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Throughcare and aftercare: approaches and promising practice in service delivery for clients released from prison or leaving residential rehabilitation

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The views expressed in this report are those of the authors, not necessarily those of the Home Office (nor do they reflect Government policy).

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Contents

Acknowledgements	ii
Executive summary	iv
1. Introduction	1
Background to the research	1
Aims of the research	1
Structure of this report	2
2. Methods	3
Aftercare services	3
Residential rehabilitation centres	3
Prisons	3
Questionnaires	4
3. Research findings	5
Approaches to aftercare delivery	5
Case management in aftercare	6
Aftercare priorities of prisoners and service users	8
Key challenges and promising practice in throughcare/aftercare for prisoners	10
Residential rehabilitation throughcare and aftercare	22
4. Discussion	25
Endnotes – outlining current relevant work	26

Executive summary

The Home Office commissioned Galahad SMS Ltd in August 2003 to examine existing approaches to throughcare and aftercare services for people with drug problems returning to the community from prison and residential rehabilitation centres. Six aftercare and four residential rehabilitation centres were selected as case studies for this project. The findings summarised in this report are based on interviews conducted with staff and clients from the case studies in conjunction with interviews from staff and prisoners in the referring agencies.

The report was commissioned in order to assist with the development of the Criminal Justice Interventions Programme (CJIP; now known as the Drug Interventions Programmeⁱ). It was recognised that, while this information would be obtained from aftercare agencies before they were formally involved in delivery of the Drug Interventions Programme, information could contribute to and inform the ongoing planning and implementation of the throughcare and aftercare programme from a national, regional and local perspective.

This report describes the main approaches to aftercare evident in the case studies, identifies the key challenges to effective delivery and highlights some of the more promising practices in service delivery. This report is intended to assist Drug Action Teams, Criminal Justice Integrated Teams (CJITs), prison staff, CARAT teams, probation staff, aftercare agency workers, and others including the policy teams in the Drug Interventions Programme, National Probation Directorate and HM Prison Service, in taking forward the throughcare and aftercare aspects of the Drug Interventions Programme. It is intended to enhance but not to replace existing guidance. Brief descriptions of the main issues identified in this report are listed below, while examples of related promising practices are presented later.

Since the fieldwork for this research was conducted, the further roll out of the Drug Interventions Programme has begun to address many of the issues and challenges raised in this report;ⁱⁱ details of where and how this is occurring are provided in endnotes at the end of the report. However, many of the findings and examples of promising practice in this report will be of wider interest to those working with offenders at all stages of the criminal justice system, including those responsible for offender management under the National Offender Management Service (NOMS).

Summary of key findings for throughcare

- *Timely assessments.*ⁱⁱⁱ On entry into custody or a rehabilitation centre an individual should be assessed as soon as possible for throughcare and aftercare needs, although these may change as the prisoner/resident progresses through treatment. In prison, priority for assessments should be given to remand and short-sentence prisoners.
- *Consistent collaboration in aftercare planning.*^{iv} To meet the post-release needs of prisoners and those in residential rehabilitation centres, effective links and communication systems need to be established (or maintained) from the very beginning of the throughcare process, across a wide range of agencies. Where prisoners have consented, CARAT and aftercare staff should be informed of, and involved in, early release (or Home Detention Curfew) planning for prisoners.
- *Comprehensive referral systems.*^v CARAT workers were the main source of referrals for the majority of aftercare agencies. However, there was evidence that other potential sources of referrals such as courts, probation, police and arrest-referral workers, were not always well integrated with local aftercare services. More information for all workers about local agencies and their functions may improve referral systems.

- *Timely access to clinical assistance.*^{vi} To maximise chances of drug users engaging with services, a speedy response to requests for help is vital. It is important, therefore, to ensure that there is consistent practice between prison and community based treatment services and that there are effective protocols and working relationships to ensure that offenders can receive continuity of care in a seamless manner. For example, aftercare workers noted varying attitudes to the prescribing of Naltrexone and the completion of Liver Function Tests (enabling speedy prescriptions of blockers on release) within prisons.
- *Maintaining engagement and motivation at the point of release.*^{vii} Aftercare staff had found that attrition (drop out) from services was reduced if, in appropriate cases, clients were collected from the prison gates on the day of release. This should be considered an option as part of a discharge plan for high risk clients.

Summary of key findings for aftercare

- *Case management in aftercare*^{viii}
There was some evidence that case management approaches were often oriented to care plans developed by a particular agency and did not take sufficient account of other agencies' interventions. This sometimes led to either duplication of work or some needs of clients remaining unmet.
- *Maintaining engagement and motivation in the community*^{ix}
Aftercare clients appeared more willing to engage with services when a persistent and non-judgemental approach was adopted by staff. In particular, regular contact with potential clients in institutions, as well as regular visits and phone calls in the community, seemed to result in higher levels of engagement.
- *Support with housing issues*^x
Released prisoners and those leaving rehabilitation centres said they needed assistance with housing. Staff stressed the importance of supporting clients in their search for stable housing through advocacy and liaison, attending appointments, transportation to appointments, links with tenancy support workers, etc. Some residential rehabilitation centres claimed that they would not discharge clients until suitable housing had been found for them. Housing is also a throughcare issue. Action is often needed to suspend tenancies and to avoid debts accruing when a person first arrives in prison or a residential rehabilitation centre.
- *Needs-led support*^{xi}
Several aftercare agencies reported that, for some of their clients, it was important to them for agencies to be flexible both in terms of their conditions for accepting clients and the amount of time for which support was offered. Peer mentors and a 24-hour point of contact were also highly valued by clients, even if the latter was rarely used.
- *Managing risk in the community*^{xii}
There was some evidence that some aftercare staff required clearer guidance/training regarding the signs or features of high-risk situations and characteristics that predisposed their clients to relapse, to overdose (deliberately or semi-deliberately) and to return to crime.
- *Commissioning and funding*^{xiii}
Aftercare staff felt that short-term funding led to unhelpful competition between agencies as well as being destabilising in terms of drug workers' job security and a reluctance to refer on appropriately. There is a role for commissioners to ensure that the contracts and service specifications they issue encourage and require effective inter-agency working.
- *Engagement of hard-to-reach groups*^{xiv}
Two groups in particular were highlighted: Black and Minority Ethnic groups (BME); and women. The majority of aftercare staff reported low levels of engagement among BME

populations and females, especially those females with children. There was a perceived fear among some female clients that their children would be taken into care by social services. While some agencies had developed strategies for encouraging greater engagement from these groups, engagement was not perceived to have improved.

- *Evaluation and monitoring*^{xv}

Agencies reported that they did not have access to an appropriate outcome-monitoring tool to record outcomes of their work with clients. Consequently, there was little evidence of systematic and objective evaluation of their services. A bespoke and standardised outcome-monitoring system would allow follow-up of individual outcomes which would in turn enable agencies to produce aggregate outcome data for evaluation purposes.

1. Introduction

Background to the research

The updated Drug Strategy (December 2002) set out measures to break the cycle of drugs and crime. The Drug Interventions Programme (formerly Criminal Justice Interventions Programme) is a critical part of the Government's strategy. The programme, which began in April 2003, aims to develop and integrate measures for directing drug-misusing offenders out of crime and into treatment. Interventions are designed to offer access to treatment and support from an offender's first point of contact with the criminal justice system. Throughcare and aftercare was therefore identified as a critical element for delivery.

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

Available reports and findings at the time, such as the Social Exclusion Unit Report – 'Reducing Re-Offending by Ex-Offenders' (July 2002), the Criminal Justice White Paper, 'Justice for All' (2002) and the updated Drug Strategy 2002 – all highlighted the need for comprehensive throughcare and aftercare provision for drug-misusing offenders leaving custody or completing a community sentence, and those leaving treatment.

Partners involved in planning and implementation of the Drug Interventions Programme identified only limited evidence and examples of practice which could be shared with local partnerships and inform effective implementation of throughcare and aftercare. A brief overview of work being progressed highlighted gaps in provision for drug misusing offenders leaving custody (remand and short term sentence) and residential treatment.

Available evidence suggested that for responses to be effective, there should be continuity and a clear pathway to a holistic package of help in the community. This should be part of a plan agreed with the individual, co-ordinated and supported by a case manager at a local level in the community. While aftercare provision was found to be patchy and ad hoc across England and Wales, there were lessons to be learned from those services that had been delivering aftercare support prior to the introduction of the Drug Interventions Programme. It was felt that further research could inform the approaches adopted to delivery, identify the key challenges addressed and investigate how they had been overcome. This work could contribute to and inform the ongoing planning of the Drug Interventions Programme as it relates to throughcare and aftercare programmes from a local, regional and national perspective.

Aims of the research

As research was already underway looking at Drug Treatment and Testing Orders, the focus of the study was to examine services both for the relatively large number of adults coming out of prison (particularly those on remand and short-term sentences) and for the smaller number of those being discharged from community-based rehabilitation units.

In particular, the aims of the research were:

- to identify and describe the different aftercare approaches used;
- to identify the key challenges, such as profiling client groups, assessing their needs, maintaining contact, setting up monitoring systems, sharing information across agencies; and
- to identify promising practice in addressing the key challenges.

At the time the research was commissioned, there was limited information about good practice in relation to aftercare in England. This research provided an opportunity to plug this gap. It is important to note that the promising practices described in this report have not been formally evaluated and are not therefore presented as 'recommended practices'. These practices, however, have been deemed worthy of wider dissemination on the basis of the self-reports of aftercare staff and their clients. They are described below for practitioners to consider their worth and applicability in the context of their own particular, local circumstances and to assist in generating innovative strategies for overcoming some of the main problems in throughcare and aftercare.

Structure of this report

After describing the methods adopted for this research in Chapter 2, the report presents the main findings. The four main approaches to service delivery identified in this research are presented at the beginning of Chapter 3. This is followed by *Case management in aftercare* which outlines the two principle types of case management found in the research. *Aftercare priorities of prisoners and service users* presents the needs of clients as perceived by the clients themselves. The main findings in respect of throughcare and aftercare challenges and practices are described in *Key challenges and promising practice in throughcare/aftercare for prisoners*. Each finding is presented in the same way. First, the main challenges to effective and successful service delivery are described from the viewpoint of staff working in throughcare and aftercare. Second, alongside each challenge, examples of good practice for addressing these challenges are provided. Where there were different issues and practices found between prison and residential rehabilitation centres, the findings specific to residential rehabilitation centres are examined separately in *Residential rehabilitation throughcare and aftercare*. The last chapter offers some concluding comments on throughcare and aftercare. Endnotes refer to relevant developments which have occurred or are occurring since the fieldwork for this report was undertaken.

2. Methods

This study used the Rapid Assessment and Response (RAR) methodology. RAR enables researchers to gather information about a population or situation rapidly and effectively through multiple methods and sources. Meaningful results and insights are extracted through continuous analysis and triangulation of data as it is collected.¹

The focus of the research was on adults who were leaving residential treatment or returning to the community from custody. Approximately 200 formal and informal interviews were conducted with prisoners, clients and staff members of rehabilitation and aftercare agencies, CARAT workers and others involved in resettling those with substance misuse issues.

Aftercare services

The research focused on six established aftercare services in England. The six aftercare agency case studies were selected from 80 services listed in a previous Home Office survey² that aimed to identify agencies employing some features of recognised good practice in case management. The six services were:

- Stockton: Holme House CARAT link workers;
- Bournemouth: Crime Reduction Initiative (CRI) Prison Liaison workers;
- Southwark: Rehabilitation of Addicted Prisoners trust (RAPt);
- Wolverhampton Re-integration Panel;
- Dudley: the CAGE Project;
- Leicester and Rutland: Drug Treatment Resettlement Team.

Residential rehabilitation centres

In addition, the research looked at four residential rehabilitation centres.

- One Day At A Time (ODAAT - run by the charity HOPE worldwide)
- The Ley Community
- Allington House (Streetscene)
- Phoenix House.

Prisons

The research also involved visiting 12 prisons from which the case-study agencies accepted the majority of referrals. Prisons visited from each case-study area included:

¹ See, for example: Stimson G.V., Fitch C., Rhodes T. and Ball A., Rapid assessment and response: methods for developing public health response to drug problems. *Drug and Alcohol Review* 1999;18:317-25; Rhodes T., Stimson G.V., Fitch C., Ball A., and Renton A., Rapid assessment, injecting drug use, and public health. *Lancet* 1999;354:65-8; Fitch C., Rhodes T. and Stimson G.V., Origins of an epidemic: the methodological and political emergence of rapid assessment. *The International Journal of Drug Policy* 2000;11:63-82.

² Home Office (Research, Development and Statistics) Aftercare Mapping Survey (unpublished, 2002).

Leicester:	HMP Leicester, HMP Stocken.
Bournemouth:	HMP Guy's Marsh, HMP Eastwood Park.
Dudley and Wolverhampton:	HMP Featherstone, HMP Blakenhurst, HMP Brockhill, HMP Drake Hall.
Middlesbrough:	HMP Holme House.
Southwark:	HMP Brixton, HMP Wandsworth, HMP Holloway.

In the 12 prisons, researchers interviewed 51 staff members (CARAT, healthcare and partnership–agency staff) and 34 prisoners. Telephone interviews were also conducted with CARAT representatives from HMP Eastwood Park and HMP Wandsworth.

Questionnaires

To ensure that the views expressed by those in the sample were not widely at variance with those held by others in the field, questionnaires were distributed to a wider sample.

- Fifty questionnaires were sent to aftercare agencies nationwide (21 were returned). The list of agencies was obtained from a previous Home Office 'mapping' exercise.³
- Sixty questionnaires were distributed (48 were returned) through CARAT workers to randomly selected prisoners in the 12 prisons that participated in the study.

³ *ibid*

3. Research findings

Approaches to aftercare delivery

From the six case studies, four main approaches to the delivery of aftercare for prisoners leaving custody were identified.

- Single-agency brokerage approach.
- Multi-agency brokerage approach.
- Prison link-worker approach.
- Probation-led approach.

These were defined by comparing key elements of practice in several organisations.

Findings: single-agency brokerage approach

At Southwark Rehabilitation of Addicted Prisoners trust (RAPt) and at Dudley (the CAGE), workers acted primarily as referral agents to other community-based agencies. They also provided proactive and intensive support to their clients in sorting out practical problems, escorting them to appointments and offering ongoing advice.

Although the CAGE project in Dudley was, strictly speaking, a single-agency brokerage service, it worked under the umbrella of a larger organisation (the Warehouse Project) and thus had access to many in-house services and resources, including prescribing.

Findings: multi-agency brokerage approach

The Wolverhampton Re-integration Panel comprised representatives of several agencies: local housing organisations, the local DAT, Addaction (substance-misuse service), Probation and Drug Treatment and Testing Order (DTTO) teams, YMCA Bridge Project, Community Drug Team, Base 25 (counselling), NACRO, Jobcentre Plus, arrest referral and YOI/HMP Brinsford and HMP Featherstone. All panel members pooled their expertise and resources to help persistent offenders (identified via a police database). Panel members felt that this multi-agency approach enabled a wide range of agencies to offer their services to the client and to better co-ordinate packages of care. Service representatives were also able to ensure that clients on the programme were transferred on to their service, quickly and efficiently. Monthly panel meetings were held to discuss a client's progress. Although clients engaged with the programme voluntarily, they were required to sign a contract which detailed the mutual expectations and responsibilities of both worker and client. The scheme required that the client cease all criminal activity, take control of their substance misuse and participate in arrangements for drug testing. In return they would receive practical help and support.

Findings: prison link-worker approach

Prison-based (Stockton)

Two workers from the Holme House CARAT link-worker project engaged with clients in custody before release and aimed to construct holistic release plans. Clients were then referred on to community agencies. Workers monitored plans and followed clients in the community for up to three months after release.

Community-based (Bournemouth)

The Bournemouth CRI agency was both a multi-agency scheme and a prison-link scheme, as it combined arrest referral, street outreach and Prison Liaison Workers (PLWs) with referrals to a network of well-integrated community substance-misuse services. The average time frame for support was six weeks.

Findings: probation-led approach

This approach to service delivery is defined by the 'Probation-led case management approach' described above and, within the case studies, was only to be found in the Leicester and Rutland Drug Treatment Resettlement Team (DTRT) service.

Conclusion

Because very little evaluation of services is conducted, it is difficult to assess the long-term success of these approaches in addressing challenges. Also, different types of service may suit different clients at different times in their life: some clients need or want close and intense supervision; others can maintain the progress they made in prison with minimal involvement with community programmes and drug workers.

Case management in aftercare

In this study, researchers noted that drug workers, prison workers and others involved in aftercare often used the terms 'case management' and 'care co-ordination' interchangeably. There was some evidence that case management approaches generally tended to focus on the care plans identified by a particular aftercare agency but little indication from most case studies that such plans systematically dovetailed care from multiple agencies. This was particularly noted where aftercare workers, mental health workers and the probation service were working with the same service users. However, two main approaches to case management of clients were identified.

- Supported-referral case management approaches.
- Probation-led case management approaches.

Findings: supported-referral case management approach

Five of the six agencies participating in this study adopted a 'supported referral' approach. The main responsibility of the workers was in referring clients to appropriate care services. All workers, however, also considered themselves responsible for general support and advocacy for their clients and for some level of progress monitoring.

In general, 'supportive-referral' agencies emphasised:

- drug-use prevention, health promotion and harm minimization;
- sustaining engagement in treatment;
- flexibility in meeting clients' needs, such as client-friendly appointment times;
- gentle persistence in encouraging clients to attend appointments;
- a needs-led, client-centred approach.

The 'supported-referral' approach can be subdivided into two groups: short-term and long-term support.

- Long-term: Dudley, Wolverhampton and Southwark offered clients ongoing assistance, monitoring and review of progress, even after the client had been referred on to other agencies for assistance.
- Short-term: Bournemouth CRI and Stockton Holme House offered short-term assistance (up to three months after release from prison) geared towards linking clients up quickly with other mainstream services.

The greatest advantage of this approach appeared to be its flexibility in meeting clients' needs. There was also some evidence from a few of the clients interviewed that the worker's persistent but non-judgemental approach encouraged those who had lapsed (returned temporarily to drug use) to re-engage quickly with these agencies and re-establish control over their substance misuse. Among the short-term referral agencies, levels of client satisfaction were high.⁴ This appeared particularly to be the case in areas with well co-ordinated and integrated networks of community services. Although 'supportive-referral' agencies provided a temporary 'safety net' for clients, they could not sustain and support them indefinitely. Eventual success in rehabilitation and resettlement of substance-misusing prisoners was still highly dependent on the availability and quality of community treatment services.

From interviews with clients and staff, it was apparent that the main disadvantage of the supported-referral approach was the lack of a coherent system to dovetail different inter-agency 'packages' of aftercare. Despite the best efforts of aftercare workers, probation officers and others, workers reported concerns about the co-ordination of inter-agency care. In some client cases, workers noted that, without close liaison with other agencies, there was the potential for duplication of activity. For example, there was evidence that false assumptions were made regarding which agency was dealing with a key area of work for the client. This resulted in some needs remaining unmet as aftercare contact came to a close. This kind of duplication or 'falling through the gaps' appeared to be a particular issue where community aftercare workers were managing clients who were also being supervised by probation officers or by community mental health teams.⁵

Findings: probation-led case management approach

Leicester and Rutland Drug Treatment Resettlement Team (DTRT) worked under the same umbrella as the Community Rehabilitation Order (CRO) and Drug Treatment and Testing Order (DTTO) teams. The overarching model was probation led with an orientation toward the enforcement of statutory orders/licences. Probation staff case managed those on licence while drug workers supervised voluntary clients – those whose statutory licences had come to an end but who had remained in contact.

Leicester and Rutland Drug Treatment Resettlement Team (DTRT) was the only agency in the study that adopted a probation-led style of case management. The key features of this approach appeared to be:

- an organisational goal of public protection and a focus upon the enforcement of statutory licences;⁶

⁴ According to scaled responses to the question: 'How satisfied are you with the service you have received?' asked on questionnaires and in interviews.

⁵ Since the fieldwork was conducted, overall responsibility for offender management now falls to NPS/NOMS, with CJITs providing support for drug-related needs where appropriate – but currently only for all sentenced 18- to 20- year-olds and adults serving over 12 months.

⁶ The work of the Probation Service is governed by a series of National Standards which provide clear guidance as to how those on statutory orders should be managed by workers. Amongst other things, these standards provide guidance about how often clients should 'report' to the service and at what point orders/licences should be legally reviewed in the event of appointments being missed. The process of managing and making decisions about statutory orders is referred to as 'enforcement'. The collection of information to evidence the Service's compliance with these National Standards is a key consideration in probation-led case-management approaches.

- a multidisciplinary team of drug workers and probation officers overseen by probation management;
- some in-house service provision by case managers;
- some referral on to other agents, but with continuing involvement of DTRT.
- frequent 'three-way' meetings between the client and probation and drug workers.

Most drug workers involved with DTRT felt that the most promising features of this approach lay in:

- the ability to provide some services such as prescribing 'on-site' which eliminated the need for clients to join waiting lists for medication. (Service users, aftercare workers and prison drug workers who participated in this study all noted that waiting periods for medication impeded the process of recovery and stabilisation.);
- frequent 'three-way' meetings between the client, the drug worker and representatives of other agencies and services involved in the client's care. Drug workers felt that the meetings formalised information-sharing procedures between drug workers and probation officers, clarifying roles and responsibilities and thus reducing duplication of work. Meetings were also organised to hand clients over to new workers or to resolve other client problems such as tenancy disputes, for example.

In interviews with drug workers, it was apparent that there were differences of opinion about the measures for success (and therefore funding) used by probation. The workers felt that measures such as numbers of clients completing accredited programmes and the strict reporting requirements of Probation National Standards were not always in accord with drug users' needs. This was because they did not take into account the common occurrence of lapses and relapses as normal features of rehabilitation from substance misuse. Drug workers saw a need for greater flexibility in decision-making, reporting of drug use and the application of sanctions, and for more 'holistic' assessments of the progress that clients had made in controlling or reducing their substance use.

Conclusion

Due to the small scale of this study clear conclusions cannot be made here about case-management practice in aftercare work in England with substance-misusing offenders. A more in-depth study of this area may be required.⁷

Aftercare priorities of prisoners and service users

Thematic analysis of interviews was conducted to identify the needs and concerns that prisoners, ex-prisoners and rehabilitation clients raised most often and the results are presented here. A 29-year-old client of a residential rehabilitation centre (an ex-offender) neatly summarised the three major aftercare needs of released prisoners:

These three factors are really important: having motivation to change; having stable housing, and having aftercare workers on release. These three factors make a person feel really good.

⁷ Further research into offender management is underway as part of the North West National Offender Management Service (NOMS) pathfinder project. See also Partridge, S. (2004) 'Examining case management models for community sentences' RDS OLR 17/04. Home Office website.

Findings: access to an aftercare worker

Most respondents stated that their own motivation was most important in order to make changes to their use of substances. It was also important to them, however, to be able to access supportive community drug workers who would offer encouragement regardless of the clients' state of readiness to change. Residential rehabilitation clients specified the value of one-to-one contact with a drug worker who ideally is available around the clock (though, in practice, clients did not often need this). This is discussed in more detail below (see 'Findings: promising practice in managing risk in the community').

In addition, most clients valued having regular access to someone who could help with practical and psychological issues associated with resettlement:

[The aftercare worker] comes to your house twice a week, phones you up every other day. They don't just chuck you in a flat and forget about you. They're constantly saying: we're here for you. So, it makes you feel better knowing that the help's there for you all the time.

(Aftercare client, male, Wolverhampton)

You know someone's out there working your corner, that's actually behind you, has actually spoken to you face to face, has believed what you want for yourself and is going out to try and find it for you.

(Aftercare client, male, Bournemouth)

Some clients valued practical support designed to help them deal with stress, day-to-day problems, and practical skills such as budgeting and tenancy management. For example, help with benefits and the ability to claim for new clothing if weight had increased was raised as an important issue to some. Other clients expressed appreciation for the support aftercare workers gave regarding other family/domestic issues.

Many interviewees considered the day of release from prison as a period of high risk for relapse and some clients felt that being picked up by a worker at the prison gates enabled them to make the transition without suffering temptation to use again.

A small proportion of users valued the opportunity to engage in voluntary drug testing on a weekly basis as it provided them with short-term goals to aim for and concrete proof to others of their achievements. Some clients felt that peer support in groups helped them to maintain change. Staff members and a small number of clients interviewed commented on their positive experiences of inter-agency meetings.

Findings: support with accessing housing

Nearly all respondents thought it was important to have speedy access to stable, safe and drug-free accommodation. A small number of interviewees also felt that they needed to get away from the area where they used to use drugs in order to sustain changes.

Findings: employment and/or leisure activities

Finding work or filling time constructively was important to most clients to help them establish and maintain a non-substance-related routine. Many interviewees felt that the process of preparing them for work was important in helping establish new routines and in raising self-esteem. Some said that securing voluntary work after release had boosted their confidence. At the Ley Community, workers

felt that volunteering and peer work was a pivotal step in preparing residents for a non-drug-oriented routine.

Findings: instant access to help and prescribing

Many clients identified a need for quicker and easier access to prison-based drug services. Many talked of having to 'chase' the help they needed in prison, especially in busier remand institutions as opposed to longer-term institutions. Prisoners indicated that good liaison and co-ordination of care plans during transfer to other establishments was sometimes lacking.

Service users who wanted to change generally felt that waiting lists for Community Drug Services (often 12 to 16 weeks long) were a hindrance to progress:

If you have to wait you think 'what's the point?'. [At the CAGE] you can get your script within a week!

(Dudley, aftercare client, female)

Some interviewees felt that they needed more factual information about the effects of drugs and about the range of services available in their locality. Some clients found it difficult to secure a place at rehabilitation units due both to the restricted availability of such places and to the length of time that was required to secure funding.

Findings: aftercare priorities of clients from residential rehabilitation centres

In addition, clients from residential rehabilitation centres also suggested the following improvements to aftercare and resettlement from the rehabilitation centres:

- Ability to return to the rehabilitation centre for weekly support sessions.
- Increased support for women with children during and after the residential component.
- Increased availability of alcohol-only programmes.
- Better information on all available community support programmes.
- Social clubs for ex-rehabilitation clients.

Conclusions

Needs assessment is central to effective commissioning and needs-led service provision. Although it is important to distinguish between needs and desires, attention to clients' perceptions of needs is likely to result in improved engagement and motivation. While there is a good overlap between clients' perceived needs and those identified by staff (see following section), one or two issues stand out, notably clients' wish for voluntary work and leisure activities and social clubs. These findings will help commissioning bodies and service providers structure their services and identify the necessary partners for inclusion in core service delivery. However, it is important to note again that this was a small scale study and the findings cannot be taken to be representative of aftercare clients generally.

Key challenges and promising practice in throughcare/aftercare for prisoners

One aim of this research was to pool experience, and find out which practices were common to the aftercare services that achieved good levels of client satisfaction and retention. The key challenges identified by staff and clients are listed here and then examined in more detail in conjunction with the related 'promising-practice' strategies and features of services that apparently produce greater client satisfaction and better staff morale.

Key throughcare challenges identified by staff and clients

- Timely assessments.
- Consistent collaboration in aftercare planning.
- Comprehensive referral systems.
- Timely access to clinical assistance.
- Maintaining engagement and motivation at the point of release.

Key aftercare challenges identified by staff and clients

- Maintaining engagement and motivation in the community.
- Support with housing issues.
- Needs-led support.
- Managing risk in the community.
- Commissioning and funding.
- Engagement of hard-to-reach groups.
- Planning and managing caseloads.
- Evaluation and monitoring.

Key throughcare challenges and promising practice

Findings: key challenge – timely assessments

Many aftercare clients and prison staff felt that, in some prisons, the lack of adequate numbers of CARAT workers to complete assessments and offer support and advice to substance-misusing prisoners was the greatest obstacle to seamless throughcare. Several prison staff members explained to researchers that prisons with fast-moving populations, such as those housing remand or short-sentence prisoners, made it difficult to link prisoners up with aftercare agencies. This was a central issue for staff in three women's prisons, mainly due to the larger populations (including remand) and higher turnover in these institutions. In one prison, a CARAT worker estimated that "*the whole jail ...turns over once a month*". Staff at community-based aftercare agencies also said they often struggled to make links with prisoners quickly enough in these institutions to initiate effective aftercare planning.

Many prisoners stated that they often wanted face-to-face contact for some quick advice or to make sure that their care plans (if they were being transferred to other institutions) were in place and going ahead. Many of those interviewed in prisons had put in requests for help but had not been able to access CARAT staff quickly, and sometimes had not had their request acknowledged. Many prisoners were very aware of the pressure their CARAT workers were under, as this aftercare client recalls:

They've got so many people to see...you've got to put your case across pretty forcibly.
(Aftercare client, male)

Findings: promising practice in timely assessments

In Featherstone prison, the CARAT team has an office on each unit. They operate an 'open-door' policy, allowing easy access to all prisoners. Workers on the wings reported being regularly approached by prisoners for assistance. The on-site office also means that prisoners can be found quickly, and there are no waiting lists.

HMP Holloway had introduced a reception 'triage' assessment system for prioritising prisoner referrals to CARAT services based on the individual's level of need and release date. Those due for early release were generally given priority to ensure that enough time was allocated for throughcare and aftercare planning.

Also at HMP Holloway, the CARAT and resettlement workers are making efforts to dovetail the work of their two teams. The resettlement team operate a two-week programme in which all prisoners, with or without substance-misuse issues, are given advice on housing, training, employment and benefits. The CARAT team hold a one-day session within that two-week course. This allows them to identify prisoners with substance-misuse issues who were missed on induction (and may therefore not have had CARAT contact or an assessment) but who feel they need support and guidance throughout their sentence. This opportunity appeared to be particularly important for crack users who, workers explained, did not readily disclose their drug issues. The Holloway CARAT team intended to relocate their office to the resettlement unit to further improve information sharing and co-operation between the two teams.

Some CARAT workers felt that 'induction' groups for prisoners provided the best opportunity to identify those requiring help with drug issues. In HMP Leicester, a 'first-night-induction' centre had been created that brought together CARAT workers, resettlement workers and other prison-based services. The advantage, they explained, was that prisoners could be seen quickly and resettlement planning could begin right from the start of a person's sentence.

In seven of the 12 prisons visited, healthcare workers acted as official links with CARAT teams. Representatives from five of these prisons felt that this system had improved the standard of throughcare and the continuity of drug treatment. Benefits had specifically been noted in the following areas:

- CARAT access to medical records.
- Information sharing between CARAT and healthcare staff regarding prisoner health, detoxification and prescribing issues.

Many prison staff members (particularly those in remand prisons) noted that having healthcare-CARAT link workers at reception and in detoxification units had improved communication streams and facilitated throughcare. The healthcare-CARAT link workers liaised with community health workers to ensure continuity of any treatment/medication which had been previously initiated in the community, investigated prescribing opportunities for prisoners due for release, and referred those in need of ongoing help to CARAT workers.

Findings: key challenge – consistent collaboration in aftercare planning

Poor communication between prison teams or with external agencies can result in late referrals to the aftercare agencies, which are sometimes not included in the early-release planning process. To place prisoners with substance-misuse issues into aftercare services, improved collaborative practice is needed between prison departments (such as healthcare, CARAT and resettlement teams), and between prisons and community services.

There was a feeling among prisoners that the substance-misuse-related implications of early release (especially on Home Detention Curfew – HDC) were not always considered. In one case, fearful of his own potential for relapse, a prisoner himself refused the option of early release. Another interviewee had overdosed shortly after early release. Aftercare agency staff felt that substance misuse should be given a greater priority in the co-ordination and communications relating to

arrangements for early release and HDC. Staff felt that this would greatly enhance their efforts to stabilise prisoners and prevent drug-related deaths.⁸

In several prisons, staff members commented on the 'high turnover' of aftercare agencies and said that it was often hard to keep up-to-date with new community services offering aftercare assistance.

Findings: promising practice in consistent collaboration in aftercare planning

In prisons where formal or semi-formal protocols for such co-operation existed, prisoner interviews indicated that they had a more seamless access to community services after release, and were therefore at less risk of post-release relapse. Some prisons employed 'link nurses' who enable cross-departmental communication within prisons and better-informed case conferencing.

Findings: promising practice in early release

Although not all prisoners eligible for early release had been able to co-ordinate aftercare assistance with a community-based drug worker, there were several cases of promising practice by both aftercare agencies and prison staff. These depend, of course, on prisoners' consent to these types of planning. At HMP Blakenhurst, for example, one prisoner interviewed described a 'contingency plan' he had devised with aftercare workers to cover the possibility of early release. This plan included: arranging a 'short-notice' pick-up at the gate; negotiating temporary accommodation with a parent; informing the Community Drug Team (CDT) he might be released early and making a 'contingency' appointment with them to obtain a prescription for Naltrexone. For another prisoner, the Governor deferred the decision about his HDC release until CARAT workers could devise a realistic and safe release plan. In another institution, communication had been improved through the HDC clerk taking systematic action to inform CARAT workers of HDC eligibility and decision-making.

Findings: promising practice in CARAT/community collaboration

Many CARAT workers felt that pre-release meetings with an aftercare worker improved a prisoner's chances of engaging with services after release:

The [aftercare] agencies who... send people in to see [prisoners] before they are actually released work... far better than having to turn up to a complete stranger. (CARAT worker)

Where aftercare link workers are actively involved as 'go-betweens' in pre-release care planning for offenders with substance-misuse issues, the 'handover' of released offenders to an appropriate agency appeared to them to be less problematic. Staff at both the Holme House prison-based link-worker project and the Bournemouth community-based link-worker scheme felt that their presence within the custodial institution facilitated the process of identification, referral and assessment.

In Bournemouth, arrest-referral workers worked closely both with CARAT workers in prison and with prison link-workers in the Bournemouth area. Faxes were exchanged between all parties to alert them to potential clients. Prison link-workers had keys to Dorset prisons, and so could have easy access to clients and their CARAT workers.

In HMP Brockhill, a women's prison with a very fast moving population, CARAT workers arranged access to a range of community 'mentoring' agencies that could support prisoners with housing issues, pick them up from prison and help them with practical difficulties (e.g. ANAWIN, a service

⁸ The prison service have proposed that in HDC cases information about prisoners' behaviour and participation in programmes while in prison should be built into the Prison Service HDC documentary process and transmitted to home probation supervisors.

that assisted female prisoners who had also been involved in sex work, and CONNECT, a service that helped prisoners primarily with housing needs).

In Wolverhampton, a new system of e-mailing between the police and the prisons improved the exchange of information about prisoner mobility.

Findings: key challenge – comprehensive referral systems

This research found that CARAT workers remain the main source of referrals for the majority of aftercare agencies. The large numbers of referrals coming through CARAT teams means that other potential sources such as courts, probation, police and arrest-referral workers did not always have good links with local aftercare agencies. Only one or two agencies received referrals from GPs and from mental-health agencies.

Findings: promising practice in referrals

Discussions with partnership agencies and aftercare staff revealed that agents other than CARAT workers could refer offenders for help. In Dudley, for example, local outreach workers noted an increase in contact at drop-ins by chaotic users who had just been released from short-term sentences. Drop-in workers and aftercare workers planned to meet to consider developing a more effective referral system for these clients.

Staff members in prisons felt that Arrest Referral workers could play a key initial part in aftercare planning by:

- informing prisoners about aftercare services;
- encouraging them to link up with such services;
- informing prison staff about clients who may require aftercare assistance.

Findings: key challenge – timely access to clinical assistance

Many CARAT workers in the study thought that difficulties in arranging for post-release clinical support impeded successful rehabilitation after release. Some aftercare workers echoed these frustrations, particularly in relation to variations in practice with regard to preparing prisoners for the prescription of ‘blocker’ medication on release from custody, as this manager explains:

We have difficulties arranging for our clients getting a liver function test in prison. We have difficulties obtaining the results of those liver function tests (LFTs), which are necessary for us to be able to prescribe Naltrexone and, finally, we are unclear why some prisons will provide LFTs and small amounts of Naltrexone on release and others won't even enter into dialogue!

(Manager, aftercare agency)

Approximately a third of all prisoners and ex-prisoners interviewed also raised the issue of variation in prescribing practice and in availability: many had lost motivation to address their substance use when faced with long waiting lists for treatment or for prescribing services.

Findings: promising practice in accessing timely clinical assistance

To ensure continuity of prescribing before and after release, Holme House CARAT link workers would refer prisoners in need of this to healthcare. Healthcare staff would conduct a Liver Function Test, prescribe blockers seven to ten days before release and give the client Naltrexone on the day of release. The CARAT worker considered this preparation important as clients felt more confident about maintaining abstinence after release knowing that heroin would not have the desired or expected effect. CARAT link workers could arrange for prescriptions to be collected the day after release from the Community Drug Teams (CDP – one in Stockton and one in Middlesbrough) and

from family GPs. CARAT link workers said they tended to use Community Drug Teams more than family GPs as their doctors specialised in drug treatment. One link worker reported a big improvement since CJIP was implemented: clients can get straight into treatment with the Middlesbrough CDP, and in Stockton the waiting lists are getting shorter.

Two of the six aftercare agencies studied had managed to secure the on-site services of GPs who also worked in the Drug Testing and Treatment Order (DTTO – where offenders receive drug testing and treatment as part of a community sentence). These GPs provided immediate access to clients in need. Other agencies were reliant on local GPs or Community Drug Teams. Most aftercare staff and clients agreed that the best chance for total rehabilitation lies in a fast response from services when an individual's motivation peaks.

Findings: key challenge – maintaining engagement and motivation at the point of release

The period of transition and discharge into the community was seen as high risk. Six ex-prisoners referred specifically to the vulnerability they felt on the day of release and the value of support from the aftercare workers who picked them up. One young woman described the reality of temptation after release and the value of immediate support from services:

[Being picked up by an aftercare worker] was most helpful, 'cos that's such a dangerous time: you've gone without, you've deprived your body of what it's been screaming for, and you think you've got over it. As soon as the gates open, it's back on you. The body's recovered, but the mind hasn't recovered. You think you've got it all under control 'cos you couldn't get it so readily in prison, so your body recovers from malnutrition, from abuse, but your head isn't quite right. And then you think 'I deserve it. I'm out of prison. I deserve to do this for myself', which is take drugs, and thinking 'just have one and it'll be all right'. But you never are all right. As soon as you've had that one, you've opened hell's gates basically.

(Aftercare client, female, Bournemouth)

Findings: promising practice in maintaining engagement and motivation at the point of release

In Southwark, Bournemouth and Stockton, aftercare staff members visited prisoners pre-release and asked them how they felt about leaving prison alone on their release day. If there was any doubt, workers offered to pick the prisoner up and escort them home or to appointments with community services (e.g. Probation, Community Drugs Team for prescription, job centre, etc.). Bournemouth aftercare workers felt that their smaller caseloads per worker allowed them to offer this service to most prisoners.

In Southwark, aftercare workers said that their engagement rates for post-release appointments showed marked improvement since the decision was made to pick clients up from the prison gates.

Although not all prisoners needed or wanted this service, for many, it was a lifeline without which they would undoubtedly have lapsed back into drug use and/or re-offending soon after release.

The practice of collecting prisoners at the gate on the day of their release appeared more systematic in areas with largely local prison populations (for example, in London and Bournemouth). In Dudley, CAGE staff did not offer prison pick-ups as a matter of course; they said this was partly because some clients were located in Liverpool prisons, and partly because many had already arranged lifts home. In Wolverhampton, a small number of cases were picked up from prisons. Police officers said that, for clients in prisons outside the project's catchment area, picking clients up on the day of release often took up an entire day of their time, and this did not include the time needed to link the client up with initial appointments. Leicester aftercare staff also said they felt

unable to offer prison pick-ups because of distance and the time required for the task. Meeting clients at the point of release will not be appropriate in all cases and should only be offered primarily to those at greater risk of relapse.

Findings: initial appointments

Typical appointments on the day of release tended to be:

- housing appointments: one aftercare worker in Dudley said that it was not unusual to have to wait for over an hour to see housing staff; and further appointments were often necessary during the first few weeks to make sure the housing application progressed correctly. In Southwark, where the team was located in the same building as NACRO, a direct link was established to help clients with housing needs. Aftercare workers also often escorted clients to the local Homeless Persons Unit;
- benefit appointments: Dudley CAGE staff said that their attendance with clients at benefits appointments could be time-consuming, taking up to a full day depending on the client's needs. However, some prisons not included in this study run 'Benefit surgeries' where much of the necessary paperwork is completed before release;
- prescribing sources: in agencies where access to prescribing was via other providers, aftercare workers accompanied clients to meetings. Agencies at Dudley and Leicester, however, were able to provide some in-house prescribing, and felt that this freed up staff time for other client services;
- family visits: at Wolverhampton and Dudley, aftercare staff reported making visits to clients' families during the week of release, to provide initial support;
- treatment services: in Bournemouth, if clients needed emergency accommodation, CRI workers accompanied them to St Paul's Nightshelter, where they could also access a doctor for basic health needs. Workers also escorted clients to the Providence Project, which provides a seven-day treatment programme, also with access to an in-house GP for prescribing.

Key aftercare challenges and promising practice

Findings: key challenge – maintaining engagement and motivation in the community

Those with problematic drug use are prone to relapse and attrition levels are often high. A key challenge in providing aftercare in the community is maintaining a client's level of motivation and engagement with services.

Findings: promising practice in maintaining engagement and motivation in the community

Some clients who had been unready or unwilling to engage with drug services said that continued contact with non-judgemental, supportive workers resulted in eventual engagement and lifestyle change. In particular, the persistence of Arrest Referral and Outreach workers was mentioned by several service users who had been encouraged to link up with throughcare/aftercare assistance. As this aftercare client explained:

I was six stone. I was just smoking Crack to function. It wasn't working no more...it was like my fourth time in the cells that week. I knew I was going to prison. I says to my solicitor 'can you go and get [name of Arrest Referral worker] for me'? [name of Arrest Referral worker] had been down loads of time... and wrote a report about me cos I needed help and I couldn't do it on my own. I was so grateful for them being there. I could be dead; I could be raped; I could be out there; I could be using. I wake up today glad I'm not dead.

(Aftercare client, female, Bournemouth)

Ongoing support after the formal end of aftercare contact was also viewed by many clients as an important safety net, as one explained:

This year has been something I wasn't expecting. I wasn't expecting to get this far and now I have a job and everything is fitting into place. I've come a long way. If I need help I can just pick up the phone and the help is there.

(Aftercare client, male, Leicester DTRT)

Findings: key challenge – providing support with housing issues

Among those interviewed for this research, nearly all CARAT, aftercare and rehabilitation centre staff felt that stable and safe accommodation was a prerequisite for successful rehabilitation and resettlement. Prison staff noted that mid- and long-term sentenced prisoners often lost their accommodation while in prison due to housing benefit regulations. The majority of prisoners, and many aftercare and rehabilitation centre clients said that they needed assistance with housing. Several released offenders said that lack of housing was the main reason for their failure to remain drug-free after release from prison. Although many aftercare workers interviewed in this study had found creative ways to secure safe accommodation for their clients, many more described it as a losing battle. A drugs worker in Dudley felt that without advocacy work, housing agencies were unlikely to treat their clients as priority cases. Without support from the aftercare workers, he said, some clients could also feel under pressure to take accommodation in locations that would put them at high risk of relapse.

Findings: promising practice in housing support

In Bournemouth, CRI had established a positive inter-agency working relationship with many of the local housing agencies, including the local authority housing department. Where possible, they also aimed to undertake joint visits with housing workers to potential clients in prison. The Dudley team had a liaison worker in their local housing office to help with forwarding housing applications. The housing department had introduced a tenancy-support officer to help those who may have had difficulties with budgeting, independent-living skills, cooking, etc. Aftercare workers used this officer with the ex-prisoners who were in council accommodation.

In Southwark, workers shared their building with NACRO, and were able to refer clients to and from the service with ease. The team also aimed to accompany clients to housing appointments.

The Wolverhampton Reintegration Panel employed an ex-housing officer, who brought to the service invaluable information and contacts for future referrals.

In both Wolverhampton and Dudley, the service offered advice on budgeting and life skills to help sustain housing tenancies. In Dudley, the local housing office had established a rent-guarantee scheme, which avoided the need to pay high deposits and thus improved accessibility to local housing. The housing department agreed with local landlords to guarantee deposits, so that individuals did not have to come up with money in advance. The deposit was then deducted on a weekly basis from the client's benefit at a more manageable rate.

In HMP Stocken (Leicester), the CARAT team had joined forces with a resettlement officer, so that housing and employment issues could be dealt with before release.

Findings: key challenge – needs-led support

Several agencies reported that, for some of their clients, inflexible referral criteria constituted a disincentive to attend. Some aftercare agencies could only accept clients who had 'pre-booked' while in custody; others could only accept 'walk-ins' if they had been out of prison for a very short time. Aftercare workers recognised that these practices did not fit the actual experience of ex-

offenders, many of whom did not acknowledge the need for help until they had been out of prison for some time. There was a real need for aftercare agencies that could 'fast-track' those at risk into services at any time. Although 'instant-access' drug services should, ideally, be universally available to all substance users, most respondents in this study believed that those with a history of offending behaviour were at greatest risk of harm to themselves and that community efforts should be made to facilitate their access to treatment.

Findings: promising practice in needs-led support

Many aftercare clients felt more secure knowing that they had ongoing help from the service, as typified by the following two comments:

They're there till I come right out of this, I know that. They're there for me; for my recovery. It gives me a bit of faith in myself and other people.
(Aftercare client, female, Bournemouth)

But even when I've finished my license she said I can come in and have a chat whenever I want... This will be useful as I find it easier to talk to someone about my problems rather than just bottling them away.
(Aftercare client, male, Leicester DTRT)

Aftercare clients generally expressed a wish for help to be offered until such time as they felt they no longer needed it. Realistically, satisfying this need may not be feasible. In one case study area, however, clients appeared satisfied with time-limited contact. Staff felt that this could be a result of effective services' commissioning in this area which had created a range of treatment services of differing intensity. Those who were waiting to access mainstream detoxification or tier-three substance-misuse services were offered activities and support in the interim. In these favourable conditions of high choice, shorter programmes appeared to be more acceptable to clients.

The evidence suggests that clients need to have access to a range of services which differ in intensity and response. Peer mentoring was particularly valued by some clients discharged from residential rehabilitation centres (see 'Findings: promising practice in ongoing support' below) and a '24/7' contact number also offered reassurance to clients (see 'Findings: promising practice in managing risk in the community' below).

Findings: key challenge – managing risk in the community

In the sample of 40 aftercare clients interviewed for this research, two had experienced an accidental overdose after release from prison; one had survived a deliberate overdose; and one spoke seriously about wanting to self-harm through overdose. There was evidence, from these and other case histories, that a previous history of overdose was not always taken into account in risk assessments by aftercare staff. Although prison and probation assessments systematically recorded some issues related to self-harm, researchers noted that many aftercare workers did not seem to register the significance of a previous history of self-harming as an indicator of future risk or of deliberate overdose. Many aftercare workers lacked clear guidance regarding the signs or features of high-risk situations and characteristics that predisposed their clients to relapse, to overdose (deliberately or semi-deliberately) and to return to crime.

In addition to this, the amount of time that aftercare staff spent with clients varied from service to service and it was often difficult to find consistent strategies for matching the level of intervention to the degree of need or risk presented by an individual. Most workers agreed, however, that the general pattern was for time-intensive involvement in the first few weeks after release, and then gradually decreasing involvement as clients stabilised.

Findings: promising practice in managing risk in the community

To reduce risk of relapse among clients, some agencies had devised systems for out-of-hours service provision. At Leicester DTRT, for example:

[Name of aftercare worker] has a mobile: if the answer machine is on, you can leave a message and she checks it. She'll contact you as soon as she gets the message. It's good to know that I could have contacted her 24 hours.

(Female aftercare client, Leicester DTRT)

Staff at the CAGE project in Dudley thought that the fast-track on-site prescribing that they offer clients can prevent minor lapses into occasional drug use from turning into full-blown relapses or a return to dependency.

Most clients valued what many described as '24/7 access' to a drugs worker. In fact few services in this study actually provided 24-hour and weekend cover. What appeared important to clients, however, was the increased accessibility which they felt they had to a worker when they had an 'all-hours' number to call – even if they rarely used the number. Many clients also said they felt safe and supported when they received prompt replies to messages left on answering machines, and when they felt they could drop in at any time.

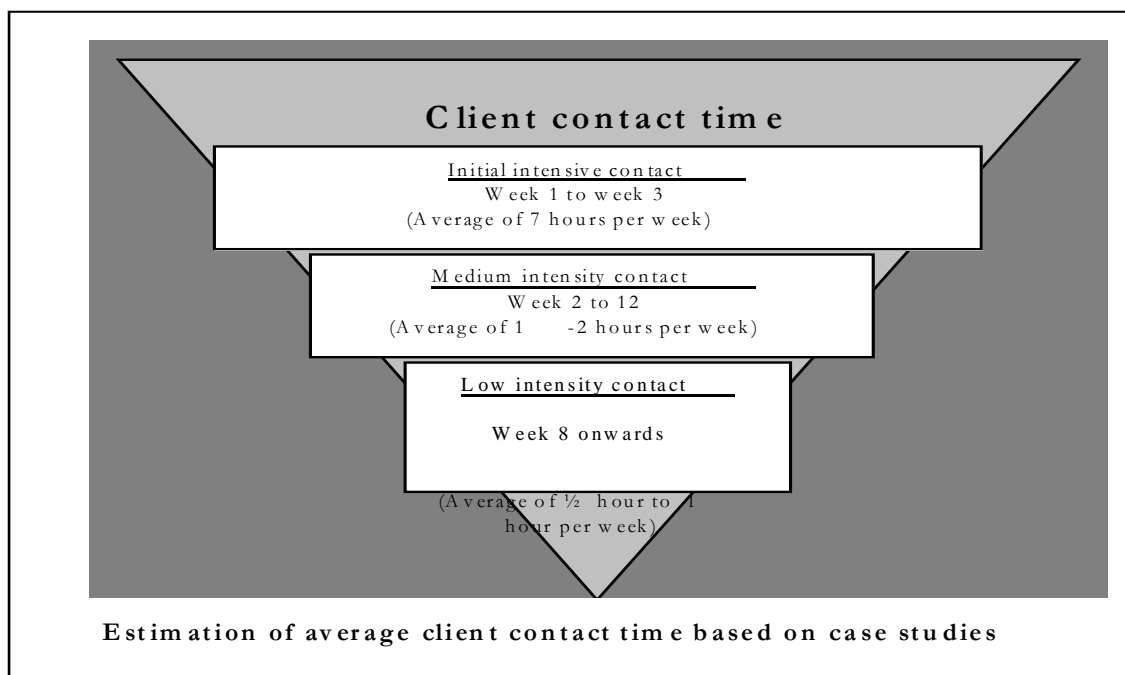
If I am in trouble I can ring 'em up. She [Drugs worker] says if you're ever wobbling, come into the office for one-to-one counselling. [They are] always on the ball and there is a hell of a lot of time for support.

(Aftercare client, male, Southwark)

In some aftercare agencies, some workers felt that the terms and conditions of their contracts prevented them from contacting clients outside of normal working hours. In general, researchers noted wide variation in the practical aspect of offering 24/7 contact. Many aftercare staff and clients confirmed that clients were often more likely to contact a worker directly in times of crises rather than going through a third party or agency receptionist. Consequently, in Wolverhampton and Leicester, although there was no official agency policy in either case, workers would, at their own discretion, give their work mobile-phone numbers to clients who they felt were particularly vulnerable or at risk. These clients could therefore speak to a drugs worker at any time. In Southwark and Dudley, workers were available on mobile phones until the end of the working day. At nighttime and on weekends, Southwark clients could call a confidential hotline number.

Findings: promising practice in planning and managing caseloads

The manager of Dudley CAGE based his assessment of suitable aftercare caseloads on the following calculation: each aftercare client required, on average, four hours of input from aftercare workers a week for as long as they remained an active case. Those coming out with strong family support and stable accommodation would require slightly less: around one hour of contact during the week of release. Those coming out of prison with complex issues, however, such as housing difficulties or mental-health problems, might require an entire day devoted to their care on the day of release, with daily monitoring for some time thereafter.



Findings: key challenge – commissioning and funding

Uncertainty about continued funding was an issue for some staff and was found to cause some stress and tension. Workers in the Wolverhampton aftercare scheme faced ongoing uncertainty about the project's funding. The workers talked about the anxiety they felt at the prospect of their employment ceasing. They also had ethical concerns about promising clients aftercare services when the organisation might cease to exist in six months' time. The situation was temporarily relieved through 'ad hoc' budgets, available only for a further six months. Workers at the CRI project in Bournemouth described a similar pattern of staff anxiety and morale difficulties concerning past patterns of funding which had offered little long-term stability. They explained that uncertain funding had diverted workers from core tasks in favour of lobbying efforts for funding. Staff said this situation had improved when they were no longer responsible for raising funds directly, and longer-term funding was introduced.

This study also found some evidence of competitive practice between aftercare agencies. In one case-study area, aftercare clients, CARAT workers and aftercare staff all felt that the criteria set for continued funding engendered a sense of territoriality amongst aftercare agencies regarding clients and encouraged an approach to care that was driven by funding rather than by needs.

Findings: promising practice in commissioning and funding

In contrast to some of the above views, service staff in Bournemouth felt that they were part of a co-operative and integrated service network. Here, the DAT apparently played a key role in setting targets and commissioning parameters that fostered collaborative rather than competitive practices.

Findings: key challenge – engagement of hard-to-reach groups

Two groups were highlighted in this study as being difficult to engage – Black and Minority Ethnic (BME) groups and women. All but one of the agencies participating in this project reported low levels of engagement among BME populations. The CAGE had invested significant effort into improving engagement rates through the employment of specialist workers focussing upon improving

liaison and engagement with BME groups locally. There was disappointment among staff that little improvement had been achieved through this initiative.

Interviews with female prisoners indicated that many had not engaged with substance-misuse services before custody out of fear that their children would be removed from their care by social services. This fear of disclosure was common to most of the mothers in prison and female clients of aftercare services. Several female aftercare and rehabilitation centre clients had engaged with services only after their substance use reached a crisis stage and social services had become involved for the protection of the children. A few female aftercare clients commented on the need for more substance-misuse services geared to help mothers with small children.

Rapid turnover of the prison population and the challenge this presented to CARAT workers trying to complete assessments were the main throughcare issues of concern among staff at women's prisons (see also 'Key challenge: timely CARAT interventions' above).

Findings: promising practice in engaging hard-to-reach groups

CARAT workers in HMP Brixton believed that the existence of a credible specialist drugs project for Asian users in Tower Hamlets had raised the profile of drug services among Asian prisoners in Brixton, and that this had contributed to increased willingness among Asian prisoners to engage with services in general.

At Southwark RAPt, about half of clients were from BME populations. A Southwark RAPt worker felt that the diverse backgrounds of their staff helped to attract clients from several ethnic origins. Researchers were told, however, that ethnic diversity in other aftercare teams had not resulted in an increase in BME referral rates. The reasons for such variations in engagement levels remained unclear and indicated a need for further investigation.

In Southwark and Leicester, agency staff held meetings with local BME community groups. Dudley and Southwark aftercare services provided and promoted a range of services addressing the needs of different types of drug users (e.g. services for stimulant users). The Wolverhampton Reintegration Panel worked closely with ACCI, an agency offering an outreach service, counselling and support for African-Caribbean drug users.

At CRI in Bournemouth, the female link workers undertook prison visits and gate pickups to encourage female prisoners to engage with the service. CRI staff felt that female prisoners often needed more time pre-release to develop trust in the drug worker. Female aftercare clients indicated that they particularly valued the friendship they had built up with their CRI drug worker.

Findings: key challenge – evaluation and monitoring

Many agencies wanted to evaluate the impact of their service more accurately, but felt that they lacked time, staff and funding to follow clients up after they leave the service. This research examined the evaluation systems used by the aftercare agencies (the six agencies used as case studies and also those that responded to the survey). Very few agencies used systematic and objective methods of assessing the short- or long-term impact on the client of their service. This lack of programme evaluation could affect future funding decisions. Staff members interviewed did not feel that the existing tools for outcome monitoring were appropriate for use in resettlement work with substance misusers.

Findings: promising practice in evaluation and monitoring

At the time of the research the Ley Community residential rehabilitation centre employed a research psychologist to collect data and undertake research that contributed to their annual report

summarising the year's progress.⁹ The annual report of 2002/2003 details progress on treatment programmes, resettlement, equal opportunities, research, staff development, redevelopment and refurbishment, external relations and financial management. It also outlines a list of targets and matches them with outcomes. The appointment of the research psychologist resulted in published research into the effectiveness of the Ley Community Programme. This research document defines a positive outcome for someone recovering from substance misuse as "a reduction in crime, no further drug use, stable employment, and better health".

Leicester and Rutland Criminal Justice Drug Team (CJDT) fund two researchers to evaluate the work of the Community Rehabilitation Order (CRO) and Drug Treatment Resettlement Team (DTRT). The researchers provide monthly, quarterly and annual reports to the DAT, and account for the number of referrals to DTRT, how many get accepted, results of drug tests, etc. The researchers were tasked with conducting a two-year follow-up of clients to gauge the success of the intervention, but the logistical problems involved proved insurmountable.

Residential rehabilitation throughcare and aftercare

None of the residential rehabilitation centres studied in this report separated the aftercare portion of the rehabilitation programme from the residential portion: all viewed it as a seamless package. Most centres were able to develop comprehensive resettlement strategies for their clients. Although not all of these throughcare and aftercare strategies will be options for those leaving prison, they are included in the research to illustrate the full range of promising practices currently in operation.

In three of the four centres, comprehensive community re-integration procedures were in place to ensure that clients maintained the gains already made in treatment. In interviews, former clients of rehabilitation centres expressed great appreciation for the aftercare support they received from the organisation. Many clients who returned to the centres for aftercare were helped by staff and mentors to apply the disciplines and structures they developed during their residential stay (e.g. understanding risk and relapse management, keeping busy and occupied, etc.).

Throughcare and aftercare approaches of rehabilitation centres

Staff from these centres felt that if re-integration was not well planned and managed, and if support was withdrawn too soon, recovery could be quickly reversed. For example, clients were not discharged until their safety and stability in the community was assured; some moved to halfway houses; most had a 'gradual release' plan.

Findings: promising practice in support with housing

Effective resettlement of drug misusers requires the development of a holistic package of support. Since drug misusers without accommodation are unlikely to be offered drug treatment and those leaving treatment without suitable accommodation and support are likely to relapse and may re-offend, the provision of housing is key. Rehabilitation centres would not usually discharge a client unless appropriate housing had been secured. Halfway houses were regarded as a vital component of successful resettlement for many clients and this accommodation was available for six to eight months after leaving The Ley Community and Phoenix House. A few clients, however, thought they would need housing assistance for longer than this period.

⁹ Therapeutic Communities (2003) Vol 24 No 2 Marian Small and Sara Lewis; and Therapeutic Communities (2001) Vol 22, No 2 Marian Small and Sara Lewis.

Findings: promising practice in ongoing support

Staff at the rehabilitation centres felt that it was best practice to begin preparation for aftercare immediately after a client enters the facility and continue to support clients well after their departure. Aftercare in the residential centres generally centered on continuing support from staff or from ex-clients of the centres. At most centres, clients were able to return for counselling, advice or even social activities long after they had completed their course of treatment.

My support here is ongoing. I know I can come here and they [ODAAT staff] will help me with whatever I need. I feel welcome, and, even though I don't have the resources I would like, I can still come in and use the things like the telephone, internet, or even just [have] a chat.

(ODAAT client, male)

Peer support programmes were particularly well developed at the ODAAT centre. After completing the programme, ten of the 12 clients interviewed had returned to the centre to assist others. Most had felt that this was a key feature of the ODAAT treatment:

... people [who] have done this programme still have dealings with this place. There are so many people that have done the programme, are in the area, and come in and do support work.

(ODAAT client, male)

Findings: other promising aftercare practices

- Most centres encouraged and facilitated their clients' participation in Narcotics Anonymous or Alcoholics Anonymous groups before and after their discharge from residential programmes.
- A gradual introduction into community life was promoted through early planning and preparation for challenges.
- Counselling and sessional work was available for clients after departure from the rehabilitation centres.
- Clients had use of telephones, and use of the internet for job searching.
- Rehabilitation centres had close links with colleges, and some offered funding for courses.
- While undergoing rehabilitation, clients were encouraged to undertake voluntary work, either in the community or with other clients, to prepare them for the working environment.
- Stage five of six at The Ley Community involved employment: staff held back £25 a week from the clients' wages, giving it back to them on completion of stage six.
- Aftercare included social events such as reunions, barbecues and football matches.

Findings: key challenge – funding for aftercare

Some funding arrangements for clients do not allow for ongoing support to be offered as part of their residential treatment. A worker at the Ley community explained that the local authority did not fund people for the aftercare portion of their treatment. In one centre, however, staff explained that the organisation was obliged to take responsibility for obtaining funding for clients who needed longer-than-usual support after completion of the programme.

Findings: key challenge – accessing places in rehabilitation units

Although an expansion of this sector is being initiated by the National Treatment Agency (NTA), at the time of this study there were approximately 140 residential rehabilitation centres in England, providing 4,000 places for recovering alcohol and drug misusers.

Rehabilitation centres receive relatively few residents directly from prisons. Many prisoners and aftercare clients interviewed felt frustrated by what they perceived as the 'red tape' involved in applying for and securing a place at a residential rehabilitation centre. Although this issue was not the focus of this study, in one area, researchers found an example of collaborative working practice that appeared to facilitate this process.

Findings: promising practice in accessing places

In Southwark, the Social Services Community Care Assessment Team (CCAT) assessed clients' suitability for structured treatment funding (residential rehabilitation). The team had about 40 active clients. Funding for structured programmes covered placements for approximately eight clients a month. Priority was given to offenders, women and children, and people with enduring mental or physical health problems. The team manager explained that, since the introduction of CJIP, the co-operation between the CCAT, CARATs and Southwark RAPt had steadily increased. The result of this co-operation was increased options for care and support, even when a client's initial application for residential rehabilitation funding was turned down. The manager talked about previous 'all or nothing' approaches to rehab applications. When someone applied and was 'not ready', not only were they denied a place in rehab, but waiting lists for other help from Community Drugs Teams usually meant there was no 'safety net' alternative either. He also explained, there used to be little help for short-sentence prisoners on release. But things have now improved: although the CCAT can still say no to someone who is deemed 'not ready' for rehab, they can refer them to an alternative 'holding' service on release – Southwark RAPt – where clients can be reassured that their case will be looked at again and helped to prepare them to get the most out of rehab when they are accepted:

Before CJIP came in ... a decision would be ... a yes-or-no answer: you can go to rehab or you can't. But now it's not like that. It might be 'No, you can't go to rehab, but when you get released you can make contact with [Southwark RAPt], engage with their service, show us you've got some motivation, and then they will bring you back to our attention and we'll look at getting you into a more structured treatment environment.' It works very well. ... [CARAT], [RAPt], ourselves and the DTTO all realised that we were essentially dealing with the same problem. We wanted to make sure we serviced these people best with the minimum amount of delays and repetition. We came together as a group to discuss how we could work more effectively together.

(Southwark Social Services CCAT team manager)¹⁰

The CCAT appeared to focus exclusively on assessments for funding of rehabilitation places, not on aftercare. Although the CCAT manager did indicate that other forms of support (mostly referrals) are provided, the team does not provide clients with the kind of 'hands-on' care that RAPt offers and complements rather than duplicates their work.

¹⁰ As an intensive area, Southwark introduced CJIP in the first phase.

4. Discussion

It was the opinion of the vast majority of respondents in this study (staff and clients) that much could be done to improve the resettlement process of those with substance misuse problems returning to the community from structured, sheltered environments such as prison and residential rehabilitation centres. Many of the 'promising-practice' strategies evolved in response to the challenging task of stabilising, rehabilitating, and re-integrating prisoners and rehabilitation centre clients. In the worst-case scenarios, clients had substance-misuse problems throughout custody, were released homeless or into a drug-using environment, could not get quick access to clinical assistance, were despondent or poorly motivated, and had no vocational skills.

From this research study, it was clear that a wealth of experience existed in throughcare and aftercare practice. Most practitioners agreed that the ideal throughcare and aftercare package for released prisoners would include: carefully planned release; assertive and proactive engagement strategies; varied and flexible support programmes; a non-judgemental, motivational approach; fast-access to clinical services; stable housing; leisure and employment opportunities; and responsive, trained and experienced drug workers. Implementation of this demands multi-agency co-operation, a central accountable worker to co-ordinate services based on each individual client's needs, and secure funding to meet demand. The agencies and individuals who participated in this study demonstrated great dedication to meeting clients' needs, often under less than ideal conditions.

Endnotes – outlining current relevant work

ⁱ **Drug Interventions Programme**

Delivery of the Drug Interventions Programme at a local level is through Drug Action Teams (DATs) using integrated teams (Criminal Justice Integrated Teams – CJITs), adopting a case management approach to offer access to treatment and support from an offender's first point of contact with the criminal justice system through custody, court, sentence and beyond. In addition to the work with adult offenders, the Drug Interventions Programme is also implementing special measures for young people (under the age of 18 years) to reduce the risk of continued offending behaviour although these are not included in this study.

In the first year (2003/4), a package of 'intensive' interventions including drug testing on charge, as well as enhanced arrest referral and throughcare and aftercare was introduced to 30 police Basic Command Units (BCUs) covering 25 Drug Action Team (DAT) areas that had the highest levels of acquisitive crime (such as property crime, burglary, shoplifting, robbery). From April 2004 the package of intensive interventions was extended to a further 36 BCUs and 22 DATs; and funding for throughcare and aftercare was made available to 102 DAT partnerships in England. Funding for Wales is being allocated by the Welsh Assembly. Funding for enhanced arrest referral and Drug Treatment and Testing Orders (DTTOs) and prison-based drug treatment programmes continues to be available across England and Wales.

ⁱⁱ **CARAT Review**

The findings highlighted in the research also pre-date the CARAT Review which is addressing many of the issues identified in this report. The findings of the Review informed the new CARAT specification and the Good Practice Manual which will be implemented in 2005. A further £5m has been made available as part of the Drug Interventions Programme to support the CARAT service and is targeted at local and remand prisons.

Also of importance is a high intensity, short duration programme that has been introduced in local and remand prisons to address the substance-misuse needs of those in custody for short periods.

ⁱⁱⁱ **Timely assessments**

In the community:

Guidance for DATs and CJITs recommend that assessments should be in line with the NTA 'Models of Change' and address needs which support resettlement e.g. housing. To improve access to referral and assessments, CJITs provide a single point of contact for referrals from workers e.g. CARAT teams.

In prisons:

Prison Service guidance (September 2003) highlights the need to inform CJITs of initial assessments as part of the pre-release plan and identifies healthcare as single point of contact – for referrals into prison from CJITs.

^{iv} **Consistent collaboration in aftercare planning**

In the community:

Consistent collaboration is promoted through introduction of the Integrated Team Minimum Data form in 47 intensive DATs (ITMDF) alongside Continuity of Care Guidance and NTA Models of Care. The guidance promotes the links needed between CJITs in the community and prison (Healthcare

and CARATs). The guidance and ITMDF are being reviewed and revised versions will be rolled out to all DAT partnerships from April 2005.

In prisons:

CARAT teams already work with CJITs and DATs in line with existing guidance. This work will be reinforced through the revised CARAT specification.

^v **Comprehensive referral systems**

In the community:

Guidance encourages DAT partnerships to map pathways for those clients going into and leaving the CJS and treatment. These should be used to inform pathways into and out of local service provision. In line with guidance, DAT partnerships are requested to: provide arrangements for Single Point of Contact for referrals from workers; 24/7 phone support for clients; and produce a directory of service provision.

In prisons:

Work is ongoing through CARAT teams. Under the new CARAT specification CARAT workers will become care managers for all drug treatment in custody.

^{vi} **Timely access to clinical assistance**

In the community:

In line with the DAT treatment plan and related guidance throughcare and aftercare funding can be used to fund rapid prescribing provision. In line with guidance – arrangements are in place for the 47 intensive DAT partnerships to share information with consent to inform Continuity of Care through Section B of the ITMDF – these arrangements will be rolled out to all DAT partnerships from April 2005 with revised guidance.

In prisons:

Prison healthcare services are developing new guidance for clinical services which will further improve joint working between CARATs and Healthcare. There is ongoing work by National Institute of Clinical Excellence on the use of Naltrexone.

^{vii} **Maintaining engagement and motivation at the point of release**

In the community:

Guidance promotes the proactive approach of CJITs to support and sustain engagement. Includes joint working between CJITs and CARAT teams from initial assessment in the community, to prison and pre-release. A proactive approach is encouraged, including the need to agree, where appropriate, the best form of contact by CJIT pre-release i.e. by phone, letter, video conference or face to face visit. Clients' immediate needs should be identified as part of a pre-release plan in conjunction with CARATs, for example, assessing the risk of relapse, whether pick-up at the gate is appropriate and whether an appointment is appropriate on day of release.

In prisons:

Prison Service Guidance highlights that pre-release contact with the CJIT should occur at a minimum of three weeks. New CARAT specification and Good Practice Manual continues to emphasise this pre-release work.

^{viii} **Case management in aftercare**

In the community:

Guidance has been produced in line with NTA Models of Change, which provides a framework for case management, integrated working and care planning.

CJIT will allocate a worker after a drug-misusing offender has been assessed and it has been agreed that he/she will be taken onto the CJIT caseload. This can happen at any point in the criminal justice system or on leaving treatment. The worker will develop a care plan with the offender and link with appropriate interventions.

Since the research was conducted, overall responsibility for offender management will fall to NPS/NOMS, with CJITs in the community providing support for drug-related needs where appropriate. Currently this is only for all sentenced 18- to 20- year-olds and adults serving over 12 months. Work continues to be undertaken with NOMS to ensure appropriate links with developments of Offender Management.

In prisons:

Since the fieldwork was conducted, overall responsibility for offender management will fall to NPS/NOMS, with CARAT teams providing support for drug-related needs where appropriate. Currently this is only for all sentenced 18- to 20- year-olds and adults serving over 12 months. The new CARAT specification and Good Practice Manual will provide a consistency of approach.

^{ix} **Maintaining engagement and motivation in the community**

In the community:

Guidance highlights that a proactive approach is needed as described above e.g. that case workers use a range of strategies which include phoning and texting clients who don't turn up, and going with them to appointments.

^x **Support with housing issues**

In the community:

ODPM, NTA and Home Office are working closely together to ensure that the housing/accommodation needs of clients are properly taken into account and reflected in wider strategies. Further briefing for DAT partnerships and CJITs was made available at the end of December 2004.

In prisons:

Through the National Re-Offending Action Plan, a Community Gateway Model has been developed which will include Drug Interventions Programme clients as one of six core groups whose needs are to be addressed in resettlement to the community.

A shadow prison Accommodation Key Performance Indicator sets out to a) build on the 71 per cent of prisoners with arranged accommodation on release and b) develop a common housing needs assessment for correctional services.

Clear referral processes for the housing needs of DIP clients have been established through CARATs.

New Housing Advice and Support Services (HACS) provide interventions and housing assessment on reception, which includes housing benefit advice. CARATs work for accommodation solutions on exit.

^{xi} **Needs-led support**

In the community:

Resources are now available to DAT partnerships to enable integrated teams in each area to provide access through a single point of contact to the CJIT, enabling existing or potential clients to

have one phone number with 24/7 coverage which provides information about drug misuse (including harm reduction), to carry out initial screenings, make referrals and appointments to the CJIT and provide information and contact details about local health services and wraparound services. Work is being progressed with NTA, HO, DSD and the independent sector on developing peer support and support for families in line with policy and good practice.

^{xii} **Managing risk in the community**

In the community:

To ensure local strategies are in place to address risk of overdose on release from prison or completing treatment, it is important to ensure that DATs make CJITs aware of the work being taken forward as part of their local strategy on managing drug related deaths.

In prisons:

The new CARAT service specification includes pre-release information which must include addressing risk of overdose on release.

^{xiii} **Commissioning and funding**

In the community:

From April 2004, funding for Throughcare and Aftercare is now available to all DATs and Partnerships in England and Wales. Funding guidance (December 2003) available to all DATs set out the purpose and use. Commissioning should be in line with local plans and strategies e.g. DAT treatment plan and local homelessness strategy.

^{xiv} **Engagement of hard-to-reach groups**

In the community:

A briefing on Diversity and Throughcare and Aftercare was produced by DATs in partnership with NTA, Home Office and The Federation to emphasise information and resources already available. A programme of work is being developed building on existing good practice and findings. This will contribute to DAT partnership work and implementation of their diversity strategies.

In prisons:

Prison service has commissioned research on access to services to highlight needs of Black and Minority Ethnic Prisoners.

^{xv} **Evaluation and monitoring**

In the community:

From April 2005 the revised Integrated Team Minimum Data form will be introduced for all DAT partnerships. A research programme as part of Drug Intervention Programme has also been commissioned. Work on appropriate targets and outcomes is to be progressed.

In prisons:

Work is being taken forward as part of the ITMDF review to align CARAT information.

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