Nugget 13.8

Post-release continuity vital to success of prison treatment

Findings Though the original regimens were diametrically opposed, two long-term follow-up studies have confirmed that post-release continuity is vital to sustain the benefits of treatment in prison.

An earlier report on study **1** had found that while in prison in Australia, far fewer opiate-dependents randomly allocated to immediate methadone maintenance continued to use heroin compared to those who had to wait four months. For the featured study, two-thirds of the 365 surviving prisoners (17 had died – all while out of methadone treatment) were re-interviewed about four years later. The longer someone had stayed on methadone, the less likely they were to have been reimprisoned or become infected with hepatitis C. The researchers concluded that it was important to use prison to provide methadone treatment which continued unbroken on release.

In California (study **2**), the Amity prison therapeutic community offered a nine to 12 months programme followed after release by up to 12 months in a similar residential regime. Applicants were randomly allocated to free beds until they had nine months left to serve, when they were dropped from the waiting list, forming a comparison group who wanted and qualified for treatment, but did not receive it. Five years after their release, records on all 715 prisoners were reviewed and 80% were re-interviewed. 76% of former Amity residents had been re-imprisoned compared to 83% of the comparison group, and on average they had stayed out six months longer. This advantage was largely due to prison treatment increasing treatment uptake on release, mostly in Amity's aftercare programme.

In context Though usually modestly beneficial in its own right, prison treatment makes its greatest contribution to reducing recidivism when it paves the way for continuing treatment on release. Take up of, retention in, and outcomes from, follow-on treatment are improved if it is compatible with the prison regime.

The featured studies exemplify these findings. In study **1**, without transfer to methadone programmes outside prison, programmes inside would usually have constituted a start-stop response ineffective in preventing infection or reimprisonment and creating windows for overdose fatality. In study **2**, without compatible aftercare to which prisoners could seamlessly transfer, Amity would have been considerably less effective and less cost-effective in preventing reimprisonment. In each case, the ex-prisoners were free to enter follow-on treatment or not and probably the most motivated did so, but without this option their motivation may not have been enough.

Practice implications Clear implications are that follow-on treatment should be made easily and immediately available on release, that (assuming prison treatment had been well targeted) this should be compatible with the previous treatment, and that investment in link-up services is vital to encourage transfer. But ensuring continuity requires prodigious feats of coordination. Transfer is maximised by pre-release contact and prison gate pick-up of released prisoners for escorting to aftercare services. The main blockages in Britain include short sentences which gave little time for planning, problems arranging housing, waiting lists for community treatment, poor coordination, and the lack of specific funding. As a result, in recent research aftercare arrangements rarely took the form of a particular service and programme arranged in advance.

Each of these issues is being addressed by new or reshaped agencies, including in England and Wales the Drug Interventions Programme and the newly combined prison and probation service, and in Scotland the new National Addiction Throughcare service to be run by local authorities, replacing a linkage initiative whose workers were unable to meet up with most prisoners on release or to make a difference to those they did meet. Across the UK there are plans to shift the balance from detoxification of opiate dependent prisoners towards maintenance and to ensure its continuation on release, and some evidence that a start is being made.

Featured studies 1 Dolan K.A. *et al*. "Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection." *Addiction*: 2005, 100(6), p. 820–828 **2** Prendergast M.L. *et al*. "Amity prison-based therapeutic community: 5-year outcomes." Prison Journal: 2004, 84(1), p. 36–60.

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Links Nuggets **11.5 10.8 4.12 3.13**

Appendix to Nugget 13.8

NB This appendix is not nor is it intended to be a comprehensive review of the literature but to be sufficient to support the statements made in the main text. It consists if the uncut text of the entry plus further notes.

Findings Though the original regimes were diametrically opposed, two long-term follow-up studies have confirmed that continuity of treatment after release is vital to sustain the benefits of treatment in prison.

An earlier report on study **1** had found that while in prison in Australia, a quarter of the opiate-dependent prisoners randomly allocated to immediate methadone maintenance continued to use heroin compared to two-thirds of those who had to wait four months ; see *Nugget* 10.8.[1] For the featured study, two-thirds of the 365 surviving prisoners (another 17 had died, none while in methadone treatment) were re-interviewed about four years after first being seen in prison. Nearly all had been released from their original sentence though most had been reimprisoned. The longer someone had stayed in methadone treatment the less likely they were to be reimprisoned or to become hepatitis C positive. The researchers concluded that it was important to use prison to initiate methadone treatment which continued unbroken on release.

In California in the early '90s, the Amity therapeutic community at Donovan prison offered nine to 12 months of therapy followed after release by another six to 12 months in a similar residential regime, both on a voluntary basis. Applicants waiting to enter the unit were randomly allocated to beds as they became available. Those not allocated within nine months of their release date were dropped from the waiting list, forming a comparison group who wanted and were eligible for treatment, but did not receive it. Five years after their release official records on all 715 prisoners in the study were reviewed and 531 were re-interviewed, 90% of those out for at least a year and available for interview. 76% of former Amity residents had been re-imprisoned compared to 83% who had not entered the unit, and on average they had stayed out of prison for six months longer. Further analysis showed that this advantage was entirely due to the fact that being treated in prison led to further treatment on release, for an average of 4.6 months (mostly in the prison's aftercare programme) compared to just 1.7 months for prisoners who did not start treatment in prison.

In context Throughcare is pivotal to the rehabilitation of drug dependents[2] because so many experience prison[3 4] so often,[5 6] because a large minority will have been in treatment before entering prison, because each spell in prison is usually too short for a full programme of care, and because drug use reductions made in prison could quickly evaporate once on the outside.[7 8] Data collected before the recent expansion of prison treatment in Britain shows that prison itself does little to curb drug use and crime: treatment participation is no greater after prison than before, drug use resumes at more or less the same level,[9] and criminal recidivism and reimprisonment are common.[10 11 12]

In-prison treatment generally has a beneficial impact on recidivism but only a minor one[13 14 15] and sometimes none at all[16] unless followed by further treatment on release.[17] This is partly because prison programmes are rarely optimal[18] and

perhaps also because they face the powerful countervailing force of the criminogenic nature of the prison environment.[19] Where they are effective it is probably partly because they dilute these forces, for example, by reducing fear of other inmates, providing more autonomy, reducing hostility to the prison and its staff, and countering socialisation into the prison culture.[20 21] US evidence on the role of post-release aftercare and continuing supervision in reducing recidivism and drug use is much stronger than for prison treatment itself, in the USA generally conducted on therapeutic community lines.[22 23 24] Prison treatment has been found relatively ineffective in the absence of aftercare,[25 26 27] and post-prison rehabilitation on its own has exerted a greater positive effect than prison treatment.[28] A preliminary study controlling for motivation still found that entry into aftercare was a significant factor in good outcomes.[29] Take up of, retention in and outcomes from the follow-on treatment are improved if it is compatible with the prison regime.[30 31]

Without a dedicated aftercare programme to which prisoners could relatively seamlessly transfer, it seems likely that the Amity in-prison regime would been considerably less effective in preventing reimprisonment. Based on the first year after release, an earlier report on the same study found that the cheapest way for the prison to 'buy' an extra day out of prison was to provide aftercare as well as prison treatment rather than just prison treatment.[32]

With a raft of new initiatives in Britain including new prison treatment services, CARAT teams and the DIP programme intended to improve continuity of care from arrest onwards, it is unclear how far the situation has improved since the late '90s when concrete aftercare arrangements for drug using prisoners treated in prison were the exception rather than the rule.[33]

Whilst many will have been receiving maintenance and harm reduction interventions, on entering prison they encounter treatment and post-release plans which emphasise detoxification[34 35 36] followed by drug-free counselling and therapy.[37]

Discontinuity of treatment is particularly unfortunate when, like methadone maintenance, its essence is stability. After imprisonment less than a third of the prisoners in England and Wales surveyed in 1997 who were on methadone treatment before prison continued to receive it in prison, even on a detoxification basis.[38] In Glasgow imprisonment was the most common cause (39% of cases) of the interruptions to methadone maintenance which made the treatment less effective in reducing injecting and non-fatal overdose.[39] Even unconvicted remand prisoners rarely receive continued methadone and even more rarely on a maintenance basis.[40]

Between 2002 and 2003 57% more prisoners in Scotland said they had taken methadone in the past month, an increase attributed to the introduction of methadone maintenance regimes. Nevertheless three times as many had used opiates, suggesting considerable unmet need.[41] In England too women's prisons moved from short-term detoxification to longer term maintenance for a minority of opiate addicted prisoners[42]

From their accounts, treatment inside and outside prison in Scotland differed

widely. Nearly two-thirds of the community sample had been prescribed methadone but just 24% of the prisoners, even though 80% had recently used heroin. Instead, prison services relied on drugs such as lofexidine and dyhydrocodeine to ease withdrawal. Counselling and advice/information were the mainstays of community psychosocial help (77% and 65% respectively) but under half as common in prison (both 31%); similarly with group work (43% v. 18%). Only where, in either setting, few clients received a service were the proportions comparable. For example, inside or outside prison, only 1 in 6 recalled vocational/educational help, though nearly all were unemployed.[43] Asked how they felt about the service, around 60% of the community sample rated it at least "good" and felt it had motivated them to sort out their problems, but just a quarter of the former prisoners. The adequacy of the services seemed reflected in the eight-month follow-up. On all but two of 24 measures of drug use, drug problems, health, and crime, the community sample had improved more, generally ending up better than the prisoners despite starting from a worse position. For example, 30% had stopped using heroin but only 10% from prison, typical of other forms of drug use. The upshot was that compared to before treatment, 40% fewer of the community sample were seriously troubled by drug problems but just 12% fewer of the ex-prisoners.[44] The study confirms that UK prisons continue to avoid methadone maintenance,[45 46 47 48] despite now strong evidence of effectiveness in this setting.[49]

Reports on Scotland's Transitional Care Initiative intended to link released problem drug users to community services suggest that this too has run into implementation difficulties, especially in respect of remand prisoners who were often not seen before release.[50] Despite signing up to the service, just 28% out of 158 prisoners followed up four months after release had seen their transitional care worker and half of these had not kept all their (up to three) appointments.[51] No differences could be discerned in health, drug and alcohol use, offending, accommodation and economic activity between ex-prisoners who had or had not attended appointments after leaving prison. The service is being terminated at the end of July 2005 when it is intended that the same role will be played by the criminal justice sections of local authorities which will run an "inreach" service to prisons to be known as the National Addiction Throughcare service.[52]

Practice implications In England and Wales prison CARAT teams are responsible for arranging aftercare and have quickly forged links with community services, now aided by Drug Intervention Programme teams which from April 2005 should be working to a new national framework for ensuring continuity of care.[53] The Drug Intervention Programme teams should now provide a single referral point for prison services which can be involved before release to ensure continuity of care.[54 55] Research conducted since 2003 found that the main blockages were short sentences which gave little time for aftercare planning, arranging housing, waiting lists for community treatment, poor coordination between services involved in aftercare planning and provision, and the lack of specific funding.[56 57 58] As a result co-ordination and consistency of service provision for drug misusing offenders released from prison is patchy and fragmented.[59]

Each of these issues is being addressed. From 2004/05 £55m is being made available to drug action teams in England to fund the throughcare and aftercare of drug users involved with the criminal justice system,[60] such funding is also being made

available in Wales,[61] guidance has been issued on housing these clients,[62]

For the first time DATs in 2003/04 were requested to outline in the DAT treatment plan what action will be undertaken to address the linkages between drug treatment services in prison and those in the community; projects aimed at ensuring the continuation of substitute prescriptions as patients enter and leave the prison system; services aimed at picking up referrals from CARAT teams and successfully placing them in appropriate community based services on release.[63]

Service shortcomings are being addressed. In England the Criminal Justice Interventions Programme aims to improve coordination of treatment for offenders and a special programme[64] is being trialled to provide treatment for short-term prisoners.[65] In England and Wales, transfer of responsibility for prison health services to NHS bodies[66] may help close the gap between services inside and outside prison. In Scotland, steps have recently been taken to improve methadone and therapeutic services, there are plans to expand the range of treatment provision,[67] and the new initiative may yet improve throughcare. But as long as the main community-based pharmacotherapy (methadone maintenance) is denied most prisoners, and psychosocial approaches differ widely, it is hard to see how continuity and equity of provision inside and outside prison can be achieved. Official guidance approves methadone maintenance where it continues the pre-prison treatment of short-term prisoners[68] [69] but prison is also an opportunity to introduce many dependent opiate users to this treatment with a view to continuing it on release.[70] Pre-release contact and prison gate pick-up of released prisoners for escorting to aftercare services are vital components.[71] [72]

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