

Treatment of Offenders

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Key Points

Aimed at adult offenders (aged 18 and above)

- Community treatments are likely to be more effective for most problem substance misusing offenders. Imprisonment can have unintended negative consequences for problem substance misusing offenders, and there are many practical issues that frustrate the delivery of successful drug treatment programmes in prisons, particularly for short term prisoners.
- Successful community programmes are based upon having a wide range of services to meet the differing needs of individual drug using offenders e.g. services that promote reintegration (such as housing, education and employment) in order to improve long-term outcomes.
- An effective Arrest Referral service, managed within the Criminal Justice Integrated Teams (CJIT) is central to the management of offenders with substance misuse problems in Criminal Justice settings.
- The Drug Interventions Programme (DIP) provides a package of support for drug misusing offenders reaching the end of a prison based treatment programme, completing a community sentence or leaving treatment.
- Good practice in prisons based programmes for treating substance misuse are based upon having a range of treatment options and access similar to those in the community, including maintenance and substitution options. High quality harm prevention programmes, to reduce drug-related deaths both from overdose/toxicity and blood-borne viruses need to be included.
- A comprehensive assessment of the offender's needs and level of risk should begin as soon as possible after entering prison so that appropriate care and support can be provided.
- Effective links between prison and community services are vital and the use of a common client record, care plan and collaborative care planning will facilitate this.
- Protocols should be developed between prisons and aftercare services to deal with early, unanticipated, and Friday releases.
- Drug-related mortality amongst newly released male and specifically female prisoners is significantly higher than the rate amongst their peers in the community and should be a major consideration in discharge planning.
- Aftercare individuals appear more willing to engage with services when a persistent and non judgemental approach is adopted. Regular contact with potential clients in institutions is likely to result in higher levels of engagement.

1 Purpose

1.1 Overview

This document provides a summary from the evidence and professional opinion on what is best practice in relation to the treatment of offenders with substance misuse problems.

It is targeted at planners, commissioners and providers of substance misuse treatment services in both the community and prisons. It is intended to assist them in the planning and delivery of appropriate services and development of standards for the provision of these services.

It has to be set in the context of the new Welsh Assembly Government substance misuse strategy for Wales “Working together to reduce harm”.

The document also has to be read in conjunction with previous evidence based good practice guidance for Welsh Assembly Government particularly those for:

- Community Prescribing
- Psychosocial interventions
- Coexisting Substance Misuse/Mental Health Problems
- Alcohol Misuse in Wales.

The module also has to be read in conjunction with the publications - Drug misuse and dependence: UK guidelines on clinical management (2007), and the Welsh Assembly Government Prison Mental Health Pathway (2006).

The document does not address the particular problems of young offenders which will be the subject of separate guidance.

Whilst it is accepted that the prison estate within Wales does not accommodate women prisoners, the guidance contained within this document by definition applies. Operational protocols are in place with linked custodial establishments throughout the UK, designed to ensure that any women being discharged into Wales are dealt with in accordance with presenting need.

The module is based upon technical reports provided by the National Public Health Service for Wales (NPHS) Vulnerable Groups Team which are accessible on the NPHS website. A summary of the evidence for community based drug provision is included in Appendix 1 this document.

1.2 Structure of report

The report is essentially in three parts section and details good practice in:

- Community Settings (including early interventions)
- Prisons
- Resettlement



2 Community based treatment

2.1 Overview

- Community treatments are likely to be more effective than imprisonment for most problem substance misusing offenders.
- Imprisonment can have unintended negative consequences for problem substance misusing offenders, and there are many practical issues that frustrate the delivery of successful drug treatment programmes in prisons, particularly for short term prisoners.
- Maximising the use and effectiveness of community sentences is likely to be more beneficial than imprisonment of problem substance misusing offenders for comparatively less serious acquisitive crimes and drug possession offences.
- Community sentences have the potential to offer better value for money and deliver similar reductions in offending.
- A wide and complex range of substance misuse intervention provision exists in Wales. These include processes to identify substance misusers, interventions to promote engagement with treatment; and other services and interventions that address substance use and/or offending. (This provision is summarised in Appendix 2).
- Many of these interventions are delivered within the Drug Interventions Programme (DIP). The DIP purpose is to 'break the cycle' of drug related offending and prison by encouraging offenders to engage and remain engaged with treatment services. *(Figure 3 illustrates how the Programme intervenes in the cycle to move offenders out of crime and into treatment.)*
- The DIP will also provide a package of support for drug misusing offenders reaching the end of a prison based treatment programme, completing a community sentence or leaving treatment.

2.2 Good practice for community programmes/interventions

Successful community programmes are based upon:

- Having a wider range of services to meet the differing needs of individual drug using offenders, for example services that address the specific needs of stimulant users.
- Effective assessment of problem drug-using offenders, in order to match them to appropriate interventions, with regular reviews and reassessment.
- Having services that promote reintegration (such as housing, education and employment) in order to improve long-term outcomes.
- A focus on the impact on outcomes of delivery issues, such as staff skills and personal development, morale and management, that improve consistency of service quality.

- Adequate attention to supervision and monitoring of practice, including, considering the potential for greater use of positive incentive based strategies to ensure compliance (contingency management) rather than the current punishment orientated focus.
- Interventions that adopt holistic, problem solving approaches to addressing drug use.
- Extending the use of drug testing on Arrest in specific police custody suites, by expanding the range of trigger offences or testing for a wider range of drugs, is a Home Office initiative, to be implemented as from the 1 April 2009. Testing on arrest rather than testing on charge has been shown to be effective in increasing the numbers engaging in treatment.
- Using schemes, (e.g. Drug Intervention Programme (DIP) Conditional Cautioning), that divert drug using offenders in the early stages of their offending and problem drug using careers from prosecution, on condition that they address their substance use and other problems may have merit.

2.3 Key phases of community programmes

2.3.1 Arrest and the period following arrest

An effective **Arrest Referral (Criminal Justice Interventions Team - (CJIT)) Service** is central to the management of offenders with substance misuse problems. This service can be provided by Arrest Referral Workers, custody suite nurses, forensic medical examiners or custody suite staff, applying their specialist skills. Good practice guidelines for the clinical management of substance misuse detainees in police custody have been published by the Faculty of Forensic and Legal Medicine Royal College of Psychiatrists (2007). The Royal Pharmaceutical Society of Great Britain has published guidance on the pharmaceutical care of detainees in police custody (2007).

CJIT teams working in the custody suites should:

- Identify those with substance misuse problems.
- Undertake drug testing on arrest.
- Assess, advise, support and provide information.
- Refer for treatment.
- Identify hazardous, harmful and dependent drinkers.
- Provide a screening assessment.
- Give advice on alcohol and its impact and provide relevant information.
- Provide simple brief interventions for hazardous and harmful drinkers which could be delivered by a range of appropriately trained non-specialist practitioners.
- Refer moderate to heavy drinkers including those with dependence for more intensive interventions.
- Be aware of the key issue of safety for offenders at all times.

In *community settings* the provision of specific programmes by Criminal Justice Intervention Teams (CJIT) caseworkers should provide:

- Further assessment, care planning and case management, for a minimum period of 13 weeks.
- Counselling, (which in some circumstances can include alcohol misuse) group work, education, diversionary activities, psychosocial interventions.
- Family support, including housing, financial management, support with family relationships.
- Prescribing/rapid prescribing services.
- A single assessment/client record.
- An assurance that where Bail restrictions are imposed, they are adhered to in a manner consistent with clear operational guidelines.

2.3.2 Court appearance

The key workers at the court phase are CJIT workers, providing the 'Arrest Referral' service. Their major responsibilities are to provide:

- Assessment, advice, support and information (drugs and alcohol).
- Referral for treatment to drug and alcohol service providers.
- Effective Liaison with Counselling Assessment Referral Advice and Through care (CARAT) services and for those given custodial sentences via joint CARAT/CJIT protocols.

2.3.3 Community sentence

With regards to the community sentence stage the service is managed by the Probation service/National Offenders Management Service (NOMS).

Their major responsibility is the delivery of Drug Rehabilitation Requirements and the community management of Persistent and Prolific Offenders (PPO's). NOMS has clear responsibilities in managing the transition between Custody, DIP and Tier 3 services. In this area of work it is important to emphasise that abstinence based approaches to treatment may have limited success, if there is an expectation that offenders will be completely drug free within weeks. The Probation Service also offers alcohol treatment programmes delivered in a community setting.

3 Prison based substance misuse programmes

3.1 Good practice for substance misuse programmes in prisons

Good practice in prisons based programmes for treating substance misuse are based upon:

- High quality systems of clinical governance.
- Assessment of needs across the four domains of drug and alcohol misuse; health; social functioning; and criminal involvement.
- A range of treatment options similar to those in the community, including maintenance and substitution options, with the same level of access as in the community.
- A range of interventions for substance misuse treatment, including psychosocial and pharmacological interventions as appropriate.
- High quality prevention programmes to reduce drug-related deaths both from overdose/toxicity and blood-borne viruses.
- A care or treatment plan based on the needs of the individual, which is regularly reviewed.
- Management of the care or treatment plan by a named individual.
- Support to maximise continuity of care, especially on release.
- Assessment of risks to dependant children for all substance misusing parents in relation to home visits and release.

3.2 Assessment

The assessment process begins at reception into prison custody, with reception screening for substance misuse, the purpose of which is to:

- Enquire about drug and alcohol misuse, and to screen for evidence of dependence in those who report current or recent use.
- Determine immediate healthcare needs, including withdrawal, for which there should be access to adequate and effective prescribing for management upon reception into local prison custody.

After **an initial assessment** including a risk assessment, clinicians should develop plans of care with offenders to address immediate concerns.

Assessing **risk** is an integral element in screening, triage assessment and comprehensive assessment. It provides information that will inform the care planning process. Risk assessments should include:

- risks associated with substance misuse (such as physical/mental health damage, acute toxicity/overdose);
- risk of self-harm or suicide;
- risk of harm to others (including child protection and other domestic violence, abusive and/or exploitative relationships, and harm to treatment staff);

- risk of harm from others (including domestic abuse); and
- risk of self-neglect.

When risks are identified, management plans will need to be developed and implemented to help mitigate immediate concerns.

If clinicians have concerns about the needs and safety of children of substance misusers or of vulnerable adults, local protocols must be followed.

A comprehensive assessment of the offender's needs and level of risk should begin during the **first night and induction** period so that appropriate care and support can be provided.

Rapid withdrawal from drugs can upset an individual's mental equilibrium, heightening their risk of impulsive self-destructive behaviour. An offender coming into custody with complex needs should, therefore, be provided with clinical treatment to stabilise their withdrawal from opioid or benzodiazepine dependence. Consideration should be given at this early stage to the indication for maintenance opioid substitution treatment.

A **comprehensive assessment** should include the following:

- treating any emergency or acute problem;
- confirming that the offender is misusing substances (history, examination and drug testing);
- assessing degree of dependence;
- identifying physical and mental health problems;
- identifying social problems, including housing, employment and domestic violence;
- assessing risk behaviour;
- determining the offender's expectations of treatment and desire to change; and
- determining the need for substitute medication.

The assessment process also provides an excellent opportunity for clinicians to provide brief interventions to reduce immediate harm from substance misuse. It is also important to assess the most appropriate level of expertise required to manage the individual's treatment (this may alter over time), and refer or liaise appropriately.

The assessment process should result in a written document that can be referred to and used as a basis for discussing care planning, goals and objectives with the offender.

Agreement on common 'standards' of screening, assessment and recording, is important in developing an integrated system of care in the prison setting.

Basic awareness training of assessments to custodial suite staff and escort staff can only add value to the care and attention of prisoners.

3.3 Care planning

Assessment provides information that will contribute to the development of a care plan, which meets agreed standards and should be agreed with the offender. It should normally cover their needs (and how these will be met) in one or more of the following domains; substance misuse, physical and psychological health, and offending. Ideally the care plan should be integrated with the Care Programme Approach (CPA), the Drug Intervention Record (DIR), and The Wales In-Depth Integrated Substance Misuse Assessment Toolkit (WIISMAT) specialist substance misuse assessment process for people using specialist, substance misuse treatment services.

The care plan should include the following:

- Setting the goals for treatment and milestones for achievement.
- Indicating interventions planned and by whom.
- Making explicit reference to risk management.
- Identifying information given to other professionals/agencies.
- Indicating the name of the key worker.
- Identify a review date.

As with substance misuse management in other settings, there is a need to integrate prescribing practice with psychological, medical and social interventions. This will require clinicians to have input from, or facilitate referral to, a range of other professionals. Integration with mental health and primary healthcare services is also very important to address the high levels of complex needs within the prison population.

3.4 Interventions - psychosocial

Treatment for substance misuse needs to include a psychological component. Psychosocial interventions are the mainstay of treatment for the misuse of cocaine and other stimulants, and for cannabis and hallucinogens.

Psychosocial interventions can be delivered alongside pharmacological interventions or alone, depending on assessed need and the goals of treatment. Discrete formal psychosocial interventions may be provided either for substance misuse problems, such as cocaine misuse, or to address common, associated or co-occurring mental health disorders such as depression or anxiety.

Key working is a basic delivery mechanism for a range of key components, including the review of care or treatment plans and goals, provision of drug-related advice and information, harm reduction interventions, and interventions to increase motivation and prevent relapse. Help to address social problems, such as housing and employment, is also important as part of throughcare and aftercare. Discrete formal psychosocial interventions may be provided in addition to keyworking. These should be targeted to addressing need.

Standards for psychological interventions for substance misuse have been issued by the Welsh Assembly Government. A structured care package of psychosocial support should be provided for offenders with substance misuse problems in order to:

- complement clinical interventions;
- take into account previous treatment in the community or custody; and
- provide a platform for longer-term substance misuse treatment in prison and on release.

Interventions that need to be available in the context of substance misuse include brief motivational interventions and mutual aid (self-help) approaches. A range of more intensive, structured psychosocial interventions may be required for offenders with high levels of dependence on substance(s), for those with recurrent problems, for those with complex needs and for those who may be more vulnerable. Psychological interventions should always be considered for offenders who are dependent on benzodiazepine. Evaluation of the approach, together with the training and support needed to support it, will be needed before it can be implemented

Offenders with significant drug misuse problems may be considered for a therapeutic community developed for the specific purpose of treating drug misuse within the prison environment. For those who have made an informed decision to remain abstinent after release from prison, residential treatment should be considered as part of an overall care plan.

It is worth denoting that offenders with an IQ less than 80 cannot be considered for a CBT programme and support services need to be cognisant of the need for CBT or other psychosocial interventions. This places a demand on commissioners to ensure these are catered for.

3.5 Interventions - pharmacological

3.5.1 Appropriate prescribing

In view of the potentially rapid onset of withdrawal effects in prison and a heightened risk of self-harm and suicide among substance misusers during the early days of custody, a clinical response to physical dependence is essential. Prescribing protocols may provide a solution to the clinical challenges presented by the prison environment.

As with practice in community services, non-medical prescribing should be encouraged and developed.

A decision to prescribe, what and how much to prescribe will depend on:

- the overall treatment plan for the individual;
- clinical guidelines;
- the clinician's experience and competencies;
- discussion with other members of a multidisciplinary team; and
- advice, where necessary, from a specialist in substance misuse.

In the context of prescribing, the *British National Formulary* (BNF), which is updated twice a year, is a key reference. The dosages stated in the Drug Misuse and Dependence: UK Guidelines on Clinical Management and in the BNF are intended for general guidance and represent, unless otherwise stated, the range of doses that are generally regarded as being suitable for prescribing, in the context of treating adults who have become dependant.

Offenders must be made fully aware of the risks of their medication. Prescribing arrangements should also aim to reduce risks, including accidental ingestion, to children and others in the context of home visits or release.

Clinicians should aim to optimise treatment interventions for offenders who are not benefiting from treatment, usually by providing additional and more intensive interventions (pharmacological and psychosocial) that may increase retention and improve outcomes. Treatment exits should be negotiable and revisited. In the event of relapse in prison, the clinician should explore the reasons for this with the service user, and discuss treatment options.

3.5.2 Opioids

Opioid substitution treatment

Where opioid misusers are received into prison having had their community dose continued in police custody, this treatment should be continued in prison, subject to regular review. Time spent in police and court custody often results in a break in offenders receiving substitute medication between the day of their arrest and their subsequent reception into prison.

Clinicians should seek to verify prescriptions and consumption with community services, the police or both, and use appropriate drug tests to verify the presence of opioids in the body. As offenders frequently arrive in prison in the evening, it may not be possible to secure this information during an initial assessment. Prescribing will therefore need to be circumspect enough to address the risks related to this absence of information.

Methadone or buprenorphine, used at the optimal dose range, are effective medicines for maintenance treatment. Buprenorphine and naloxone combination (Suboxone®) has been approved for restricted use within NHS Wales for the treatment for opioid dependence, interim to guidance from the National Institute for Health and Clinical Excellence (NICE) should it subsequently be published.

In the context of low availability of illicit drugs, offenders may stabilise on lower doses of opioid substitution treatments in prison, than they would in the community. However, clinicians should be prepared to use equivalent doses to those used in the community where needed, to a level that achieves appropriate clinical stability.

Prior to release, consideration should be given to reviewing the current dose of opioid substitute with the service user, to optimise their likely retention in treatment on return to the community. This may entail increasing the dose prior to release, in consultation with the community prescriber, and explaining to the service user why this is appropriate.

Where dose induction is clinically appropriate, the individual should be started on a suitable dose of opioid substitute and the dose optimised through titration. This should aim to achieve an effective dose while also exercising caution about the inherent risks of too rapid an increase.

Detoxification from opioids

People in prison should have the same treatment options for opioid detoxification as people in the community. Clinicians should take into account additional considerations specific to the prison setting, including:

- practical difficulties in assessing dependence and the associated risk of opioid toxicity early in treatment;
- length of sentence or remand period, and the possibility of unplanned release; and
- risks of self-harm, death or post-release overdose/toxicity.

Polydrug use is common among offenders entering custody. In cases of co-dependency on any combination of alcohol, opioids and benzodiazepines, more than one reduction regimen may be required, with additional caution necessary due to the interaction of these substances. Detoxification from more than one substance should not take place concurrently. When this is required, alcohol detoxification should usually be the initial priority.

Methadone, buprenorphine and lofexidine are all effective in detoxification regimens. Opioid detoxification, using the medication the individual has been maintained on, should be offered in an appropriate setting to those ready for and committed to abstinence.

When an opioid substitute is prescribed, a period of stabilisation over the first five days is advisable rather than an immediate reduction of the dose, because of the risk of self-harm and suicide in this period. There may also be an increased risk of suicide close to the end of, or just following, completion of a detoxification regimen.

Detoxification should be provided in association with psychosocial support, as part of a package which includes preparation and post-detoxification support to prevent relapse.

3.5.3 Alcohol

Offenders with an alcohol problem will need support particularly when the risk of withdrawal symptoms is high. Pharmacological interventions are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care. This usually involves detoxification followed by a range of psychosocial and pharmacological interventions as appropriate to prevent relapse. The standard treatments for alcohol dependence and misuse apply to those who also misuse other drugs.

Three classes of pharmacological treatments have been identified that are effective in the treatment of alcohol misusers:

- medicines for treating withdrawal symptoms during assisted alcohol withdrawal,
- medicines to promote abstinence or prevent relapse, including anti-craving agents and sensitising agents, and
- nutritional supplements, including vitamin supplements, as a harm reduction measure for heavy drinkers and high dose parenteral thiamine for the prevention and treatment of individuals with Wernicke's encephalopathy.

3.5.4 Benzodiazepines

Sudden cessation in benzodiazepine use in those who are dependent can lead to a recognised withdrawal state. However, there is little evidence to suggest that long-term substitute prescribing of benzodiazepines reduces the harm associated with benzodiazepine misuse.

Prescribing to assist withdrawal should only be initiated where there is clear evidence of benzodiazepine dependency from the service user's history, observed symptoms and drug testing.

If the service user is also receiving a long-term prescription of methadone for concomitant opioid dependency, the methadone dose should be kept stable throughout the benzodiazepine reduction period. Concurrent detoxification from both medicines is not recommended in community settings.

3.5.5 Stimulants

Clinicians will see stimulant users with a wide range of severity of problems. The mainstay of treatment is psychosocial and non-pharmacological. There are no effective pharmacological treatments to alleviate the effects of withdrawal from stimulants at present, including cocaine. Likewise, none have convincingly been demonstrated to be useful in promoting abstinence. Stimulant withdrawal should be treated according to clinical indications.

Emerging symptoms, such as depressed mood and insomnia, are likely to be short-lived and any prescribing for this should generally be short-term and reviewed before renewal. Offenders arriving in prison with a recent history of stimulant use should be observed during the first three days of custody for any sign of emerging acute physical or psychological problems. Offenders demonstrating symptoms of psychological distress should continue to be monitored and referred for mental health assessment if they are showing signs of psychosis or other serious mental health problems.

3.5.6 Supervised consumption

Supervised consumption should be available for all offenders for a length of time appropriate to their needs and risks. This is usually continued throughout the period of remand or prison sentence for opioid substitution treatment.

Additionally, benzodiazepines may be prescribed for supervised consumption to enhance control of diversion.

3.5.7 Preparing for release

Research on drug-related mortality amongst newly released male and female prisoners highlights that they are 29 and 69 times more likely, respectively, to die during the first week of release from prison, compared to males and females in the general population. Around 90% of these deaths were drug-related with opioids involved in almost 97% of them.

The principal objective in preparing a substance-misusing offender for release should be to prevent overdose/toxicity. Preventing relapse and facilitating continuation in treatment (if needed) or access to suitable aftercare provision or support are important in themselves and as a means of preventing overdose/toxicity. The following interventions can all help achieve these objectives.

Detoxified, formerly opioid-dependant individuals who are motivated to remain in a supportive care abstinence programme may start treatment with naltrexone prior to release from prison. However, naltrexone should be administered under supervision and its effectiveness in preventing opioid misuse reviewed regularly.

Prior to release some offenders request re-induction onto opioid substitution treatment. Re-induction should be considered for offenders who are about to leave prison and for whom there is a clearly identifiable risk of overdose/toxicity. Those with the most significant risk of death have a history of injecting opioid misuse immediately prior to custody, longstanding opioid dependence and polydrug dependence. They may also have a history of non-fatal overdose/toxicity. Re-induction may be offered after the individual has been offered and declined relapse prevention interventions, and once the implications of restarting opioid misuse have been explained.

Prescribing to promote abstinence or prevent relapse in alcohol dependence, including anti-craving agents and sensitising agents, may be started prior to release where appropriate.

Preparations for substance misuse treatment post-release, if required, should be planned wherever possible. Where release is unanticipated (when an offender is released following an order from the court, for instance, or where an individual leaves prison outside of standard working hours), clinicians should operate a contingency arrangement, which may involve making a direct referral to a community-based substance misuse treatment service.

In addition to a substance misuse treatment service referral, clinicians should attempt to secure GPs for offenders before they leave prison, advise both the substance misuse treatment provider and GP of discharge medicines and, if appropriate, the need to quickly take over prescribing.

3.6 Preventing substance-related deaths

3.6.1 Overdose/toxicity prevention

All prisons should have an emergency protocol in place that covers the management of substance-related overdose/toxicity.

Substance-related deaths are high in the first weeks following release from prison. Reduced/loss of tolerance is considered to be a significant risk factor.

Fatal overdose/toxicity often involves the use of opioids alone or in combination with other respiratory depressants such as alcohol and/or benzodiazepines. Likewise, alcohol alone or in combination also has a significant role in substance-related overdose/toxicity.

Retaining service users in high quality treatment protects against overdose/toxicity. This protection may be enhanced by other interventions including training substance misusers in the risks of overdose/toxicity, its prevention and how to respond in an emergency.

3.6.2 Naloxone

Naloxone is an opioid antagonist which temporarily reverses the effects of opioids such as heroin and methadone. Its use as part of a package of overdose/toxicity prevention measures is established practice in some parts of the UK. A number of demonstration sites are being established in community and prison settings in Wales to provide training on overdose/toxicity management and naloxone provision to opioid users and their family/carers if appropriate.

The prison sites will issue naloxone to offenders who are assessed as being at risk of overdose on release from prison. Where offenders are released from prison without an assessment or if they need to have their initial supply replaced, they can visit a demonstration site in the community. We will learn the lessons from the demonstration sites and consideration will be given to rolling out the provision as appropriate.

3.6.3 Blood-borne viruses

The general principles in relation to blood-borne viruses and other infections apply equally to prisons. Many offenders in prison are at particular risk of blood-borne viral infections not only due to injecting drug use prior to prison, but also due to the risks of ongoing transmission whilst in prison, such as sharing injecting equipment and paraphernalia, unprotected sex and tattooing.

Prisons need to have high quality programmes of harm reduction prevention interventions in place. Reducing potential harm due to overdose, blood-borne viruses and other infections should be a part of care for all offenders in prison.

At present, policy for prisons in England and Wales is not to introduce needle exchange where security remains of paramount importance. Although provision of disinfectant tablets has been introduced, there is some conditional international evidence to suggest that it may not be particularly effective. There is good international evidence that it is possible to provide a range of harm reduction measures, including needle exchange, within a custodial setting. The emerging evidence base needs to be taken into account in determining best practice.

Prison presents an opportunity and a challenge to address a wide range of clinical needs of substance misusers, especially harm reduction interventions such as hepatitis B vaccination and hepatitis C treatment.

As stated in the Immunisation against Infectious Disease guidelines The Green Book, all high risk drug misusers should be offered vaccination against hepatitis B, and against hepatitis A, where indicated. Hepatitis B vaccinations should be completed (on a super-accelerated schedule). This should include information on how individuals can complete vaccination and receive a booster in the community, if released before completion.

All drug misusers should be offered testing, and if required, treatment for hepatitis C, and human immunodeficiency virus infections.

3.7 Co-occurring substance misuse and mental health problems

It is common for those with substance misuse problems to also have other mental health difficulties. Interventions for the mental health problems may also need to be provided in the prison setting. An integrated approach is recognised as being the best way of managing people with complex needs. This involves consultation between the CARAT, clinical substance misuse, primary healthcare and mental health teams.

Those with severe mental health problems should have high quality care integrated with mental health services. Details of any planned care provided by the patient's community mental health team and substance misuse services prior to custody should be established. The offender's informed wishes and the advice of community providers should be taken into account when clinical substance misuse care is planned in the prison setting. If detoxification is the preferred action, then a gradual reduction programme should be provided.

Whilst in prison, where there is less ready access to illicit drugs, an offender's mental state may appear to be relatively stable. The release care plan needs to take into account the previous history of substance misuse, as the offender may return to substance misuse upon release. Similarly, a previous history of substance misuse must also be considered when an offender is transferred to another prison.

3.8 Tobacco

Smoking-related diseases are highly prevalent in substance misusers. Dependent tobacco smokers are likely to gain significant health benefits from quitting. Evidence suggests that help with smoking cessation may be associated with improved drug treatment outcomes. Changes in societal attitudes and the smoking ban that was introduced in Wales in April 2007 may increase the demand for treatment for tobacco dependence generally. Offenders with substance misuse problems who smoke tobacco should be offered smoking cessation interventions.

3.9 Offenders with a learning disability

Offenders with both a learning disability and a substance misuse problem have particular requirements. These are essentially around issues associated with communication. It is important that prison staff are aware of their particular needs and that programmes and interventions are delivered around accepted good practice. Contact with specialist learning disability services and professionals are an important part of this approach.

4. Release and resettlement programmes

4.1 Good practice in release/resettlement programmes

With regards to good practice in substance misuse treatment following release, evidence indicates that:

- On entry into custody or 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.
- Effective links between prison and community services are vital and the use of a common client record, care plan and collaborative care planning will facilitate this.
- Protocols should be developed between prisons and aftercare services to deal with early, unanticipated, and Friday releases.
- Aftercare clients appear more willing to engage with services when a persistent and non judgemental approach is adopted by staff. Regular contact with potential clients in institutions is likely to result in higher levels of engagement.
- Routine meeting of clients at the prison gate will help ensure that they are, and remain, in contact with services.
- Agencies should be flexible, both in terms of their conditions for accepting clients, and the amount of time for which support is offered
- Wherever possible, community based treatment services should carry out a post release care plan for those held in custody, ideally prior to release. This process should include the securing of continued prescribing at an appropriate clinical level.
- Working relationships between Transitional Support Services (TSS) and prison staff need to be good to facilitate referrals.
- Peer mentors and a 24-hour point of contact are highly valued by clients, even if the latter is rarely used.
- Aftercare staff require clear guidance/training regarding the signs or features of high-risk situations and characteristics that predispose their clients to relapse, to overdose (deliberately or semi-deliberately), and to return to crime.
- It is worth acknowledging that the Probation Service also offers alcohol treatment programmes delivered in a community setting.

Main types of community-based drug provision in England and Wales

Type of Provision	Evidence/Evaluation
<p>Testing on arrest to identify heroin, crack and cocaine users following arrest for acquisitive crimes.</p>	<p>There is no evidence on the effectiveness of testing either as a stand alone form of routine monitoring or in provided added value when used in combination with treatment interventions.</p> <p>‘Tough Choices’ which introduced testing on arrest and mandatory assessment has increased the numbers being tested and engaging in treatment (Type IV evidence).</p> <p>There is some evidence that suggests the effectiveness of drug testing on arrest for identifying problem drug using offenders not in contact with services may be eroded over time. (Type V evidence).</p>
<p>Mandatory assessments following a positive test which may lead to a referral to drug treatment services. It is an offence to refuse the assessment but not the treatment.</p>	<p>Introduction of mandatory assessments following a positive drug test on arrest has improved the rates of participation in assessment.(Type IV evidence).</p>
<p>Arrest referral involves specialist workers seeing detainees in police custody suites, and increasingly in court to provide information and, where appropriate, referral to treatment or other means of assistance.</p>	<p>Arrest referral (in areas where there is no testing) has been showed to be successful in identifying and engaging drug users in treatment. (Type IV evidence) Currently there are no published evaluations that compare the effectiveness and value for money of approaches for identifying problem drug using offenders in custody suites.</p>
<p>Criminal Justice Integrated Teams (CJITs) are the core of the DIP. They case manage offenders over 18 and coordinate services and agencies.</p>	<p>A national evaluation (undertaken before the introduction of mandatory drug testing) reported significant reductions in drug use and offending amongst those taken on to CJIT caseloads (Type IV evidence).</p>
<p>Restrictions on Bail (RoB) following a positive test allows for drug treatment to be a condition of court bail.</p>	<p>Evaluation of pilots in three English sites concluded that the impact on illicit drug use and offending was unclear but there were some positive findings in terms of compliance and treatment engagement (Type IV evidence).</p>

Type of Provision	Evidence/Evaluation
<p>Prolific and other priority offender programme aims to target resources at offenders in the community with six or more convictions in the previous 12 months.</p>	<p>Evaluation of the scheme showed a 43% reduction in offending comparing the total number of convictions in the 17 months before and the 17 months after the programme implementation (Type IV evidence).</p>
<p>Conditional cautioning allows for a condition conducive to rehabilitation, which can include drug treatment, to be a condition of a police caution, with prosecution for the original offence possible if the offender does not comply.</p>	<p>An assessment of the early stages of implementation showed that the use of conditional cautions varied widely between areas. Of those given a conditional caution about a fifth had some sort of drug referral condition. About a quarter of those given a conditional cautions failed to comply with some aspects of this and were prosecuted.</p>
<p>Drug Treatment and Testing Orders (DTTOs) and now Drug Rehabilitation Requirements (DRRs) are community sentences which result in sanctions if the requirements are not met.</p>	<p>To date no evaluation of DRR has been published but a report on the impact of DTTOs on offending was published by the Home Office in 2003. This report was based on 210 offenders followed up for 2 years after the start of the order.</p> <ul style="list-style-type: none"> ▪ Data were only available on 174 offenders, of these 80% had been reconvicted within 2 years. ▪ Completion rates for DTTOs were low. Outcome information was available for 161 offenders, 30% finished their orders successfully, 67% had their orders revoked. ▪ There was a statistically significant difference in offending between those who completed their orders (53%) and those whose orders were revoked (91%). ▪ 44% of offenders in England and Wales who started DRR/DTTO in 2006/2007 completed compared with 28% of those who started in 2003 (Type IV evidence).
<p>The Offender Substance Abuse Programme (OASP) and Addressing Substance Related Offending (ASRO) are accredited behaviour-change programmes, sometimes attached to community orders. P-ASRO is a prison based version of ASRO.</p>	<p>There is no published evidence assessing OASP, ASRO and P-ASRO, however these programmes are accredited The Joint Prison Probation Accreditation Panel.</p>

Type of Provision	Evidence/Evaluation
Drug courts and similar community justice courts have been piloted. They build on DTTOs and DRRs by providing continuity of sentence for the review process and use a problem-solving and inter-agency approach to help address the causes of offending.	Good international evidence base. Evaluation of the drug court pilots in Scotland found that a sizable proportion of clients made subject to Drug Court Orders were able to achieve and sustain reductions in drug use and associated offending behaviour. (Type IV evidence)

Type I evidence (strongest evidence): at least one good systematic review (including at least one randomised controlled trial).

Type II evidence: at least one good randomised controlled trial.

Type III evidence: well designed interventional studies without randomisation.

Type IV evidence: well designed observational studies.

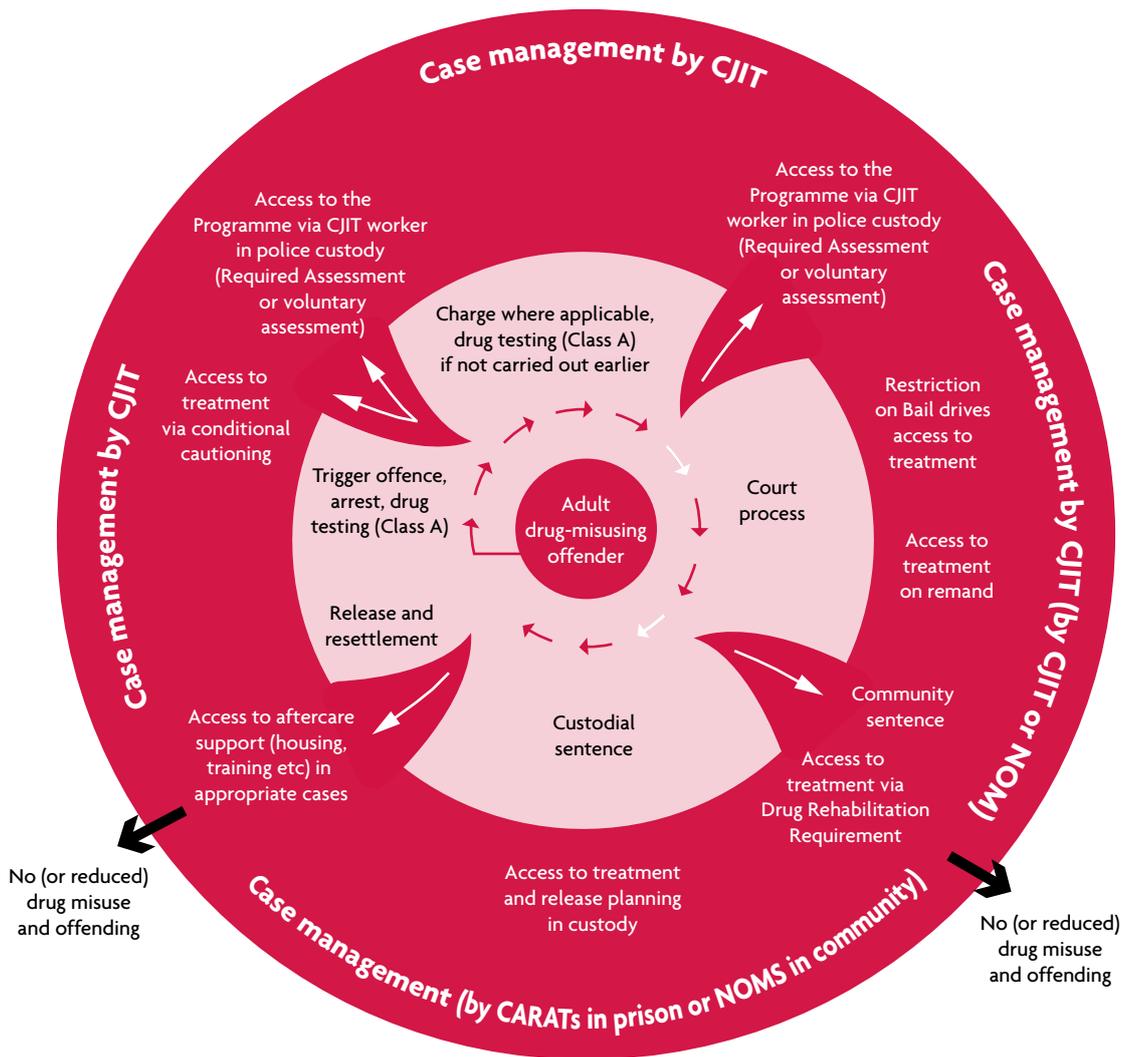
Type V evidence (weakest evidence): expert opinion; influential reports and studies.

Source: Barker J, Weightman A L, Lancaster J. Project for the enhancement of the Welsh Protocols for Health Gain: project methodology 2. Cardiff: Duthie Library; 1997.

Figure 1: Interventions for problem drug-using offenders within the criminal justice system - community-based provision

Processes to identify drug users for interventions	Interventions to promote engagement with treatment and other services (or maintain drug-free status)	Interventions addressing substance use and/or offending
<p>Drug testing and mandatory assessment</p> <p>Arrest Referral</p> <p>Court-based assessments</p>	<p>Criminal justice interventions team (CJIT) case-management</p> <p>Prolific and other priority offender (PPO) programme</p> <p>Restrictions on Bail (RoB)</p> <p>Conditional cautioning</p> <p>Diversion from prosecution</p> <p>Probation orders with drug treatment conditions</p> <p>Drug Rehabilitation Requirements (DRRs)</p> <p>Drug Courts and Community Justice Courts</p> <p>Intervention Orders</p> <p>Drug testing and other drug-related conditions on release on licence</p>	<p>Addressing Substance Related Offending (ASRO)</p> <p>Offender Substance Abuse Programme (OASP)</p>

Figure 3: How the DIP programme works at all stages of the CJS



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Glossary

Arrest referral service	Arrest referral workers operate in police stations and interview arrestees to identify those with a drug problem for onward referral to other agencies.
CARAT	Counselling, Assessment, Referral, Advice and Throughcare teams operate within prisons. They undertake assessments of the need for drug services and provide one-to-one motivational support and group work for problem drug users. They also provide case management facilitating access to a wider range of services both in custody and on initial release.
CJIT	Criminal Justice Integrated Teams are community based and assess offenders who test positive. They provide case management, referring offenders to treatment and organising the provision of other support such as housing and employment services.
DIP Drug Interventions	Programme provides a range of interventions aimed at getting problem drug-using offenders into treatment and other support.
TSS	The Transitional Support Service aims to provide 'through the gate' mentoring and support for short sentence prisoners (usually less than 12 months sentence) for up to 12 weeks following their release. The service is designed to address the practical resettlement needs of those with on-going substance misuse problems. The primary focus is on increasing access to drug treatment but the scheme also addresses problems that may lead to re-offending, such as homelessness, relationship difficulties, finance, low educational attainment and unemployment.
NOMS	The National Offender Management Service is responsible for overseeing the management of offenders in prison and in the community. NOMS uses the concept of the 'end-to-end management' of offenders. A single offender manager will supervise each offender throughout their contact with the Criminal Justice System (CJS), and draw on an appropriate range of services provided by agencies from all sectors.