2015 up to end of August: 12 offenders from the Probation Service admitted and treated (target was 14 for whole year). 5 completed treatment, 45% (target was 60% for whole year), 6 still in treatment. 5 attended aftercare, 45% (target was 50% for whole year). 5 return to training, education or employment, 45% (target was 50% for whole year).
- Cuan Mhuire Farnanes 2015: 17 admissions (target was 10). 17 completed detox and engaged in treatment, 100%. 5 completed treatment, 4 are still in treatment and 8 dropped out. Of the 5 who completed, 4 transferred to transitional housing of which 2 relapsed and were readmitted and 2 have remained in recovery.
- Aiseiri Wexford 2014: 13 assessed and 9 admitted (target of minimum of 10). 8 completed, 80% (target was 60%). 3 in aftercare (target was 50%). Progression to training, education or employment not known (target was 50%).
- Aiseiri Wexford 2015 up to end of August: 14 assessed of which 10 admitted (target of minimum of 10). 9 completed, 100% (target was 60%). 3 in aftercare including 2 in secondary care (target was 50%). Progression – 1 on CE, 1 PT job, 1 FT job, 1 on literacy course, 1 applying for course, 1 on waiting list for methadone substitution, 2 on job seekers, 1 moved to UK, (target was 50%).

¹ Babineau, K., Harris, A., 2015, 'Pathways through Treatment. A mixed-methods longitudinal outcomes study of Coolmine Therapeutic Community'.

- Aiseiri Cahir 2014: 18 assessed and 16 admitted (target was 16). 13 completed treatment, 75% (target was 60%). Progression to aftercare, training education and employment not available.
- Aiseiri Cahir 2015 up to August: 17 assessed (target was 16 for full year). 13 completed, 77% (target was 60%). 9 in aftercare, 69% (target was 50%), 7 in training, education or employment, 53% (target was 50%).
- MQI 2015 up to end of August: 19 admissions to detox (target was 12 for whole year). 12 complete detox, 63% (target was 8 or 67% for whole year). 29 admissions to residential treatment (target was 28 for whole year). 11 complete treatment, 38% (target was 14, 50% for whole year). 15 in aftercare including supported housing (target was 20 for whole year). 7 complete aftercare, 47% (target was 14, 70% for whole year). 7 who completed aftercare are drug free.

From the limited data available, positive outcomes are evident. Overall, we can expect between 70% and 100% of those who enter detox to complete it, and between 60% and 80% of those who commence treatment to complete it. Of those who complete treatment we can expect around half to return to training, education or employment. Around one-third will achieve total recovery, another one-third will manage their addiction safely and around one-third will relapse.

Probation Officers have a range of outcomes they consider successful and that these vary from person to person. These include:

- Not re-offending during the time of their bond.
- Positive self-management.
- Participation in aftercare after completing treatment.
- Harm reduction.
- Stability in the community, e.g. able to function, attending methadone clinics, keeping appointments.
- Abstinence, but this may not be realistic for every person.
- Rebuilding family relationships.
- Remaining in accommodation and not regressing to homelessness.

The Probation Service has developed a central computerised database that CBOs report into. Basic data on referrals and offender profile is currently gathered. As yet there are no links to the system for reporting on the achievement of outputs or outcomes as specified in SLAs. This aspect of reporting requires development.

During 2014, a total of 415 new referrals were made to service providers. This includes direct referrals by Probation Officers and self-referrals by those who were on a probation

¹⁹ Babineau, K., Harris, A., 2015, 'Pathways through Treatment. A mixed-methods longitudinal outcomes study of Coolmine Therapeutic Community'.

supervision order. In addition, 50 offenders had been referred in 2013 and were waiting to commence a programme at the start of 2014. Throughput for 2014 was as follows:

- 412 started programmes of which 50 had been waiting from 2013.
- 381 completed programmes (some of which would have been amongst the 89 who had carried over from 2013).
- 127 were still in programmes at the end of 2014.
- 46 had been referred but had yet to commence a programme at the end of 2014.

The total number engaged in or waiting to commence a programme for 2014 was 554.

Of these 554 offenders, 82% were male and 18% were female.

The majority were aged 25-44 (59%), with a significant minority aged 18-24 (36%).

Table 14.1: Age Profile of Referrals to CBOs by Probation Service

	Under 18	18-24	25-44	45-64	65+	Total
Male	6	164	264	17	1	452
Female	0	32	62	8	0	102
Total	6	196	326	25	1	554

(Source: Probation Service database)

Three service providers had over 70 offenders each (47% of the total): Coolmine TC, MQI and Cuan Mhuire Bruree.

Three others accounted for between 30 and 70 offenders each (21% of the total): Matt Talbot Community Trust, Cuan Mhuire Athy and Bushypark.

Nine each had between 11 and 25 offenders (28% of the total): Aftercare Recovery, Aiseiri Cahir, Aiseiri Wexford, Ana Liffey, Ceim Eile, Cuan Mhuire Coolarne, Cuan Mhuire Farnanes, Fellowship House and Tabor Lodge.

Three had ten or fewer offenders: Ballymun Youth Project, Fusion CPL and Crinan.

14.3 Outcomes Measurement in Prisons

Apart from initial outcomes monitored by MQI in Mountjoy, there is currently no robust systematic tracking of outcomes for prisoners treated in the prison estate.

The pharmacists in Mountjoy (Cronin and Ryan) conducted outcomes research between 2010 and 2014 examining the self-directed detox that they manage and supervise. Their research

found that of the 805 prisoners on methadone maintenance, 52% chose to undertake self-directed detox. Of these, 51% detoxed completely off methadone and 49% reduced their use by 20mls or more. Thirteen percent either relapsed temporarily or went back on methadone.

Output data provided from MQI in respect of their addiction counselling service provided in the prison estate indicated the following for the period January to August 2015:

- 2,023 referrals for addiction counselling in the prison estate.
- 902 assessments completed.
- 2,058 brief interventions.
- 7,670 addiction counselling sessions delivered.
- 2,210 group work attendances.
- 2,366 individuals availed of one to one or group addiction counselling.
- 744 average monthly caseload.

14.4 Feedback from Offenders

During the site visits to CBOs eight offenders who had availed of services were interviewed. These included three women and five men. All had been in prison (Mountjoy, the Dochas Centre and Wheatfield) and had come directly from prison to the treatment centre. They had heard about the treatment option from a variety of sources including Prison Officers, ISMs, Probation Officers, prison health staff and MQI addiction counsellors.

With one exception, a person who had been brought to the treatment centre for a site visit by their Probation Officer in advance of admission, the rest did not feel adequately prepped for moving into a treatment setting in the community and found the structure of the treatment programmes both a challenge and a culture shock. They commented on how structured and timetabled their days were when compared to being in prison. This included attending group therapy, one to one counselling, meditation, carrying out tasks such as personal assignments, cooking, laundry, gardening, etc., with comparatively little free time.

All were at different stages of rehabilitation or recovery. A number were fairly new to the treatment centres, having arrived within the past month. Others were nearing the end of their treatment and were preparing to move into step-down facilities or aftercare. Two had completed their treatment and aftercare and were now engaged in employment and education and had remained drug-free since completing their programmes. Both of these were also engaged in volunteering and giving back to society.

All commented on the importance of motivation and wanting to change and the importance of managing transitions into and out of treatment. They noted that drop out of treatment was more likely to happen for those coming from prison; those who were motivated to attend for the wrong reasons (e.g. treatment was perceived as ‘an easy option’ or a way out of prison or

to get their Probation Officer ‘off their back’), and those who were not willing to address not only their addiction, but also wider issues in their lives. Those who were preparing to leave the treatment centre were in some trepidation of the transition but were thankful they had a step down facility or structured aftercare programme to attend.

14.5 Summary

Outcomes measurement is at the early stages of development and more work is required to gather a minimum data set across all services funded by the Probation Service and the IPS and within the prison estate in order to assess the effectiveness of treatment approaches.

Chapter Fifteen

Conclusions and Recommendations

The research highlights a number of recurring themes each of which is discussed below. Recommendations are set out under each theme.

15.1 Themes and Recommendations

The following summarises the themes to emerge from the review along with relevant recommendations under each theme.

15.1.1 NDRIC

NDRIC is an important national framework that is at the early stages of implementation. There are opportunities to further strengthen alignment of the work that is funded by the Probation Service and the IPS providing treatment and interventions for addiction in offenders. A number of wider issues of relevance to NDRIC arose from the research and the Probation Service and the IPS, both of whom are represented on NDRIC, should bring these wider issues to NDRIC to inform the development of national solutions.

Recommendation 1: NDRIC

- a) Wherever feasible, align the work in treating addictions in offenders with NDRIC.
- b) Issues of national concern highlighted in this review should be raised at NDRIC, e.g. case management co-ordination, care plans not moving between different settings, etc.

15.1.2 Model of Effective Practice

Chapter five sets out a model of effective practice based on NDRIC and national and international best practice. It recognises that recovery from addiction is a long-term process that may require multiple episodes of treatment.

Recommendation 2: Model of Effective Practice

- a) Adopt the model of effective practice across community and prison settings.
- b) Reintroduce cross training events to support application of the model and inter-agency working.

15.1.3 Funding

The combined expenditure by the Probation Service and the IPS on addiction treatment is approximately €3.33m per annum. While the Probation Service element of this budget has remained stable in recent years, the IPS portion has reduced in line with the reduction in prison numbers in general. However, a strong argument can be made for increasing the IPS budget back to 2011 levels based on the unique opportunity that the prison setting provides to address addiction directly (and indirectly, recidivism arising from addiction). This is coupled with the fact that many of those who are now in prison pose the highest risk to society and are more likely to have serious addiction issues, often combined with mental health issues.

Recommendation 3: Funding

- a) Consideration should be given to restoring IPS expenditure on addiction treatment to 2011 levels. The Cork prison model, or one similar to it, should be the minimum standard that applies across all prisons. Gaps in current provision also require addressing. One area that is a gap in current provision is the provision of drug-free environments within the prison setting (see section 15.1.4). The issues of non-opiate based treatment, alcohol addiction and dual diagnosis require further development (see section 15.1.4). There may also be opportunities to disseminate the DTP once it is proven to other prisons outside the Mountjoy campus (see section 15.1.9).
- b) Consideration should be given to maintaining the current level of expenditure by the Probation Service. However, consideration also needs to be given to the types of services these funds support. We recommend that funding should focus on services with evidence-based proven treatment regimes that include integrated aftercare programmes. Efforts to address gaps in service provision for women should also continue.

15.1.4 Gaps

Given the changing nature of addiction, gaps in provision or implementation are not surprising. Key treatment issues include access to treatment for difficult cohorts such as sex offenders, the need to further develop alcohol treatment programmes in prisons, development on non-opiate based detox and treatment programmes in the community and in prisons, development of integrated treatment of offenders with addiction and mental health issues and access to drug-free environments in prisons. Opiate based prescription medication within the prison estate is also an area that requires further review along with the potential for Naloxone to minimise the lethal side effects of overdose situations. Finally, there is a strong correlation between addictive behaviour and criminal activity and recidivism and this is an area that many treatment programmes do not adequately address.

Recommendation 4: Gaps

- a) Detox and treatment programmes for non-opiate addictions should be explored for use in prison settings. In the context of funding CBOs, the Probation Service should also explore with CBOs how non-opiate addiction might be addressed to reflect changes in the market regarding the types of drugs being used by offenders.
- b) Within the prison estate an alcohol addiction programme should be developed along with a Standard Operating Procedure in respect of alcohol detox incorporating the use of prescription medication to reduce cravings and withdrawal symptoms, observation of those on detox and links into GPs on release.
- c) The Probation Service should identify and work with one or two CBOs willing to provide addiction treatment to sex offenders or offenders with a history of violence.
- d) Given that not all prisoners will come off drugs while in prison, a harm reduction strategy should be developed and applied across all prisons.
- e) Consideration should be given to extending the use of Naloxone to prisoners being released from prison who have detoxed off opiates or who are still using opiates.
- f) Appropriate arrangements on release from detox programmes within the prison estate need to be developed for each prisoner.
- g) Within the prison estate, peer-led positive drugs free environments should be developed for prisoners who have successfully detoxed and completed treatment programmes. Important considerations in the development of drug-free environments include viewing them as a clinical asset, training for prison staff, operational buy-in, selection criteria and who has control of the selection and deselection process - a multi-disciplinary approach between the clinical lead and operational lead is recommended, programme delivery to sustain recovery, appropriate use of biological analysis as a case management tool, reporting structures and discharge protocols.
- h) As not all prisoners wishing to detox will want to do so under a prescribed and fixed regime, the option of self-directed detoxification (SDD) that is supervised by healthcare staff should be provided. This would be a safer option than unsupervised SDD.
- i) Within prisons, breaks in care should be minimised and appropriate operational support should be provided for external support services.

- j) Accurate recording of the purpose of visits and communication of same to prisoners rather than the current use of generic terms such as ‘welfare’ would facilitate this along with timely provision of clearance for external staff working with prisoners.
- k) Consideration should be given to making modules on offending behaviour and its links to addiction that have been developed by the Probation Service (e.g. for its Alcohol Awareness and Offending programmes) or the IPS (e.g. elements within the DTP) available to CBOs providing treatment services to offenders.

15.1.5 Referral Protocols

The HSE is the key national player in respect of drug and alcohol treatment and as such referral pathways to its services for offenders are an important part of providing a continuum of care in line with the NDRIC framework. Referral pathways from prisons to CBOs also vary considerably.

Recommendation 5: Referral Protocols

- a) The Probation Service and the IPS should work with the HSE to develop a protocol or memorandum of understanding (MoU) on access to HSE addiction and counselling services, timely access to methadone clinics for offenders who relapse in the community, access to psychiatric and mental health services for offenders or prisoners with a dual diagnosis. This MoU should also cover communication with the Probation Service or the IPS regarding offenders released on bail who subsequently access community addiction clinics.
- b) The IPS and the Probation Service should seek to refine processes for onward referral of prisoners from prisons to funded addiction services in the community.

15.1.6 Communication

Communication comes through as a universal theme from the review at all levels. Effective communication is a critical component in providing a continuum of care as well as supporting the Probation Service and the IPS role regarding public safety.

Recommendation 6: Communication

- a) Stronger systems and protocols regarding prisoners released to CBOs on post custody supervision should be developed including a protocol on timely notification by CBOs to relevant Probation Officers or the IPS of offenders who drop out of treatment or aftercare or who are asked to leave a programme early. This latter requirement should also apply to all offenders on probation supervision.

- b) A protocol should be developed for sharing relevant care plan information to CBOs when a prisoner is referred to these services in line with NDRIC, where feasible.
- c) The requirement for CBOs to contact Probation Officers should be formalised as part of the Service Level Agreements and should incorporate contact at assessment, during treatment and on completion/drop-out/early leaving.
- d) Mechanisms to support greater inter-agency information sharing, with informed consent, when appropriate, should be explored, particularly about service availability that would support exit planning from CBOs or prison and aftercare, e.g. cross-agency awareness raising events.

15.1.7 Co-ordination

Given the range of players involved in supporting offenders with an addiction, it is not surprising that the need to improve co-ordination is another common theme to emerge from the review. This includes co-ordination of cases when an offender moves from one setting to another and responsibility for co-ordination of cases and services within the prison estate.

Recommendation 7: Co-ordination

Within the prison estate, responsibility for co-ordination of addiction services, care planning and case management should be the responsibility of the IPS nursing service, in particular, addiction nurses. Current proposals are for an addiction nurse in each closed prison who should perform a key role in care planning for offenders with addiction issues. We believe it is important that the person responsible for co-ordination of care planning and case management collaborates with Probation Officers. In addition, all relevant service providers (e.g. MQI addiction counsellors, community prison link workers, CBOs), supporting offenders with addiction, should be reporting into this staff member in each prison. This will ensure that duplication of provision is minimised, referral is appropriate and effective and relevant treatment and support structures, while in prison and on release, are maximised for each offender.

15.1.8 Managing Demand

Waiting times for access to addiction counselling within the prison estate suggests that demand exceeds supply. While MQI keep information about demand for their services, there was no evidence of a system to accurately record and manage demand across the prison estate that was accessible to Probation Officers and the IPS. Up to date accurate information is essential for the efficient management of demand and on-going review of resourcing to meet that demand. This includes information to tell how many prisoners have requested addiction

counselling and/or detox, how many are on a waiting list and for how long, how many have been assessed, how many are in addiction counselling and detox and how many have completed addiction counselling or detox.

Recommendation 8: Managing Demand

Full usage of the current recording system (Prisoner Health Management System) to record demand for services and waiting times is required. This information should be anonymised and shared with Probation Officers and care planners as well as MQI addiction counsellors.

15.1.9 Drug Treatment Programme

The DTP is an important development within the prison estate. Currently it is centralised in Mountjoy but if equity of access is to be a core principle that underpins effective practice then it is important that, once proven, the DTP or derivatives of it are available in other prisons. A number of CBOs deliver modules in the DTP but the programme lacks overall co-ordination and a clear curriculum is needed that would eliminate any duplication currently present.

Recommendation 9: Drug Treatment Programme

- a) The addiction team in Mountjoy should work with CBOs delivering modules in the DTP to develop a coherent curriculum.
- b) A member of the addiction team should be appointed as overall co-ordinator to manage, track and monitor the DTP.
- c) Outcomes should be developed and measured for the DTP.
- d) A process and outcomes evaluation of the DTP should be conducted within the next three years to determine its efficacy, efficiency and effectiveness and, if necessary, to make appropriate adjustments or changes to its content and processes.
- e) Once its efficacy is proven, consideration should be given to replicating it or a derivative of it in other prisons.
- f) Prisoners who apply to take part in the DTP but who are not selected due to operational considerations should receive feedback about why they were not selected from operational staff.

15.1.10 *Release Planning*

Considerable progress has been made in the management of release planning from prisons, e.g., the introduction of ISMs, but there are still a number of areas where release of offenders with an addiction can be problematic, e.g. those who are homeless, or who are still chaotic drug users, or who are on remand, or who are released on bail by the courts, or who are on post custody supervision.

Recommendation 10: Release Planning

- a) Each prison should have a Resettlement Support Worker or ISM responsible for co-ordinating pre-release planning and communicating both internally and externally, where appropriate, with the Probation Service and other relevant agencies or service providers.
- b) As much as possible, inputs to pre-release planning should be sought from Probation Officers, addiction nurses, community prison link workers or other service providers working with prisoners with addictions.
- c) The IPS should implement the new Quality Standards for Homeless Service Providers applicable to releases from prison²⁰.
- d) Releases from prison for non-remand prisoners at the end of the week should be eliminated.

15.1.11 *Clinical Governance*

Clinical governance and oversight is an important component of good practice in any treatment regime and this is currently absent at national level within the IPS. While there are Standard Operating Procedures, the introduction of quality standards for the treatment of offenders with addiction, along the full continuum of care while under the supervision of the Probation Service or the custody of the IPS, will strengthen the current system of provision.

Recommendation 11: Clinical Governance

- a) The IPS should either appoint a senior clinician at senior management level with responsibility for all addiction treatment within the prison estate or establish an external clinical addiction governance advisory committee to provide guidance and oversight on clinical addiction matters.

- b) A programme of continuous professional development regarding addiction that brings together relevant staff from different agencies (e.g. Probation Service, prison staff, CBOs, community prison link workers, healthcare teams, etc.) would support a culture of continuous improvement and cross-agency learning.
- c) Consideration should be given to developing Quality Standards for the treatment of addiction in offenders in consultation with service providers, Probation Officers, ISMs, addiction nurses and health teams.
- d) A system of regular team meetings between addiction counsellors and healthcare teams within prisons should be developed.
- e) The IPS should consider the possibility of establishing a protocol on safe early discharge from services within the prison or community settings.

15.1.12 *Service Level Agreements*

Service Level Agreements are a key tool in the overall governance (both financial and operational) of external service providers/CBOs contracted to provide addiction related services either in the community or within prisons. The SLAs currently in place have too much variability in their requirements for each service provider and there are inconsistencies between those of the Probation Service and the IPS, e.g. timeframes, some CBOS which provide services within the prison system are funded by the Probation Service, etc. In addition, one group of workers who currently provide services within the prison system have no SLA or oversight by either the Probation Service or the IPS, i.e. community prison link workers and this needs to be addressed given that funding for their work is channelled through the Department of Justice and Equality.

Recommendation 12: Service Level Agreements

- a) A standardised/common SLA template should be used by the Probation Service and the IPS for contracting of CBOs.
- b) Consideration should be given to a three-year multi-annual funding model for all CBOs irrespective of whether they are funded by the Probation Service or the IPS.
- c) Services delivered in a prison setting should be funded by the IPS under an IPS SLA. Where CBOs provide services to the Probation Service and the IPS there should be a joint Probation Service/IPS SLA with each of these organisations.

- d) Organisations that provide community prison link services should be governed by a joint Probation Service and IPS SLA.
- e) SLAs with organisations that provide aftercare should clearly specify reporting requirements, using a standardised reporting template, regarding attendance, or otherwise, by offenders at aftercare sessions.
- f) Probation Service and IPS SLAs should clearly specify the outcomes to be measured and reported on. For all treatment-related services, whether provided in the community by CBOs, in prison by CBOs or in prison by addiction/health teams, the following core quantitative outcomes are proposed as an initial step to developing an outcomes framework for treatment of offenders with addiction:
- Participation:*
- Number of commencements (shown separately for detox, treatment and aftercare)
 - Number of completions (shown separately for detox, treatment and aftercare)
 - Number dropping out (shown separately for detox, treatment and aftercare)
 - Attendance rates for aftercare (i.e. no. of aftercare sessions attended by each individual).
- Treatment:*
- Number who are drug or alcohol free on completion of treatment
 - Number remaining abstinent 6 months and 12 months after treatment
 - Number with stable and safe use 6 months and 12 months after treatment
 - Number relapsed 6 months and 12 months after treatment
- g) A facility to capture outcomes reported by CBOs on an annual basis needs to be developed on the Probation Service CBO database. A similar system should also apply to the community prison link workers who may fit best within the CBO model.
- h) Consideration should be given to including funding from the Probation Service and the IPS to CBOs that includes a contribution to enable longitudinal research to be carried out by CBOs on a case study basis of a sample (e.g. 10) of clients each year to assess quality of life improvements arising from treatment (e.g. health, family, accommodation, employment, education, social networks, efforts to remain crime free and eventual remaining crime-free). The Probation Service and the IPS could then jointly host a learning event/seminar or conference at least every third year to share the findings from these pieces of research.

15.2 Overall Conclusion

Addiction is a major contributory factor in criminality and prison affords a unique environment in which to support offenders to address their addiction. The Probation Service and the IPS recognise the role that drugs and alcohol abuse play in criminality and recidivism and they have invested considerable sums of money in providing access to treatments. A broad range of treatment options is provided in keeping with international good practice which recognises the importance of responding to human variation in addiction circumstances. This review identifies areas where the current system of provision could be strengthened.

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APPENDIX A: MEMBERSHIP OF REVIEW STEERING GROUP

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APPENDIX B: COMMUNITY BASED ORGANISATIONS FUNDED BY PROBATION SERVICE

The services contracted for by the Probation Service of 18 CBOs in 2015 were as follows:

Aftercare Recovery

Provides a structured rehab day programme for males and females aged 18 or over from Dublin, inner city and surrounding areas recovering from drug addiction. Services include house meetings, gender groups, disclosure groups, parenting skills sessions, education awareness groups, social activities, information sessions e.g. relapse prevention, offending behaviour, anger management), sessions about integration back into the community.

Aiseiri Cahir

Provides a 28-day residential programme for male and female adult substance misusers. Programme includes group therapy, one to one counselling, family therapy, lectures and workshops, work projects/assignments, meditation, and access to self-help groups. Also provides a two-year weekly aftercare programme involving group therapy meetings and early recovery meetings with an addiction counsellor.

Aiseiri Wexford

Provides a 28-day residential programme for male and female adult substance misusers. Programme includes group therapy, one to one counselling, family therapy, lectures and workshops, work projects/assignments, meditation, yoga and access to self-help groups. Also provides a two-year weekly aftercare programme involving group therapy meetings and early recovery meetings with an addiction counsellor.

Ana Liffey

Provides six-week drug treatment programme to offenders referred by the Probation Service. Seven drug free prison treatment programmes are provided each year which involve group work in the Mountjoy Drug Treatment Programme. The focus is on harm reduction and an educational approach to substance dependency and recovery.

Ballymun Youth Action

Provides a range of services to young people aged 12 to 18 and adults from Dublin 11 area. Services include prison visits, a drugs free prison programme in Mountjoy Medical Unit (treatment and detox – latter subject to review by IPS), counselling, day programmes, drug and alcohol awareness, information, home visits, aftercare and recovery support groups and relapse prevention.

Aiseiri Ceim Eile

Provides residential support to males usually aged over 18 following completion of a primary treatment programme for addiction. Stays last between 3 and 6 months. Individuals are prepared for return to education, training or work.

Clarecare Bushypark

Provides a 28 day residential treatment programme (MI, CBT, Rodgerian Approach, peer groups, one to one counselling, family conferences, Brief Intervention models and educational inputs) for all addictions for adults aged over 18 from Mayo, Sligo, Roscommon, Galway and mid-West. Services area also provided for persons with a dual diagnosis with a consultant psychiatrist who holds weekly clinics in the centre. Referrals to half-way house care and family therapy programmes for on-going care post treatment.

Coolmine TC

Provides a range of residential and day treatment and rehabilitation programmes to adults aged 18 or over. Also provides input to Mountjoy Drug Treatment Programme.

Crinian Youth Project

Provides day and evening treatment services (counselling, care planning, art therapy, boxing/gym, yoga, relapse prevention groups, drugs education) for males and females aged 21 or under from Dublin 1 and the north inner city. Provides court reports and urinalysis reports to the Probation Service. Also provides aftercare and family support.

Cuan Mhuire Athy

Provides residential detox, treatment and rehab for all addictions for adult males and females. Twelve week programme for alcohol addiction and 20 week programme for drug addiction (medically supervised detox, group therapy, one to one counselling, meditation, occupational skills training, personal development courses, addressing offending behaviour, alternative therapies, adult education classes, self-help support groups). Also provides a two year aftercare programme with weekly or monthly meetings with trained facilitators.

Cuan Mhuire Bruree

Provides residential detox, treatment and rehab for all addictions for adult males and females. Twelve week programme for alcohol addiction and 20 week programme for drug addiction (medically supervised detox, group therapy, one to one counselling, meditation, occupational skills training, personal development courses, addressing offending behaviour, alternative therapies, adult education classes, self-help support groups). Also provides a two year aftercare programme with weekly or monthly meetings with trained facilitators.

Cuan Mhuire Coolarne

Provides residential detox, treatment and rehab for all addictions for adult males and females. Twelve week programme for alcohol addiction and 20 week programme for drug addiction (medically supervised detox, group therapy, one to one counselling, meditation, occupational skills training, personal development courses, addressing offending behaviour, alternative therapies, adult education classes, self-help support groups). Also provides a two year aftercare programme with weekly or monthly meetings with trained facilitators.

Cuan Mhuire Farnanes

Provides treatment and rehabilitation for females aged 18 or over suffering from addiction. Twelve week programme for alcohol addiction and 20 week programme for drug addiction (medically supervised detox, group therapy, one to one counselling, meditation, occupational skills training, personal development courses, addressing offending behaviour, alternative therapies, adult education classes, self-help support groups). Also provides a two year aftercare programme with weekly or monthly meetings with trained facilitators.

Fellowship House

Provides a 12 week drugs free residential programme based on the Minnesota Model (one to one counselling, group therapy, assignments) for adult males recovering from addiction. Organisation has developed links with the Northside Community Enterprises CE scheme.

Fusion CPL

Provides one to one key working for adults aged 18 or over in prison. Care plans are developed in conjunction with the Probation Service and the Irish Prison Service. Facilitates pre-release group in Wheatfield and meets with Mountjoy visiting committee. Individuals on release are invited to take part in Fusion support groups (relapse prevention and holistic therapies). In the community, therapeutic and training groups, counselling and holistic therapy is provided. Offenders referred by the Probation Service are supported with information (e.g. financial advice), referral (e.g. family support) and to access training, education and employment.

Matt Talbot Community Trust

Provides CE, work experience, education and training, sporting and cultural events and volunteering programme for males and females aged 18 and over who are early school leavers. Counselling is also available on a needs basis. Urinalysis is provided weekly. Supports are provided to help people move from transitional to permanent housing. Support programmes are run for families. It also provides prison visits.

Merchants Quay

Provides services to males and females aged over 18 in the greater Dublin area. Provides a stabilisation day programme, a drug free day programme, a residential treatment programme, a residential detox programme, a rehab programme, an aftercare group, supported housing service and prisoner support and contact service (including community linkage).

Tabor Lodge

Provides a 28 day residential treatment programme (group therapy, one to one counselling) for adults aged over 18 with addiction and support programmes for their families. It also provides a half-way house, an aftercare programme and a relapse prevention programmes.

APPENDIX C: COMMUNITY BASED ORGANISATIONS FUNDED BY IRISH PRISON SERVICE

Merchants Quay Ireland

Counselling service for male and female juvenile offenders, prisoners on remand and committed prisoners to assist prisoners to achieve and maintain abstinence from alcohol or other drugs and for prisoners unable or unwilling to work towards total abstinence, to reduce the amount and frequency of use via harm reduction strategies. Counselling activities to include comprehensive assessment, signposting (e.g. to group work on overdose prevention) and general advice, crisis intervention, care planning (in conjunction with MDT), implementing and facilitating appropriate treatment strategies, engaging in exit/pre-release planning, referring into prescribing/detox/drug free options.

Harmony

Provides evidence-based music therapy for substance misuse help participants overcome the denial barrier of their dependence on substance misuse and realise its consequences on their life; identify the underlying root causes that developed their alcohol and/or drug misuse issue; overcome the stigma associated with addiction and find the courage to access help and support structures, and learn how to apply preventative strategies against drug misuse or relapse.

Eustace Patterson Limited

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