Prisoners Aftercare in Europe: A Four Countries Study

By
Anne Fox

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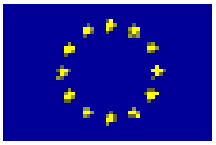

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To order a copy, please contact:

ENDSP
Cranstoun Drug Services
4th Floor Broadway House
112-134 The Broadway
Wimbledon
London SW19 1RL
United Kingdom

Tel: +44-20-85438333
Fax: +44-20-85434348

Email: euronet@cranstoun.org.uk

Web site: http://www.cranstoun.org/

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This report was prepared for Cranstoun Drug Services
By

Galahad SMS Ltd:

Specialists in drug and alcohol research, policy, education, evaluation, testing			
Anne Fox Director	**Colin Brodie, Sarah Marsh** Research assistants	**Liz Fox** Editorial consultant	**Tim Saunders, MBE** Consultant

Unit 6, Brook House Yard
Brook Hill
Oxted, Surrey
RH8 9LR
UK: +44 (0)1883 712 401

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"The day you are released from prison is the day your problems start."
Richard Göransson. KrAMI, Stockholm

"It's just one big vicious circle due to the fact that there isn't any aftercare: some come in drug addicts and go out clean, some come in clean and end up on drugs in jail, but mostly everybody I know goes back to drugs and ends up back in jail."
John, 29. Prisoner, HM Prison Barlinnie, Glasgow

"What we have here are prisoners serving life sentences … in instalments."
Mick Stoney, Unit Manager, HM Prison Barlinnie, Glasgow

"Special care for addicted criminals is primarily a question of humanity. Drug addicts have no responsibility for the drug politics that cause their problems directly or indirectly."
Arie van den Hurk.
Association of addiction treatment and care centres, Netherlands

"It has been proven, time and again, that punishment cannot heal a drug addict."
Dr Gerhard Litzka, Austrian Federal Ministry for Justice

"People should be sent to prison as punishment, not for punishment**.**

There is no direct relationship between prison and aftercare: the direct relationship is between the drugs worker in prison and aftercare."
Arie van den Hurk.

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PART 1: Background

1.1 Purpose

The purpose of this study was to identify and describe examples of best practice in prisoner aftercare in several European countries. Our overall aim is to broaden the European perspective on the treatment of drug-dependent prisoners upon release. It is too often assumed that existing paradigms are the result of wisely guided evolution – that traditional measures of punishment and rehabilitation are, by virtue of their longevity, the only way. It is hoped that by initiating this process of cross-cultural comparisons, more countries will be encouraged to research alternatives within their own systems.

1.2 Methodology

This report is based on information-gathering trips designed to produce a 'snapshot' of the aftercare systems and provision in four countries: Austria, Sweden, the Netherlands, and Scotland. The intention was to gain a better picture of the overall philosophy and practice of aftercare in each location, not the complete national picture. Many of the problems inherent in each country may not be evident in this report, as the researcher was shown examples of best practice.

In Austria, Sweden and the Netherlands, research visits were hosted by key figures within the Ministry of Justice, the prison and probation services and the key drug treatment agencies responsible for prisoners. Interviews were conducted with:

- Ministry of Justice officials
- Prison officials
- Probation officers
- Drug treatment agency workers
- Social workers

Wherever possible, the researcher conducted interviews with prisoners or clients in rehabilitation centres. Unfortunately, both access and language often presented barriers to obtaining these personal views.

In Scotland, where time, access and language were less of a problem, the research focused exclusively on Barlinnie prison in Glasgow (Scotland's largest prison). Individual semi-structured interviews were conducted with 16 prisoners, and questionnaires on experiences with aftercare were distributed to a further 80. Other key staff such as social workers and prison drug workers were also consulted.

1.3 Terminology

The terminology used in this report reflects the language used by the people who took part in the research. We have tried to be consistent wherever possible, but variations in expressions, titles, designations etc., may be apparent. For example, one country may refer to *inmates*, another to *prisoners*; one may use *therapists*, another may employ equally qualified *counsellors*. In England and Wales, the term *addict* is avoided in favour of *problematic drug-user*; but other countries still speak of addicts. In Scotland, most prisoners referred to prison staff as *guards*, but, as we found out, *prison officers* find this insulting. Any other such mis-appelation in this report that causes offence is unintentional.

1.4 Definition of aftercare

In this report we will use as a working definition of aftercare:

Any drug rehabilitation and/or social re-integration scheme or programme that actively assists prisoners after release from prison or during a staged release.

Part 2: Summary

2.1 Key Findings

• Aftercare for drug-using prisoners significantly decreases recidivism and relapse rates, and saves lives.
• Inter-agency co-operation is essential for effective aftercare. Prisons, probation services, drug treatment agencies, health, employment and social welfare services must join forces to put the varied needs of the drug-using offender first.
• Drug treatment workers must have access to prisoners during their sentence in order to encourage participation in treatment and plan for release.
• Short-sentence prisoners are worst placed to receive aftercare and most likely to re-offend. These prisoners need to be 'fast-tracked' into release planning and encouraged into treatment.
• Ex-offenders need choice and variety in aftercare. There is no 'one size fits all' in drug treatment.
• Aftercare that is built-in to the last portion of a sentence appears to increase motivation and uptake.
• In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend.
• Holistic aftercare treatment programmes that address all forms of addictive and criminal behaviour may achieve better long-term results than those focusing exclusively on drug use.

2.2 Executive Summary

1. Repeat offenders can end up in and out of prison so often that it becomes a way of life. In the four countries visited, many solutions were offered to facilitate a drug-using offender's re-integration into society and to reduce the incidence of recidivism and relapse. Rehabilitation efforts occur at different points of contact with the criminal justice system: on

entry to the system; in prison; or at the exit points. Most countries employed one of the following:

- Alternative sentence programmes: avoidance of incarceration altogether through 'coercive' sentencing involving treatment at rehabilitation facilities or other community-based programmes.
- In-prison treatment programmes: most focused on drug-free units, group therapy and drug testing
- Alternate release programmes: staged-release programmes from drug-free prison units, or completion of a sentence in an external drug treatment facility.

Only in the Netherlands were all possible solutions integrated into a coherent throughcare system.

2. Chronic recidivism among drug users is a problem in all countries. These persistent offenders are most likely to receive short sentences and therefore least likely to address their problems and behaviours. It is not unusual to find prisoners under 30 years old who have had more than 50 arrests in their lifetime. In one prison these offenders are seen as "serving a life sentence in instalments"; in another they were called "carousel prisoners" — always coming around again. This target group should be given high priority for treatment. There is a need for evaluations of experimental 'coercive' treatment for these offenders. More research is needed into alternative solutions.

3. In all countries, discord between government departments over responsibility for the drug-using prisoner after release can be a major stumbling block to successful rehabilitation. Co-ordination between government departments and inter-agency co-operation were the common denominators of all successful aftercare programmes.

4. In some countries, rehabilitative efforts were hindered by a conflict of interest between the criminal justice system, whose agenda is mainly punitive, and the medical and treatment services, whose agenda is rehabilitative.

5. Hard evidence of programme or policy effectiveness is lacking in many countries. There is a need for thorough, professional evaluation of rehabilitation and aftercare programmes. In the past, evaluations have mainly focused on the outcome of programmes, giving little concern to the manner in which the programme was implemented. Many apparent failures have more to do with practice than design, but drug policy and

rehabilitation theories are still generated based on the results of inadequate evaluations of improperly implemented programmes.

6. In all countries we found exemplary efforts to re-integrate drug-using prisoners into society. The most apparently successful programmes offered job training and placement coupled with housing and financial assistance. Examples include the Wobes programme in Vienna and the KrAMI organisation in Stockholm.

7. Other innovative programmes exploit community good will. The foster family and lay supervisor schemes in Sweden allow communities and individuals to assist released prisoners with societal re-adjustment. In Vienna, the efforts of volunteer psychology students allow more prisoners to benefit from one-on-one counselling.

8. 'Motivation to change' is seen as a pre-requisite for placement on drug treatment services in most countries. Only in the Netherlands did we find programmes designed to increase motivation among prisoners whose long-term problematic drug use or past failures have made them appear 'unmotivated'. In many places, over-emphasis on the importance of 'motivation' resulted in the exclusion of the most needy in favour of those deemed easiest to rehabilitate.

9. The Swedish and Dutch models of throughcare that allow the prisoner to serve the last portion of the sentence in an external treatment facility appear to work best to ensure that prisoners with drug problems have some form of treatment and life management assistance before final release.

10. In all countries, continuity and consistency of medical care and drug treatment before, during and after prison was seen as vital to rehabilitation and relapse prevention.

11. Unless they are directly funded by the criminal justice system, many drug treatment agencies often give prisoners or ex-offenders low priority on waiting lists, reasoning that their first duty is to non-offenders. In the Netherlands this problem has been addressed by giving the drug treatment agencies a probation task that is partly funded by the Ministry of Justice.

Part 3: The importance of Aftercare

Aftercare for drug-using prisoners is important for several reasons:

1. To maintain gains made by in-prison drug treatment.
2. To reduce the incidence of relapse.
3. To reduce the post-release risk of death by overdose.
4. To break the cycle of drug use and offending behaviour.
5. To provide prisoners with the social and practical skills necessary to survive on the outside without resorting to drugs or crime.
6. To assist released prisoners in obtaining housing, employment, welfare assistance, and appropriate medical care.

3.1. Aftercare reduces crime

In the last few years, the connection between drugs and crime has become increasingly apparent. While the causal relationship is still open to debate, the outcome is clear: drug users have more frequent contact with the criminal justice system than any other group of offenders and, as a group, commit more frequent crimes.[1] The cost of these crimes is disproportionate to the number of offenders. Estimates suggest that in the city of Glasgow, 8,500 heroin injectors steal around £200 million worth of property annually.[2]

To reduce crime, aftercare should seek to meet a released prisoner's basic needs. Prisoners who are released into the community without adequate housing, financial, or medical support are at an increased risk of illness or death and more likely to re-offend. According to a recent report by NACRO:

> *"Prisoners released homeless are two and a half times more likely to re-offend than those with homes to go to. Those who get and keep a job are less than half as likely to re-offend as unemployed ex-prisoners. Drug-addicted ex-prisoners who stay on drugs commit five times more offences than those who get help to tackle their addiction."*[3]

According to at several studies, a prison sentence, far from being a deterrent to further drug use and crime, may actually increase the chances that an

[1] Ibid...
[2] Scottish Executive, (2000) *Drugs Action Plan*.
[3] NACRO (October 2000).

individual will re-offend.[4] Research with offenders in Kent revealed that a previous prison sentence doubles the chances of re-offending.[5]

Governments across Europe are tackling these problems, both with attempts to divert drug users from the criminal justice system altogether and with programmes to treat drug use during a prison sentence. Certainly, these are the first steps towards a solution, but, in many places, the third leg of the stool – aftercare – is missing.

3.2 "Campaign effect"

The gains made by intensive in-prison therapy can be undone if the prisoner is then released into 'real life' with no aftercare support. C. Åke Farbring of the Swedish Ministry of Justice explained that prisoners' apparent motivation to change can fizzle out once the 'campaign' to help them ceases. Efforts at re-socialisation and rehabilitation must take into account the environment into which the prisoner is to be released. As Mr Farbring explains:

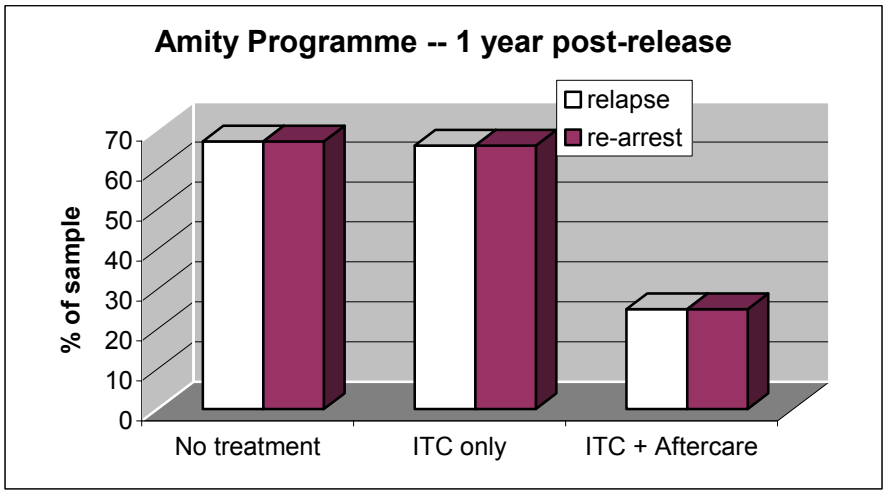
> *"Multimodality ... has also been a major theoretical underpinning* [of aftercare in Sweden]. *Change is not easy, and if it is not correlated with whole sets of attitudes, family network and friends, feelings and social arrangements, it is likely to disappear once the 'campaign effect' is over."*

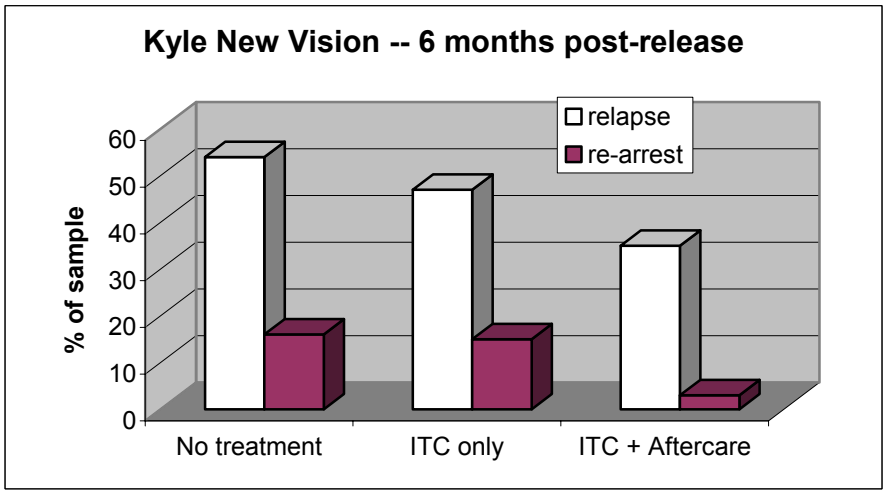
3.3 Measures of effectiveness

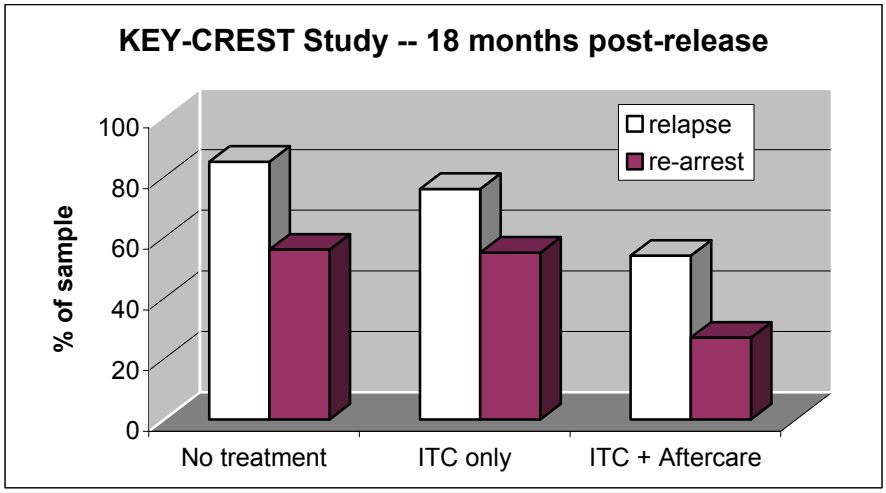
Studies support the above concept that in-prison efforts prove ineffective if not followed up by appropriate aftercare. Research in the USA shows that recidivism and relapse rates for released prisoners who have had in-prison treatment for drug misuse are only slightly lower than for control groups that have had no treatment at all. But prisoners who complete both in-prison treatment programmes *and* who attend residential aftercare programmes have significantly lower rates of drug use and re-arrest. [6] One recent report evaluates three pioneering programmes in the US: The Key-Crest plan; The Amity programme; and the Kyle New Vision programme. Outcome evaluations of these programmes have yielded consistent results.[7]

[4] Coid et al.. (2000)
[5] Kent Probation Service (1996).
[6] Inciardi , J. et al (1997)
[7] Hiller, M.L. et al. (1999)

The charts below illustrate the rates of relapse into drug use or crime by participants in these studies who received one of three treatment options: (1) no treatment, (2) in-prison therapeutic community (ITC) only, or (3) in-prison therapeutic community followed by a residential aftercare programme.







It is clear that prison-based treatment alone yields results only marginally better than no treatment at all, whereas prison treatment followed by effective aftercare significantly reduces the incidence of relapse and re-arrest.

The authors of the study concluded that:

> *"Effective in-prison treatment appears to require a continuum of care that takes the drug-involved offender from the institutional environment to the reintegrative processes of community-based initiatives. ... Only by providing quality aftercare following prison-based treatment will the impact of this programming be optimally realized."*

3.4 Aftercare saves lives

Another sound reason for providing effective aftercare is to reduce the risk of death by overdose among released prisoners. Statistics gathered over the last ten years demonstrate that this risk is significantly higher during the first two weeks after release.[8] Why? During their incarceration many heroin users may either stop using, or they may maintain their addiction with lower-quality product. Either way, their tolerance to the drug is reduced. After release, an injection of what they consider a normal dose may kill them. This problem is particularly apparent in Scotland, where more drug-dependent prisoners die during the first few weeks after release than at any other time. During 1996-1998, prisoners who had been out for less than three weeks accounted for 21% of all drug-related deaths in Glasgow.[9]

[8] Seaman et al *BMJ* Feb 1998
[9] H.M. Prison Barlinnie. Tackling drugs together in Barlinnie.

In Europe, the UK has one of the highest rates of non-intentional drug-related deaths (involving opiates, cocaine and other stimulants and hallucinogens); the Netherlands has one of the lowest.[10]

A recent study by Joanne Neale of the Centre for Drug Misuse Research at the University of Glasgow challenged the view that most overdose cases are unintentional. Seventy-seven drug users who had experienced drug overdoses were interviewed at six hospital accident and emergency departments over a two-year period. Nearly half of all patients (49%) reported having suicidal thoughts or feelings prior to overdosing. However, it would appear that previous release from prison still plays a part in intentional or accidental overdose. Overall, 80% of those in the sample had been imprisoned at some point in their lives. Among those in the sample who had overdosed intentionally, 27% had been released from prison in the previous month; among those who had overdosed accidentally, with no intention of suicide, 41% had been released from prison in the previous month.[11]

Statistics on post-release drug-related deaths were not readily available in other countries, but anecdotal evidence seemed to confirm that dangerous drug-use post-release is an international problem. For example, one female prisoner in Vienna's Favoriten prison emphasised the danger inherent in leaving prison:

> *"One month after release is the most dangerous time. In Vienna it is difficult to avoid having a relapse in those four weeks. It is very dangerous getting used to life on the outside. This time is very dangerous for drug users."* — 'Marie', 26, Favoriten prison.

[10] EMCDDA (2000)
[11] Neale, J *Addiction* (2000)

Part 4: Aftercare design: 4-country overview

4.1 Making comparisons

Treatment goals and modalities for drug-using prisoners differed between countries. All countries studied – now including the UK, with the Drug Treatment and Testing Orders (DTTOs) – have legally-enshrined measures to offer treatment as an alternative to imprisonment for drug-using offenders.

In terms of aftercare, it is important to remember that the profile of drug-using prisoners coming out of prisons in Austria, Sweden and the Netherlands is not a perfect match to the type of person released from prisons in other countries for the following reasons:

1. Different offenders in, different offenders out: in the countries studied other than Scotland, a drug user who has committed a petty crime, or is in possession of small quantities of even Class A drugs, is unlikely to receive a prison sentence. In a sense, he will receive his 'aftercare' first, by being sent to a residential, or out-patient treatment facility. Those being released from prison are more likely to have committed more serious crimes, or to be persistent re-offenders.

2. Availability of in-prison treatment: in the other countries, most forms of addiction treatment are available to the prisoner serving in a detention facility, so it is far more likely that he or she will have overcome the addiction during the sentence.

3. Long and slow approach to re-integration: the re-socialisation process offered by Favoriten prison in Austria, Österåker prison in Sweden, and prisons in the Netherlands ensures that the drug-using prisoner is given every possible assistance to find housing and a job before the end of his sentence, as well as to cease or reduce his drug use.

4. Mental state on release. Because in-prison conditions vary from country to country, the psychological needs of released prisoners also differ. In Sweden's Österåker prison, for example, prisoners felt that, apart from the stress inherent in being denied their freedom, they did not feel badly or unjustly

treated. In Barlinnie prison in Glasgow, by contrast, prisoners spoke of living with fear, humiliation, sickness and depression. Aftercare must address not only the side-effects of drugs, but the side-effects of prison itself.

4.2 Aftercare models

Three basic models of aftercare were identified in the four countries studied:

1. ***Mandatory aftercare***: treatment that is built in to a sentence. Some considered this part of a comprehensive *throughcare* package.
2. ***Coerced aftercare***: treatment that is offered with some incentive, such as early release.
3. ***Voluntary aftercare***: treatment that is available after release for self-referral by the prisoner.

In all countries visited, what throughcare there is usually occurs in three separate stages: alternatives to prison, in-prison treatment, and aftercare. With the exception of the Netherlands, it is most common for services in each stage to be provided by different agencies.

4.2.1 Mandatory aftercare

In general, the Netherlands, Sweden and Austria view aftercare as 'built-in' to an offender's sentence – that is, the prisoner receives continued care in a staged release programme. In the Netherlands and Sweden, prisoners also have the option of serving the last part of their sentence in a residential drug-treatment facility. Prisoners in Austria professed a desire for this option to become available to them as well.

4.2.2 Coerced aftercare

Leverage or coercion is often necessary to ensure prisoner participation in aftercare programmes. The Dutch and Swedish models, that allow a prisoner to spend the last phase of a sentence in a rehabilitation facility, appear to be more successful than the UK system, that expects prisoners to identify and arrange their own treatment (sometimes with assistance), and to proceed to it voluntarily after completion of the sentence. The Scandinavian model still relies on the prisoner's voluntary decision – he or she has the right to refuse and finish the sentence behind bars – but obviously, most prisoners accept the treatment option.

Most prisoners felt that it was unrealistic to expect them to organise and pursue their own aftercare. In prison, individuals with drug problems rarely have either the motivation or the organisational skills to chart their own course through the myriad of options and paperwork. Once released, most have other priorities. One prisoner from Barlinnie who has had over 20 sentences, described the illusions most of his peers harbour:

> *"They think they've got the master plan in their head: when they get out they'll get a job, settle down, stop taking drugs, stop stealing and breaking the law, stay out of jail. They live in a fantasy world: everything is going to be brilliant. I've had that plan I don't know how many times and I'm beginning to realise it never happens. … the minute you get thrown out the door you're back in reality."*
> — Anthony, 30, Barlinnie prison

A comparison between Scotland and the other countries visited makes it evident that a certain amount of coercion or extra incentive *is* necessary to get prisoners to enrol in treatment programmes after release. The statistics from Barlinnie prison show that of the small minority who do make appointments with community agencies, only 10% follow through after release.[12] By comparison, in Sweden and the Netherlands among prisoners who are offered the chance to undergo final phase treatment, the take-up and completion rates were reported to be very high.

Many prisoners in Barlinnie seemed genuinely committed and motivated to overcoming their problems; they just couldn't see doing it *in prison*. Some reasoned that prison is a different world, a time warp, and that whatever they did in prison had no bearing on the way they would conduct their life once released. Some applied to be in the drug-free units, not with the intention of achieving permanent abstinence, but merely to have a healthy break from drug use before returning to the life outside.

These attitudes make clear the need for aftercare that is both integrated into the sentence and continues beyond the point of release.

4.2.3 Voluntary aftercare

In all countries, released prisoners who are not under judicial treatment orders can still find sources of help for drug use.

[12] H.M.Prison, Barlinnie *Tackling Drugs Together in Barlinnie*

In Vienna, the main source of help is Ganslwirt, a 24-hour service offering medical care, needle exchange, counselling and crisis support. 50% of Ganslwirt's clients have past prison experience.

In the Netherlands, there are central agencies in every major town for drug users to obtain advice, support and medical assistance.

In Sweden, there appear to be fewer low-threshold outreach agencies than in other countries. This is mainly due to the criminalisation of drug use in this country and the official discouragement of harm-minimisation strategies. There are no visible street-level services or publicised help lines. Voluntary aftercare for prisoners is available through ex-prisoner organisations, Narcotics Anonymous, or other religiously affiliated groups, all of which focus on abstinence. One prisoner thought that the only option for drug users outside of prison was "going to social welfare where they put you in the hospital for crazy people." When asked what they would do if they needed further help after release, all Swedish prisoners interviewed said they would contact a psychologist they had seen while in prison, or get back in touch with the probation service.

Scotland has a myriad of services to assist drug users after release. Most prisoners could name at least one source of help in their home area. The most popular seemed to be those that gave assistance with practical matters and that doubled as gyms or social centres.

4.2.4 Throughcare

The concept of 'throughcare' – continuous assessment and assistance from the first contact with the criminal justice – is best developed in the Netherlands, where probation for drug users is operated by the drug treatment agencies, who operate 'intramural' drug services (within the prison), and 'extramural' drug probation (after the prisoner's release). Kerstin Lindblom, a Swedish probation officer who has visited her Dutch counterparts in Amsterdam, marvelled at "the power the Dutch probation officers have to deliver treatment."

Arie van den Hurk of GGZN (Association of addiction treatment and care centres, Netherlands) was keen to emphasise that this relationship between treatment provider and prisoner is the key to successful aftercare:

> *"There is no direct relationship between prison and aftercare: the direct relationship is between the drug worker in prison and aftercare."*

In the Netherlands, aftercare is an integral part of the prison sentence managed by the probation service. Although similar systems operate in Austria and Sweden, the Dutch design is unlike any other in Europe:

probation for drug users is managed not by regular probation officers, but by specially trained drug workers who work *in* prisons, but not *for* prisons – they are employees of the drug-treatment institutions.

14 of the largest such institutions belong to an umbrella organization: the SVG, or National Organization of Probation for Drug Users. In proportion to the demand for probation services in their areas, the drug-treatment organizations receive funding from the Ministry of Justice, the health service and the local councils for the probation task. For some, this may be 50% of their total budget, for others 10%. The Ministry of Justice apportions roughly 70% of its budget for regular probation service and 20% for probation for drug users.

The specialist drug probation model has worked so well that the Ministry of Justice is currently considering applying the template to a third probation service for clients with mental health problems, which would be run by the psychiatric care institutions.

Part 5: Successful aftercare – key features

5.1 Straight to rehab

When asked what most helpful, most likely to keep them clean after prison, many prisoners suggested a direct transfer from prison to a rehabilitation facility. One prisoner spoke for many fellow drug users when he said:

> *"Right now, all they* [Barlinnie] *are offering is Narcotics Anonymous. But when a guy's walking out the door, he's not thinking 'I've got to go to an NA meeting', he's thinking 'drugs'. If he had the chance to walk straight into a rehab from here, somewhere like a respite programme, then he's got a real chance."*
> — Gary, 28, Barlinnie prison

The option open to Dutch and Swedish prisoners of spending the last portion of their sentence in a residential rehabilitation facility would be popular in Scotland, according to prisoners in Barlinnie, but, again, transport directly there would have to be arranged. In the Netherlands, staff at the Piet Roordakliniek said that prisoners often 'go missing' in Amsterdam unless they are brought directly from the prison to begin treatment.

5.2 Variety

There is no one drug-treatment programme that suits every drug user. Often drug-using offenders become despondent and apathetic about changing because the one option they were given did not suit them. They then feel like failures. In Austria and the Netherlands, drug users are not labelled as failures if they do not succeed or 'take to' one form of treatment. They are encouraged to keep trying until they find a treatment plan that works for them, and given assistance in the selection.

In Scotland, many prisoners had sought help outside of prison for their drug use, and were given a single option. When this didn't work, many said that they didn't feel they could go back. Most were not aware that other treatment facilities or plans might have been available. For many, it took great courage to go to social services or to a doctor and declare that they needed help. Most are reluctant to go through the process a second time. One prisoner in Barlinnie explained his difficulties:

> *"I had a social worker and I explained to her that I was using drugs but that I was only on probation for shoplifting. I said I needed help. I just went into her office and I came clean to her. I wanted to get it sorted. She phoned the* [name] *agency for me – it's like a group counselling thing – and then she took me down there. I tried it a couple of times but I just blanked it. It never came to anything. It wasn't for me. I didn't think it was taking me anywhere. So I recognised the problem when I was out but I never seem to get anything done about it. I just ended up back in jail."*
> — Anthony, 30, Barlinnie prison

Prisoners often do not have the ability to choose the right programme for themselves without guidance.

5.3 Co-operation between services

The available literature clearly indicates that the combination of intensive prison-based therapy followed by residential treatment of at least 6 months is the most effective model for reducing drug relapse and recidivism. Implementation of this model requires great co-operation between all players: housing, employment, healthcare, social welfare, drug treatment, and prison and probation services. In all four countries we saw that successful programmes invariably were the result of good inter-agency

practice between, for example, prison and employment services, probation and treatment services, or employment and treatment services. In this report we shall see that all successful aftercare programmes relied on this multi-service co-operation.

In Vienna, many drug and social workers referred to other government departments or other institutions as "sister" organisations. Most had personal contacts within a network of public and private sector organisations. The diagram on page 61 illustrates the co-operative network of drug treatment services in Vienna.

The interface between probation and drug treatment in the Netherlands is, in itself, a model of an inter-agency structure. Within the Netherlands, separate regions have designed their own systems based on this co-operative ethos. A phased-detention programme in Noord-Holland called the new Positive Initiative (nPI) is a prime example. The project, which promotes the re-integration of prisoners into society, operates as an alliance of partners that include prisons, probation, the public prosecutor, the Department of Justice, a vocational college, and Social and Employment services.

The new Positive Initiative operates on the assumption that, with proper co-operation between services:

> *"A prison becomes a company and a prisoner a trainee who is looking towards a better future."*

Dr van den Hurk, of Netherlands GGZN, pictured drug agencies and prisons as different companies working in a joint venture on the same product:

> *"Prisons, in our vision, offer a sort of semi-manufactured product. So if you don't realise continuation of care, it doesn't work."*

In Sweden, aftercare of drug-using prisoners is a co-operative effort between the prison and probation service, the social services and the government employment agency – which has a special branch for prisoner resources. The Swedish organisation KrAMI illustrates good practice in inter-agency co-operation for the benefit of the released prisoner. KrAMI is a partnership between the prison and probation service, the employment agency, and social services – all working together to restore the working lives of ex-offenders. [see section 9.6.6.1 for details]. KrAMI also works closely with other drug rehabilitation centres such as RFHL for women, to ensure that applicants are placed in the programme most suitable for them, or move between different service providers as appropriate.

In Sweden, if a probationer is in need of long-term drug treatment, attempts are made to find a place at a residential facility such as Björka [see section 9.6.5.2 for details].

In the Netherlands, the new strategy of compulsory treatment for persistent offenders [see SOV at section 9.5.2.1] requires co-operation with the entire community. As Astrid Bödeker from the SOV programme explains:

> *"The most important issue for us is not only the problem inside the prison, but to make it transmural: you go through the walls. And we need all the people outside too, to come in here, and we also need Utrecht as a city to work with us. They have to provide houses and jobs to their citizens. We do only a part."*

5.4 Probation/treatment collaborations

In Austria, the Netherlands and Sweden, we found differing levels of collaboration between probation and the drug treatment services.

In Vienna, the probation service funds "Change", its own out-patient drug treatment service [see section 9.4.5.1]; but also offers the probationer considerable flexibility if he or she feels more comfortable with a different agency.

In Sweden, early results were discussed from a not-yet published study on the role of the probation service in preventing recidivism.[13] Researchers said that the most important factor for success is the early interaction between the prisoner and the probation officer. The aftercare planning must begin well before release. In general, the Swedes are most proud of the good relations between prison and probation officers. Some probation officers in the study, however, complained that the prisons did not forward information soon enough for release planning and that they got to know their clients too late to help them into appropriate treatment.

It would appear that the Dutch solution of the full integration of the probation and drug treatment services and the placing of probation officers permanently within prisons is the best model for ensuring that prisoners with drug problems will be seen by a specialist drug probation officer from the point of arrest through to release.

Arie van den Hurk described the Dutch duty of care to drug-using offenders as running on two tracks: the judicial process track and the treatment track. "The task of probation", he said "is to unify these two tracks."

[13] This study is still on going at the National Council for Crime Prevention, Stockholm.

5.5 Innovation

5.5.1 Volunteers in aftercare

Innovative ideas for effective, low-cost aftercare options have been found in many places. Several countries judiciously exploit the goodwill and enthusiasm of individuals outside the criminal justice system who wish to help the less fortunate.

In Vienna's Favoriten prison, which specialises in the rehabilitation of drug-using offenders, a unique experiment in aftercare was the brainchild of a group of university psychology students.

The students, who had been visiting Favoriten prisoners as part of their course work, initiated a project that would allow them to continue to help prisoners after release. The Federal Ministry of Justice funded this project, with the organisational framework provided by the Association for Probation and Social Work of Vienna.

An employed probation officer coordinated and supervised a team of volunteer probation officers. After a training seminar on inclusion, the volunteers aimed to provide continuity of care and support, both before and after release, and to help the prisoners to develop realistic perspectives on life and possibilities outside prison. The main objectives were to prevent drug-related relapses and crime. An evaluation suggested that although half of the prisoners wanted this continuity of care, only 10% were able to receive it, for a variety of reasons. The clients, however, regarded this service as practical and useful, and indicated that it had helped them considerably to prepare for and adjust to life outside.

5.5.2 Lay supervisors scheme in Sweden

A prisoner in Sweden has the option of choosing a lay supervisor rather than a probation officer for assistance and monitoring after release. The person chosen must meet eligibility criteria, such as having good standing in the community. Lay supervisors also receive basic training in their duties and responsibilities from the prison and probation service.

The scheme has many advantages over traditional probation:

1. Prisoners often choose a person they know and respect to be their supervisor, such as a former schoolteacher or employer. The desire to

gain the supervisor's approval and respect may, in some cases, be quite strong. This increases the prisoner's motivation to stay straight.
2. In turn, the lay supervisor may be more personally committed to the prisoner's success than a probation official would.
3. Personal, frequent contact between lay supervisor and prisoner can begin before release and continue after the probationary period is ended.
4. Lay supervisors often act as mentors for the released prisoner, helping them with many aspects of life, from education to relationships.
5. The financial recompense for lay supervisors is small. Generally, lay supervisors undertake the task out of a sense of civic duty and good will, not for financial gain.

5.6 Housing

According to NACRO:

> *"Prisoners released homeless are two and a half times more likely to re-offend than those with homes to go to."*[14]

The majority of prisoners we spoke with asserted again and again their desperation to get certain fundamental aspects of their lives under control. Before their housing, employment, financial and family problems are addressed, many cannot focus attention on their addiction. Housing is usually a first priority. Arie van den Hurk of the Netherlands went so far as to declare it "perverse to try to get them to talk about their drug use if they are living on the street."

NACRO's recent report, *The forgotten majority,*[15] proposes that released prisoners in the UK be legally classified as in "priority need" for housing.

Glasgow has several emergency shelter facilities for released prisoners with nowhere to go. But most prisoners we spoke to would rather take their chances on the streets. They claim these shelters are often dangerous and always full of drug users:

> *"When people get out of prison, sometimes the only place they've got to go to is a hostel and that is one of the downfalls, because in a hostel, say you've got 100 guys, 98 of them are going to be using drugs."*
> — Stephen, 28, Barlinnie prison

[14] Ibid.
[15] NACRO (2000)

One or two prisoners had come into contact with an agency called City Station that helped them to find housing and job placements. They had high praise for this service. But others who obviously needed it had never heard of it.

5.7 Employment

The NACRO report *The forgotten majority* tells us that:

> *"Those* [prisoners] *who get and keep a job are less than half as likely to re-offend as unemployed ex-prisoners."* [16]

Gainful employment gives an ex-prisoner financial stability, self-esteem, a new social environment and daily occupation – important to keep the mind off drugs. Second to housing, it is the most important factor in staying straight.

> *"If I had a job to go out to, it would occupy my mind. I would have a good chance of staying off drugs as well."*
> — John, 29, Barlinnie prison

5.7.1 Employer reluctance

The problem is that ex-prisoners have great difficulty finding work. Even with qualifications, they often cannot get past the first interview. Most employers will drop an applicant with a criminal record to the bottom of their list. Ex-prisoners with a history of problematic drug-use usually don't make the list at all. Few employers are willing to take a chance on such individuals and, as a result, those with criminal records face widespread discrimination. NACRO suggest that employers should include ex-offenders in their equal-opportunity policies.[17]

One prisoner explained the difficulty inherent in applying skills learned in prison to the "real world":

> *"You've got work sheds in here and you can do joinery and you can be really good at it, but you can't exactly go to an employer and say 'I learned that in Barlinnie'!"*
> — Stephen, 28, Barlinnie prison

[16] Ibid.
[17] Ibid.

5.7.2 Rejection

Rejection can quickly kill an ex-prisoner's motivation to work. After one or two failed attempts to find employment, many become apathetic, despondent or angry. In this frame of mind, a relapse is likely. And because a drug habit cannot be financed on the dole, a return to crime is also likely.

5.7.3 Innovative programmes

Looking to Europe for innovative solutions to this problem, we found that Sweden, with an unemployment rate of 4.1%,[18] complements relevant in-prison job training with attractive financial incentives for employers. In the first year, an employer who takes on an ex-prisoner is offered re-imbursement of up to 80% of his or her salary. The compensation decreases incrementally over five years. Not surprisingly, released prisoners in Sweden have little difficulty in finding work.

In Sweden, prisoners said that they did not have to declare a past criminal record to an employer. Prison staff found the idea preposterous:

> *"If he* [ex-prisoner] *has paid for the crime then he is a normal person like everyone else. He should not have to always say 'I have been in prison'."*
> — Guard, Österåker prison, Sweden

Co-operation between agencies in Sweden facilitates co-ordinated support for released prisoners. KrAMI is a collaboration between the prison and probation service, the social welfare department, and the employment department. It offers the offender a full programme of vocational training combined with practical 'life-skills' courses, counselling for substance misuse problems, and groupwork.

KrAMI claims a success rate – that is, ex-offenders into permanent jobs – of 54%.

In Austria and the Netherlands, we found similar examples of aftercare programmes that focused on employment, but also helped the client with housing and financial matters. Many of the residential rehabilitation centres we visited had co-operative arrangements with such work programmes. Clients could move seamlessly from the drug rehabilitation centre into a programme that combined living assistance with job training and placement. In Vienna, for example, the Wobes programme has close co-operative ties with the prison and probation services and rehabilitation centres.

[18] Statistika Centralbyran (Sweden statistics October 2000)

5.8 Social support

The social environment into which the prisoner returns is a key element in maintaining drug reduction gains made in prison. Many prisoners said that the best aftercare would be assistance in moving away from their former social group. Others say that moving in with a partner or family who is drug free and committed to helping them is necessary to stay clean after release. If a prisoner is released back into a situation where a partner is using drugs, the gains made in a prison drug-free unit are threatened, as these prisoners explain:

> *"The last time I was in prison I had my head all set for what I was going to do after I got out. I got phone numbers and addresses. I could go to a group outside every day with Narcotics Anonymous. But it all got blown out of the water because when I got home my girlfriend was using."*
> — Stephen, 28, Barlinnie prison

> *"If you have good social contacts with people who do not have anything to do with drugs it is important. If you don't, it makes a big difference because there is nobody who tries to keep you apart from the drug scene."*
> — 'Marie', 26, Favoriten prison

Many prisoners have no family or drug-free friends to turn to. If they cannot get a place in a residential rehabilitation house, or do not want further treatment, their only option is a return to a bad environment. In Sweden, these prisoners are candidates for the foster family scheme. [See section 9.6.6.2] For some, this will be their first experience of living a normal life within a family group.

5.9 Medical aftercare

5.9.1 Continuity of care

In many countries, continuity of medical care for released prisoners was a main cause for concern. In Scotland, despite free health care, prisoners were highly critical of the help and advice they had obtained through GPs. Many prisoners who had attempted to get help from their doctor had been refused methadone, lectured to, or simply sent away. Prisoners felt that most GPs had little understanding of drug addiction or the lifestyle problems associated with drug use.

Previous research has highlighted problems in continuity and consistency of medical care for drug-dependent prisoners in the UK. For example, in a conference report entitled "The Throughcare of Drug Misusers", representatives of Wandsworth prison described problems common to most prisons. Firstly, on entry to prison, many prisoners lose any previous contact with drug or medical services. Secondly, the prison may offer detoxification but not continued methadone. Thirdly, the medical treatment given in prison is "at the discretion of the principal medical officer". He or she may or may not be inclined to agree with previous treatment provided by the prisoner's GP. And finally, a prisoner's medical history may not be available to the prison doctor and subsequently may not be passed on to community drug services or GPs after release.

Lesser problems were revealed in Austria, where the main issues for released prisoners are related to obtaining health insurance to cover the cost of care and the lack of 24-hour medical services for drug users.

5.9.2 24-hour services for drug users

In several countries, the lack of 24-7-365 services for drug users was seen as a problem – especially in the larger cities. And those that *are* open 24 hours see an influx at the weekend of former heroin addicts coming to get methadone. In Vienna, Hans Haltmeyer of the Ganslwirt street agency felt that this led to the re-integration of patients on substitution into the drug scene. He thought that it was not good for those trying to stay clean to mix with injectors trading needles and stories.

5.9.3 Methadone

A UK Home Office study titled "The impact of methadone treatment on drug misuse and crime" found that criminal activity was reduced by 60% among opiate addicts in East London who were placed on a 6-month methadone programme.[19]

Yet despite well-publicised research many prisoners told us that their doctors had refused them a methadone prescription. Doctors may have had good reasons for this, but the impression left with the majority of prisoners is that, in Scotland, it is useless to ask a doctor for help with a heroin problem. Gary, a prisoner at Barlinnie, described typical frustration with his General Practitioner (GP):

[19] Coid, J. et al. (2000)

"I went to him [GP] *once. My GP was against it [methadone] as well. Because he was of the opinion that, well, why stop taking heroin and start taking methadone. He said you're just substituting one drug for the other. There's a lot of them* [GPs] *with that opinion. But I would have tried anything to stay out of jail. If I was on a prescription it would take me away from the stealing, the crime, and the jail."*
— Gary, 28, Barlinnie prison

5.9.3.1 Austria

In Austria, the medical view on methadone is surprisingly social. Getting a dependent user onto a methadone programme is not simply substituting a drug for a drug, rather it is seen as an opportunity to regulate and rehabilitate all aspects of the person's life: to get them away from criminal activity, to initiate them into a relationship with a GP who will also offer protection from addiction-related diseases such as Hepatitis and HIV, and, through social services, to assist them with employment and housing.

5.9.3.2 Sweden

The Swedes take a much harder line on methadone. Heroin substitution therapy is officially discouraged and only a handful of methadone programmes are available for a select group of patients, and only within a hospital setting.[20] Methadone is not offered within prisons. The few prisoners interviewed at Österåker prison were not bothered by this. They held opinions largely coeval with national trends: that methadone substitution is not helpful in becoming drug free:

"When you are taking drugs – any drugs – the motivation to stop is not there. Once it clicks in your brain that you have to stop then you can do it without any help."
— Paul, 30, Österåker prison, Sweden

One prisoner, however, did describe a very traumatic withdrawal during his first 6 months in prison.

"I had no medical help during withdrawal. The first 6 months the craving was very difficult."
— Johan, 25, Österåker prison, Sweden

Some probation officials and rehabilitation workers are angered by what they see as the withdrawal of government support for methadone programmes and other services for injecting drug users (IDUs) outside of

[20] Lindberg, O. & Haynes P. (2000)

prison. One drugs worker interpreted the government actions as being a response to the lowering rates of HIV infection. The government, she says, is working under the assumption that since the predicted AIDS epidemic never materialised, the need for such services is no longer justifiable. In her opinion this is extremely short-sighted: she felt that government officials fail to realise that the epidemic never materialised thanks in part to schemes such as substitution therapy and needle exchanges – and that such programmes are still necessary to prevent both the spread of HIV and drug deaths.

Other interviewees also disagreed with government policy. Several cited recent newspaper reports that up to 300 drug users a year died in Sweden. So the country with the lowest reported per capita drug use has one of the highest drug-related death rates in Europe. Some said that this near 10% death rate among heroin users is proof of the failure of the current policy on treatment.

5.9.3.3 Netherlands

In the Netherlands, by contrast, substitution therapy is officially encouraged. The Netherlands has one of the lowest drug-related death rates in Europe.

5.9.3.4 Scotland

The Scottish Prison Service now officially condones substitution therapy. In Barlinnie, the methadone programme was cited most often as the most useful service provided to drug-using prisoners.

Part 6: Obstacles to Aftercare

6.1 Who is responsible? Who pays for what?

Aftercare is greatly hampered by inter-agency conflicts arising from the philosophical struggle over who is responsible for the drug-using offender. In nearly all countries we encountered disputes and frustrations between various agencies dealing with drug-using offenders. Conflicts occur between the prison service and the treatment services; between doctors and prisons; between judges and social services; between housing departments and probation services, etc. Without resolutions, it is the prisoner who suffers most.

6.1.1 Scotland

In Scotland, some prisoners were aware of conflicting opinions about treatment even within the prison. They worried that, as a result, the Drug Support Unit (DSU) was under threat of closure:

> *"They need more money for this hall [Drug Support Unit]. The guards here, they're good, they'll try and talk to the prisoners … but most of the officials in this jail don't want this unit to help anybody. They say 'it's a waste of f***ing money'. They'd rather shut it down…"*
> — Steve, 28, Barlinnie prison

Conflicts between services created more trouble for prisoners seeking aftercare support. For example, a prisoner in Barlinnie may apply to go to a residential drug-treatment facility after release, but then be denied the opportunity due to lack of funding or places, or because the social services do not consider him or her a resident of their area. In Barlinnie, the following story is typical of many who attempted to get help in Scotland:

> *"Before I got the jail* (sic), *I had my worker* [social worker] *come up and see me and I said 'Can you get me for an assessment, an interview?' And he says yes. And the jail actually went out of their way to take me to the rehabilitation centre for an interview. The rehab place said they would take me but then all of a sudden the worker comes back and says 'there's no funding'. That set me back months. So I was in jail again and I was staying off drugs. That was my plan. I knew if I went out that gate back into Glasgow I'd be back into everything* [drugs]. *I*

> *even made an arrangement for the rehab centre to pick me up right from the gate but it all fell through due to the social office."*
> — John, 29, Barlinnie prison

During his current sentence, John again took it upon himself to make contact with a rehabilitation centre that had a place available. This time he was told that funding must be secured through the jail before he could be considered. Being on a short sentence, he knew that arrangement could never be made in time. After release he would have to re-apply through social services, and that was out of the question as he says: "I wouldn't go back to social services again. Not after they refused me last time."

6.1.2 Netherlands

In the Netherlands, conflicts over payment and responsibility do arise, but they are less prevalent than in other countries. The problem is better managed, mostly because the Dutch view drug addiction as primarily a health problem, not a legal issue. Therefore, if a prisoner needs to be treated in a residential addiction clinic, he is viewed as having a health problem and his place at the clinic is paid for by the health service. Regular drug treatment clinics have in the past been reluctant to accept clients under judicial sentences, claiming that they were not their target group or responsibility. A survey, however, proved that 90% of drug users at these clinics had previous contact with the criminal justice system.

6.1.3 Sweden

In Sweden, in principle, dependent drug users are also the responsibility of the medical and social care system — whether the person is in prison or not. In theory, prison, probation, medical and social services should participate and co-operate in all aspects and stages of a prisoner's rehabilitation. In practice, this is difficult to realise. The cost of rehabilitation falls to the prison and probation service while the offender is still serving sentence. After that, if care is to be continued, the local social welfare should pay. Several probation officers expressed frustration with this situation that allows people in need of treatment to drop through the cracks while agencies and government departments squabble over responsibility. Often prisoners are refused places at residential rehabilitation centres because they are not registered in the area where the place is available.

Since the re-organization of probation districts, probation officers said that this task is increasingly difficult. Traditional ties between agencies have been severed and re-structured. The officers in the Huddinge district complained that social services were often uncooperative in assisting ex-prisoners, as probation officer Kerstin Lindblom explained:

> *"Social services sometimes feel that they are being 'ordered' by the Prison and Probation service to deal with a particular individual. This causes resistance. They will try to claim that this person doesn't live in the district and is therefore not their responsibility. If the individual does not have a fixed address, it is difficult to find a placement. Many prisoners give up because of these difficulties."*

Due to the lack of low-threshold services, probation is of little assistance to the ex-offender whose drug use is problematic but who does not want or need residential care. A probation officer in the Huddinge district on the outskirts of Stockholm explained that the probation service is "not supposed to provide 'treatment' for drug users; if they have a problem they must go to a treatment facility." However, her probation office was allowed to provide educational classes for probationers and one-to-one advisory counselling.

6.1.4 Austria

In Austria, a spokesman from the MOJ described a similar situation in his country:

> *"There is a big discussion in our system because nobody knows who really has to pay the costs. We have a very complicated system in Austria: there is the government for the whole country, and there are special counties and provinces that have their own legislation and rules and their own government, and so both the ministry and the governments are fighting about who will pay the costs. Nobody wants responsibility for it."*

6.2 Prison's responsibility

In several countries we encountered community treatment providers who felt that prisons should take greater responsibility for the prisoner's state of health on release. A few thought that prisons are responsible for much drug use among offenders in the first place. Several prisoners interviewed in

Barlinnie prison in Glasgow did claim that they had become dependent on heroin while in prison:

> *"Basically, it was prison that got me my habit. ... It happens all the time in prisons. ... Say you get a 3-week remand. It's easy to get a drug habit in three weeks. It only took me a fortnight."*
> — Thomas, 29, Barlinnie Prison

> *"I was off drugs for nearly a year and a half and then I got jail and ended up taking drugs when I came back in."*
> — Steve, 28, Barlinnie Prison

> *"I used to steal cars for many years. I stole motors but then I stopped stealing for about a year – but I got jail. I was doing a 20-month sentence for motor offences. Then I got heavily into the drugs scene while I was in jail. After the sentence I started dealing in drugs and I ended up with a habit."*
> — Anthony, 30, Barlinnie prison

Others stressed that they not only developed a drug habit in prison but lost their home, their job, and their stable relationships as well. As Steve (above) said, "When you come out, you've got nothing." The question arises: is the prison system punishing the offender, or punishing society by taking a petty offender into prison and returning a homeless, penniless, problematic drug user to the community? These issues of responsibility were unresolved in most countries.

While Scottish prisoners blame most of their problems on prison, Nick Royle of the Scottish Prison Service stressed that the majority have drug problems before they come into prison:

> *"81% of those arriving at Barlinnie tested positive for drug misuse, almost all of whom are self-reported as using 'hard' drugs. If 81% test positive, half-lives for hard drugs suggest that probably 90% are using."*[21]

6.3 Health issue or legal issue?

The question of who pays for treatment is often a reflection of the confusion and disagreement over the cause and definition of addiction. Some countries view drug addiction as primarily a moral issue, others see it as a medical problem. If the approach is moral, the legal ramifications are likely to be more punitive than rehabilitative. If the approach is medical,

[21] Personal communication

rehabilitation is likely to take first priority, with punishment taking second place.

A country may take an official position on drug use as a health problem but then resist measures that would logically follow from this stand. As a health problem, they may make methadone treatment available in prisons, and send drug-dependent prisoners for therapeutic treatment. However, they may then eject prisoners from treatment programmes after one relapse, seeing this as a moral issue rather than a chemical dependence not yet resolved: this may simply expose the influence of public opinion. In certain respects, Austria's drug policy is prone to this paradox.

A reversal of this paradox occurs in Sweden, where not only is possession a crime but so is ingestion of illegal drugs. The logical extension would be zero-tolerance policing, but public opinion in Sweden sways towards sympathetic treatment of dependent drug users. In the eyes of the law a person who has swallowed an illegal substance may be an offender, but in the public eye he is ill and in need of special care. Again, this ambivalence creates practical problems. While a prisoner is still under sentence, treatment is paid for by the prison and probation service. After completion of his sentence, it must be paid for by the social welfare. These overlaps in treatment can create chaos in accounting and reluctance among providers to adequate, continuous treatment for offenders on release.

In the Netherlands, the official stance on addiction for the last 25 years has been that it is a health matter and that all citizens, whether in or out of prison, deserve access to proper treatment. Perhaps because the law is largely in line with public opinion, treatment for ex-offenders seems to be less problematic than in other countries.

6.4 Criminalisation of drug users

The criminalisation of drug users is a big frustration for those working with drug users outside of prison.

Hans Haltmeyer from the Ganslwirt street outreach centre in Vienna described some of the ramifications of the Austrian drug policy:

> *"I think* [the biggest frustration is] *the criminalisation of the people, I think that's the biggest problem I see because all of our work – safer-use support – it doesn't work when the people know how to use safe but they have no place to use safe. It's impossible to make safer use on a toilet, you have sterile syringes but you use it on a toilet! That's the problem, there are no ... safer using centres ... safe houses… Where*

they can fix in a clean way, it doesn't exist in Austria. They lose their job because they go to jail and it's hard to get them re-integration, it's another reason to take more drugs and they go to jail again, I think that's the biggest problem."

In the Netherlands, most would agree with Arie van den Hurk of GGZN (Association of addiction treatment and care centres, Netherlands) that drug users should not suffer because of political trends:

"... special care for addicted criminals is primarily a question of humanity. Drug addicts have no responsibility for the drug politics that cause their problems directly or indirectly."

6.5 Prison/treatment conflicts

Metaphorically and practically speaking, the prisons do hold the key to successful rehabilitation of drug-using offenders. If prisons won't allow drugs workers, probation officers, or drug treatment agencies access to the drug-using offenders, there is little chance of unifying the two tracks.

While some prisons, or some individual officers in prisons, may be committed to the rehabilitation of prisoners, their efforts usually focus on job-skills training. But, as many drug-treatment specialists pointed out, drug users do not function well enough to be part of this group or to benefit from these job programmes. What they need is care in prison and continuity of care on release. For this to happen, drug workers must be allowed access to their clients in prison. For this, they are at the mercy of the prison philosophy.

In the Netherlands, the conflict of interest between prisons and drug-treatment agencies is reduced due to greater unity of vision and integration of services. But the system is not problem-free, and difficulties arise where there is a conflict of interest. Tie Keterburg, the manager of the Piet Roordakliniek (a residential treatment facility for offenders) thought the problems in the Netherlands stemmed from there being "too many prisons, all of which want 100% occupancy." The result, he went on to explain, is that prisons are reluctant to promote alternatives, such as clinics offering conditional release treatment, if it means that their occupancy quotas are not met.

6.6 Scene of the crime

Even if they do have a home to go to, resettlement in the wrong location can result in re-offending. Many prisoners say that the only way they are going to stay drug free is to move and find a new set of friends. To go back to their old haunts would, most think, guarantee a relapse, as this Barlinnie prisoner explains:

> *"If I stayed* here [in Glasgow], *I would risk it* [relapse]. *I'm going back to the same environment and it's surrounded with drugs. I don't think I'm strong enough to stay away from that. In my eyes, I need to take myself out of that environment. ... If I continue to live up here I can't see much of a life. I can see maybe dead in 15 years. If I get out of Scotland I've got half a chance."*
> — Gary, 28, Barlinnie prison

In Austria, Sweden and the Netherlands, this fear is taken seriously. Measures are often taken to remove the drug user from former social circles. This may involve finding housing for a prisoner in another area, placing the person with a foster family in a rural area, or finding a place in a remote residential rehabilitation centre.

In Glasgow, those involved in the aftercare of prisoners were not so understanding. The prevailing attitude on the subject was expressed by the manager of a Glasgow residential rehabilitation centre:

> *"If they can't sort out their addiction in their own back yard, then they won't ever kick it."*

Another explained that people suffering with addiction problems often fixate on an easy solution: the grass is always greener and life is always easier somewhere else.

Both these points have some merit: drug users should not be allowed to believe that a change of scenery will solve their problems; but there is also a legitimate concern that punitive standards are being applied to those with an illegal drug addiction that would not be applied to someone with, for example, an alcohol addiction. It is inconceivable that a recovering alcoholic would be told he must still frequent the pub or he will never truly overcome the problem. Placing a recovering drug user back on his housing estate, surrounded by drugs and drug users, may be equally counter-productive.

Funds may not be available to relocate released prisoners in better neighbourhoods, but other solutions are possible. Many prisoners want a placement in a rehabilitation facility after release, but reject offers because the location is "too close to home". Repeatedly, they are turned down for places at locations run by the same agency only a few towns or miles distant. Prisoners fail to understand the system that forces them back to the scene of their crimes.

Part 7: Research and evaluation

7.1 Lack of evaluation

Shocking statistics make powerful politics.

- Up to 90% of prisoners are drug users[22]
- 21% of drug deaths are among recently released prisoners[23]
- 60% of arrestees test positive for illegal drugs[24]

Facts such as these can trigger moral panics and spur governments to take hasty action. Unfortunately, it is most often the case that far less research goes into the solutions than went in to the problem. Researchers are tasked with defining the problems, but, most often, the solutions are then thrown open to the marketplace, with the prize going to the lowest bid.

Programme evaluation is considered low priority or avoided altogether when:

1. there is no perceived alternative to a programme
2. it is politically expedient to be seen to be doing *something* about a well-publicised problem
3. programmes are based on a political agenda such as 'zero-tolerance'
4. there is strong competition for funds between agencies with different goals, for example between prison services and treatment agencies.

In some countries there appears to be a certain amount of research fatigue, or even research phobia. Eyes glaze over when a sentence starts with "studies show that…" The pessimistic conclusion often drawn is that studies can be used to show just about anything. This is certainly the case when agencies with contrasting philosophies are asked to make decisions. Arie van den Hurk recalled that the Dutch government came up against this problem when developing plans for the compulsory treatment of addicted recidivists - the SOV programme [see section 9.5.2.1 for details]:

[22] EMCDDA (2000)
[23] HM Prison, Barlinnie. *Tackling drugs together in Barlinnie*
[24] Bennet, T. (1998)

> *"In the Netherlands we've had a long discussion because many people are against this* [SOV]. *The Ministry of Justice did a literature review on the success of compulsory treatment mainly based on US studies and they concluded that we should try; that there were no real signs that it should not work. Another scientist was asked by the Department of Health to review the same body of literature. Now the Department of Health does not like this idea and this academic got a completely different conclusion."*

Evaluations of many prison-based drug-treatment programmes are available and, in some cases, ongoing. Both Favoriten prison in Vienna and Österåker prison in Sweden have been subjects of research.[25]

Evaluations of aftercare were harder to come by in most countries visited. It is unfair to say that they do not exist; it is possible that, had the researcher had multi-lingual abilities and unlimited time to search libraries and databases in each country, that documents would have surfaced. But it is fair to say that the majority of those working in the field, at the programme management level, were unable to supply objective evidence of the success of their drug-treatment endeavours and had no knowledge of past evaluations. Time and again, the criteria for success were based on the number of clients processed through the programme. Follow-up, or tracking of participants to determine the actual outcome of the programme, was hardly ever attempted. Some agencies cited the number of postcards they had received from past clients as evidence of success.

Exceptions are found, however. One notable one is a research project underway at the National Council for Crime Prevention in Stockholm. This 6-month study is investigating the outcome of conditional release for drug users under probation supervision.

7.2 Reliance on US studies

Several people felt that there was too much reliance on US studies. Given the American record on drug use and crime, some felt that it was perverse to imitate their methods. In addition, many felt that US research did not apply to Europe: most US research concerns different populations of drug users, using different drugs in different environments, who are subject to different societal pressures and laws, and different treatments with goals and methods totally dissimilar to European standards. Whether a US study

[25] Farbring, (2000); Berggren, O, et al (1999). A worldwide meta-analysis of prison-based drug treatment programmes is also forthcoming from Douglas Lipton of the National Development and Research Institutes in New York. For updates, connect to URL:http://www.ncjrs.org

judges a particular programme or policy to be successful or not has little bearing on its application to a European setting.

Many new ideas are developing in the field of drug treatment and prisoner aftercare in Europe. Protagonists here feel that European countries should do their own research and promote their own successes for the rest of the world to follow.

7.3 Recidivism research

7.3.1 Lack of statistics on recidivism.

Few agencies had procedures for collection of data related to recidivism. Most did no more than record numbers of clients seen. Follow-up of clients was not routine. The exception was the Netherlands, where drug treatment agencies are part of the probation system. This merger greatly facilitates tracking of individuals. It also places greater pressure on the system to account for failures.

7.3.1.1 Scotland

The problem of recidivism is so acute among prisoners in Barlinnie that prison officials speak of the prisoners as "serving life sentences – in instalments". Out of a sample of 82, 80% had been in and out of prison more than 5 times. The average number of releases was 9.

7.3.1.2 Netherlands

Arie van den Hurk describes a similar picture among Dutch prisoners:

> *"In my research I had a sample of 178 prisoners and only one was a first offender. A few of them had over 100 contacts with police. What they cost society is enormous. It is frustrating for them too if they don't believe that there is anything they can do to change this pattern."*

Statistics are kept by most of the largest drug-treatment organisations in the Netherlands. For example, in Utrecht, aftercare for prisoners is a co-operative effort between the police, the public prosecutor, and Centrum Malieban, the local drug treatment agency. [See section 9.5.6.1 for details]. Because of this shared responsibility, it is possible to track clients through the system. The statistics show good results: in its first year of operation (1994) Centrum Malieban saw 31 drug-using offenders. Between them they

had committed a total of 851 crimes in the previous year. A recent follow-up shows that in the four-year period after completing the treatment, these individuals committed a combined average of 205 crimes per year. This represents a decrease in criminality of 75%.

7.4 Addicted to drugs or crime?

Many people interviewed raised the issue of the illusion of perfect co-dependence between hard-drug addiction and crime. Many practitioners in the drug-treatment field recognise that addiction may be successfully treated, yet the client goes on to commit the same types of crimes anyway.

Tie Katerburg, from the Piet Roordakliniek in the Netherlands explained that the therapeutic treatment his clinic provides to offenders forces clients to address all addictive behaviours, not just drug addiction. Arie van den Hurk of the Association of addiction treatment and care centres (GGZN), explained that relapse into crime often *precedes* a relapse into drug use. He elaborated on the accepted theories on the pathways between drugs and crime:

> *"A study from Amsterdam shows three basic models:*
> *1. Drugs → Crime: Drug use leads to crime*
> *2. Crime → Drugs: Crime leads to drug use*
> *3. Neither. The cause of both is involvement in a subculture or peer group that uses drugs and commits crimes."*

But, he says, there is no one model that is true. For some clients it is one or the other, and in some cases it is impossible to find out which way the arrow is going between drugs and crime. But he stressed that:

> *"The important thing to realise is that the issues are more complicated than 'crime is caused by drugs'. This is maybe true for 30% of drug users, but not all. Some individuals are so used to committing crimes that, even if he does get rid of his drugs problem, he still knows only one way to get money."*

Many prisoners said that, for some, it was harder to give up crime than drugs – specifically, to give up drug dealing. Two offenders serving the last year of their sentence in the Schweizer Haus drug treatment centre near Vienna confirmed privately that a life of crime had its attractions.

> *"I was a dealer but I also was addicted to Ecstasy and Speed and cocaine. I imported drugs from other EU countries and, well, I made a lot of money at the weekends. A lot of money! It will be much harder*

for me to adjust to a lifestyle without this money than without the drugs."
— 'Hans'. Schweizer Haus, Austria

Craving the good life is also a common experience of many released prisoners as Johan from Österåker explains:

"When I got out of prison the first time, all I owned was in one small carry bag. You get out of prison, you want a better life, you want money, you want things: a new car, clothes, gold things, a holiday in Thailand. You feel you have lost many years of your life and all you owned so you try to catch up, to make up for what you have lost. And for this you need money. You need a lot of money fast. So you sell [drugs]. ... But, when you deal, you lose and especially if you take drugs. As the guys say: 'when you use, you lose'. But, it is very easy to make money with drugs."
— Johan, 25, Österåker prison

An ex-prisoner in the UK candidly described the frustration inherent in 'staying straight':

"It's hard trying to make an honest living. You just work and work and work and pay all the bills and at the end of the month there's nothing left, nothing to show for all that work. It's tempting to just go out and nick something. It's a lot easier."
— 'Craig', 26, Ex-prisoner, HMP Maidstone

'Marie', a prisoner at Favoriten prison in Vienna, echoed this attitude:

"Drugs are very very good business. It is much harder to give up dealing than giving up drugs. But, if you are addicted, drugs are not good business."
– 'Marie', 26, Favoriten prison

For some prisoners, making money quickly when they get out can be a matter of life and death. C. Åke Farbring of the Swedish Ministry of Justice points out that prisoners can often incur debts prior to or during their sentence. On release, many feel threatened or pressured by debtors to repay the money quickly. Dealing is usually the only way they know to make fast money.

Part 8: Prison issues

8.1 Sentencing

In Austria, Sweden, and the Netherlands, there was a powerful impetus to avoid sending a drug-using offender to prison if at all possible. Numerous studies, dating back to the 1950s, prove that offenders placed on probation are less likely to re-offend. Many players in this study agreed that drug addiction can start or become worse in a prison environment.

8.2 Short-sentence prisoners

In the UK, offenders sentenced to less than a year are missing opportunities for treatment both in prison and after release. This occurs for two reasons: (1) because a short sentence does not allow necessary time for release planning and (2) these prisoners are not subject to statutory supervision by the Probation Service.

In England and Wales, two-thirds of all offenders are sentenced to less than 12 months. The majority of these (61% of males and 52% of females) are reconvicted within 2 years of release.[26]

Austria and Sweden have the same problems with short-sentence prisoners. At the National Council on Crime Prevention in Sweden, we were told that short-sentence prisoners are unlikely to receive release planning because, just as in England and Wales, offenders serving less than 12 months are not subject to probation. Researcher with the Council suggested that a 'fast track' system be developed for drug users in this situation.

8.3 In-prison drug treatment:

8.3.1 Motivation

Motivation to change is seen as a pre-requisite for placement on drug programmes in most countries. In some cases we found that despondency, low self-esteem and past failures accounted for unwillingness to participate in treatment. Only in the Netherlands did we find programmes designed to increase motivation itself.

[26] NACRO, October 16, 2000.

In many places, over-emphasis on the importance of motivation resulted in the exclusion of the most needy in favour of those deemed easiest to rehabilitate.

One of the problems seems to be that the illusive concept of motivation remains largely undefined. The concept is used to grant or deny treatment places within prison and, more frighteningly, to allocate or deny funds for rehabilitation units themselves. Yet, during this research, no one, neither prisoners nor prison officials nor drug treatment specialists, could clearly explain what they meant when they said a client was motivated. Nearly all were familiar with the 'stages of change' described by Prochaska and DiClemente[27], but failed to see how this might be applied differently, or not at all, to addicts within a prison setting. Many also conveniently drop the crucial practice of 'motivational interviewing' before passing judgement on a prisoner's motivation to change.

Arie van den Hurk, a spokesman for the Netherlands drug-treatment agencies, explained that in some prisons in the Netherlands

> *"There is not any investment in those who do not show 'motivation'. But this is a difficult concept. And prison environment is not conducive to motivation."*

His solution was to enrol the prisoner in a programme anyway, work with him and disregard what he says about his own motivation:

> *"The only thing you can do is to make a contract* [programme plan] *with someone and if he stays on it and does what you agree with him to do, then it doesn't matter if he thinks or says he is not motivated. You make a plan and if they co-operate then my conclusion would be he is motivated."*

Prisoners themselves will often say that they *do* want to change, they *do* want to give up drugs and live a different life, but they *don't* want to do it in prison.

It was also clear from the interviews that very few prisoners had a clear understanding of the different forms of therapy or options available to them. When asked if they want to participate in rehabilitation or addiction therapy, most have no basis on which to make an informed decision. The easiest route is to say 'No'. In Barlinnie, if a prisoner who is presented with several options still chooses to do nothing about his problem, he is often labelled as unmotivated. In reality, he may be making assumptions about

[27] Prochaska and DiClemente (described in Miller and Rollnick 1991)

the options available based on rumours, hearsay, or 'gut feelings' that this is not for him.

In Austria, where addiction is viewed as a disease, the poor motivation of the drug user does not exclude him or her from receiving proper medical care. Participation in therapy is another matter: a spokesman for the Ministry of Justice acknowledged that there were not enough funds to provide therapy for all prisoners who requested it:

> *"The prisoner has to make the effort to get the therapy. I don't say we can provide for all prisoners who want therapy, but more and more they are not motivated… but if he is really interested then he gets it. But it's not so that anybody can get therapy who says 'I want therapy'. So the prisoners have to make the effort, a little bit, or it would cost too much money to provide it for everybody."*

So when funds fall short, the squeaky wheel gets the grease, as the Americans say.

The Dutch, who perhaps have more funds available for prison programmes, go to great lengths to encourage the wheels to squeak. Treatment is not forced on drug-using prisoners, but we were told that anyone, anywhere within the system, would get help if they asked for it. Prisoners identified as poorly motivated to address their drug problems, or those who have refused or failed treatment, are nonetheless given persistent attention and encouraged. Some are sent to 'pre-treatment' treatment, or 'motivation centres' where they are given support.

In a report for the Pompidou Group, it is suggested that, at the point of entry to the criminal justice system, there should be routes of treatment available to all individuals whether they are identified drug users or not. We suggest that this should also apply to their perceived level of motivation.[28]

8.3.2 Poor programmes

Prisoners who appear unmotivated and refuse help may also have been victims of badly run or poorly funded programmes in the past. Arie van den Hurk felt that poor funding of programmes could produce results worse than no funding at all:

> *"*[Government] *should invest a lot or not invest at all but it should not do this type of window-dressing. This can sometimes even make things worse because then they* [prisoners] *get inadequate treatment*

[28] Alem, V.C.M. van et al 1999

> *and they fail and the client blames himself and says ' I can do nothing to get rid of my problem'. This group has very low self-respect already so if you offer bad treatment services then they think 'I can't even do this right".*

This issue came up in several interviews with prisoners at Barlinnie prison. Many had experienced some form of treatment for drugs in the past – usually group therapy – and found it didn't meet their needs. They genuinely wanted to overcome their addiction but were reluctant to, as one put it, "go through all that bollocks again."

8.3.3 Group vs. one-on-one counselling

In Austria and Scotland, the number-one prisoner complaint about in-prison drug treatment concerned the group counselling, or group therapy session.

In both countries, prisoners complained that they felt uncomfortable talking about their problems in front of others. Several explained that relationships with others are different in prison. There are hidden hierarchies, or pecking orders that are strictly maintained. Gossip about other inmates can be used as a weapon. A tough image is often the only protection against those higher up the ladder of importance. Prisoners who do reveal information about themselves in groups say that they are quick to deny it afterwards in the company of others to avoid being bullied or mocked.

Prisoners in both Scotland and Vienna explained that, to get by, one had to learn the language that the group counsellor favoured, to learn the catch phrases and buzzwords and sprinkle them liberally into made-up stories. Other prisoners, who lacked this creative linguistic ability but who still did not want to participate in group therapy, used silence as rebellion. Others became as disruptive as possible. In Favoriten prison, a psychologist confessed that it is very common for a group leader to lose control:

> *"Some* [counsellors] *just give in if they have three or four in a group who don't want to participate and they say 'OK, just talk about anything'. But this is why the inmates sometimes have the impression that it doesn't work very well. I know groups where they just talk about the weather."*

In Barlinnie prison in Glasgow, a few prisoners felt frustrated by the emphasis on talking. As one said:

> *"… all the talk does your head in. At the end of the day, it's not going to help you when you walk out and you still have nothing but drugs to get you through the day."*
> — 'Roy', 26, Barlinnie Prison

In Sweden's Österåker prison, group therapy was viewed more favourably. As one prisoner said:

> *"Group talk is very good. It is good to share experience. A while ago I thought that it was only me having these feelings* [about drugs]. *But now I see it is the other guys too."*
> — Johan, 25, Österåker prison

8.3.4 Internal vs. external counsellors

In Barlinnie, there was a certain amount of debate regarding the use of prison staff as drug counsellors. All the prison officers who act in this capacity on the Drug Rehabilitation Unit are given a training course. Some prisoners said that, in general, they felt far more comfortable with these staff members than with officers in other parts of the prison, but the majority objected to "being counselled by the guy who locks you in."

For some prisoners, breaking the cycles of drugs and crime means talking openly about both. In a prison setting, with officers as counsellors, it is unlikely that many will talk honestly about their crimes, as many may have gone undetected. By focusing exclusively on the drug addiction, the prisoner may bury aspects of offending behaviour that are important to his full rehabilitation.

The other burning issue was the counsellors' credibility. The majority of prisoners want counsellors who have some first-hand understanding of drug addiction, who know what the prisoner is going through. As these Barlinnie prisoners explained:

> *"There's got to be counselling and support who know what it's like. Because like right now I'm seeing a counsellor and I'm trying to explain about a drug problem and she's saying 'well Gary, do this" or "Gary do that" and she doesn't know what I'm talking about. Because I'm lying in a cell strung out, head busting, you know what I mean? And she's never been there. There's got to be an agency that we can go to that the people know exactly what we're going through. There isn't any such thing."*
> — Gary, 28, Barlinnie prison

> *"The guards have not really been there, you know? I mean, they've not been in the situation we've been in. So why can't they employ people that's been there, that's maybe been off it* [drugs] *for 10 or so years, that's qualified to do it* [counselling] *now."*
> —Thomas, 29, Barlinnie prison

Effective drug counselling can be delivered by people who have never themselves experienced drug use. Most prisoners acknowledged this and would not demand this qualification of an external counsellor. But most see prison officers as too far removed from the world of drugs to even approach understanding of the issues and pressures they face.

Another former prisoner explained that prison officers, even those trained in counselling techniques, have a "hard attitude" towards prisoners that no amount of training can soften. He agreed with Barlinnie prisoners in that "You get a lot of feedback from prison counsellors". In prison lingo, 'feedback' is a euphemism for verbal abuse, lecturing, sarcasm, criticism or intolerant comments from prison officers.

In most other countries, we heard few complaints of this nature. In Sweden, prisoners appeared content with the in-prison counselling they received. In the Netherlands, most counselling is provided by external drug agencies. In Austria, it appears that group therapy is conducted by trained psychologists who work within the prison and probation system.

Part 9: Additional information by country

9.1 Background

9.1.1 Prison Statistics

	Prison Population (1995)	Rate per 100,000 of general population (1995)	Prison capacity	Occupancy rate
Sweden	5,767	65	6,259	92.10
Netherlands	10,143	65	10,138	100.00
Austria	6,761	85	8,097	83.5
England & Wales	51,265	100	50,239	102.00
Scotland	5,697	110	5,655	100.7

Source: *Prison populations in Europe and North America: some background information*, Heuni Paper No. 10, by Roy Walmsley, 1997

9.2 England

Although England was not one of the countries selected for study, many participants in this research were keen to know how English aftercare compared to its European counterpart. The following information was gleaned from interviews with drug agency staff in London and from research and conference reports.

The last few years have seen a change in national priorities regarding the treatment of drug-using offenders. Paul Cavadino, the policy director of NACRO, praised the new developments:

> *"Until recently two-thirds of all the money this country spent on tackling drug problems went into law enforcement and only one-third into treatment, prevention and education combined. Shifting the balance strongly in the direction of treatment makes sense from the standpoint of reducing crime as well as reclaiming the lives of those addicted to drugs."*

9.2.1 CARAT

The best hope for the future of aftercare in England appears to lie with the CARAT (Counselling, Assessment, Referral, Advice and Throughcare) system.

On paper and in principle, the CARAT system resembles the Dutch probation system of integrated drug treatment and probation services. In practice, things may not be so well organised.

The CARAT programme was launched in October 1999 with £23.5 million pounds to fund multi-agency co-ordination of services to prisoners. At its launch, Home Secretary Jack Straw was confident that the collaborative approach would provide:

> *"…a seamless transition from prison into the community without interrupting the vital support and treatment which, if cut off, all too often leads straight back to prison."*

By November 1999, it was clear that such a transition was far from seamless, as one CARAT worker explained:

> *"We are already acutely aware of limited resources in the community and in many cases substantial waiting lists, and the very real concern is that much positive work undertaken in prisons may be undone by virtue of limited follow-up being available on release."*

Some of the pre-CARAT problems with throughcare were highlighted at a conference on the subject in 1997 at the headquarters of the Inner London Probation Service:

> *"Uncertainty about and alteration in release dates for parolees make it very difficult to plan referrals to community-based agencies, particularly residential rehabilitation. …*
>
> *Some Social Services Departments refuse to assess prisoners while they are in prison; this makes it impossible to formulate discharge plans before release. …*
>
> *As community care funding is rationed and eligibility criteria gets tighter, ex-prisoners are squeezed out, as they have to wait for a relapse before they can receive help. …*

> *The concept of continuity of care is nullified if the purchasers of care in the community do not recognise prisoners as being their responsibility."*[29]

However, in some places, the CARAT system seems to be strengthening what is already good practice. In the Bolton District of Greater Manchester, it was found that up to 70% of all individuals on probation had a need for drug services.[30] Consequently, the Bolton Drug Misusing Offenders project sought to incorporate drug specialists within the probation service and to co-operate with other agencies to provide integrated care for these probationers. Drug-using offenders are still served within the Bolton probation office but now by a 'satellite' of the Community Drug Team. The project involves co-operation between probation, the Health department, the social services department and the drug treatment agencies. Project workers now work closely with CARAT workers as well.

9.2.2 Recommendations for the UK

1. Neither prisoners nor communities are served by incarcerating non-violent offenders whose crimes are directly related to their drug use. Alternatives to prison should be sought for all eligible drug-using offenders.

2. Drug-using offenders with short sentences, if they cannot be diverted from prison to treatment, should be given a 'fast-track' priority status for aftercare planning and in-prison treatment.

3. In-prison treatment should be provided by drug agencies, external to the prison system, who can co-ordinate aftercare and continue contact with the prisoner after release.

4. A perceived lack of motivation to change should not exclude a prisoner from all treatment options. Motivational programmes for those identified in the 'pre-contemplation' stage of change should be developed in prisons that have a high percentage of prisoners who refuse help.

5. Some degree of leverage, coercion or incentive should accompany both in-prison treatment and aftercare options.

[29] Inner London Probation Sevice (1997).
[30] Druglink (July/August 2000)

6. UK prisons should consider the Swedish and Dutch models of staged release and/or completion of the final phase of a sentence in a treatment facility.

7. Government funds need to be ring-fenced for aftercare. Until this is the case, allocation of scarce resources will favour those individuals considered by local communities as 'most deserving'. The drug-using offender has little hope of help in this environment.

8. Many released prisoners fail to access services due to the chaotic nature of their lifestyle or their inability to comprehend and navigate the maze of services. Drug-using prisoners need a 'one-stop', or 'brokerage' service to address their need for financial assistance, medical care, housing, employment advice, and referrals.

9. The Dutch have an experimental programme [SOV] to treat drug-dependent repeat offenders who have not responded to previous rehabilitative attempts. As this is also a chronic problem in the UK, close attention should be paid to the development of this programme. An independent evaluation should be initiated to assess the effectiveness of the programme and its potential application in the UK.

10. We suggest that the government consider a 'New Deal for ex-offenders' that would combine relevant and appropriate in-prison job training for offenders with financial incentives, and special training for employers who take on ex-offenders with previous drug problems. The benefits in reduction of crime and nuisance would, we believe, far outweigh the costs of such a venture. We suggest that research be initiated to assess the feasibility of several possible schemes.

9.3 Scotland

9.3.1 Prison as a way of life

Drug use in Scotland has reached alarming proportions. 10% have experimented with illegal drugs by age 11, according to a Glasgow University study; among young offenders, the average age of first use is 13.[31] Young offenders are apparently "undaunted" by the legal consequences of drug use. A recent survey of young criminals commissioned by the Scottish Prison Service has made evident that prison has become a part of life for certain segments of the population. The survey found that almost 50% of young prisoners said that they were not worried by the prospect of returning to prison. 75% felt that nothing could be done to stop them from re-offending.[32]

Our research among older prisoners found evidence of this same attitude. Many felt that repeated sentences were an inevitable part of life. The majority expected to spend at least a third of every year in prison.

9.3.2 In-prison care

Currently, prisoners in Barlinnie have two options for drug treatment: obtaining a place on the Drug Rehabilitation Unit (a 4-week intensive group therapy course), or a transfer to the Drug Support Unit, the prison's drug-free hall.

Recently, methadone has become available as a treatment option for all prisoners in Barlinnie prison. Most prisoners on the programme feel confident that it is helping them to become drug free or at least to stay clean while in prison.

Barlinnie has built a new addiction unit facility that will allow external drug-treatment agencies greater access to prisoners.

[31] Lasmar, P. (4 September, 2000)
[32] Faulconbridge, L. and McInnes, P. (6 Nov 2000).

9.3.3 Aftercare

Barlinnie prisoners' attendance at post-release referrals is poor, by all accounts. Once out of prison, most drug users think they can sort out their own problems. Most prisoners were optimistic that they would stay clean after release. 34% thought they would stop using drugs after release; 16% thought that their drug use would decrease. 17% thought it would increase.

The majority have good intentions, but fail to follow through as chart 4 below illustrates. The only service that was used more than anticipated after release was needle exchange.

9.3.3.1 Options for voluntary aftercare

Most prisoners welcomed aftercare options that filled their time and kept their minds off drugs. A clear past favourite of Barlinnie prisoners was the Carlton-Athletic centre, unfortunately now closed. The main attraction of the centre was its sports facilities. As one prisoner explained:

> *"Carlton athletic were like a group, to go 7 days a week, basically to go bowling, movies, camping, things like that. They do little groups as well. To talk about what you've done in the past, your hope for the future and things like that. That was interesting as well. I think they should do something like that in jail, I know they can't take us camping! But you know what I mean, something to keep you interested and occupied."*
> — Thomas, 29, Barlinnie prison

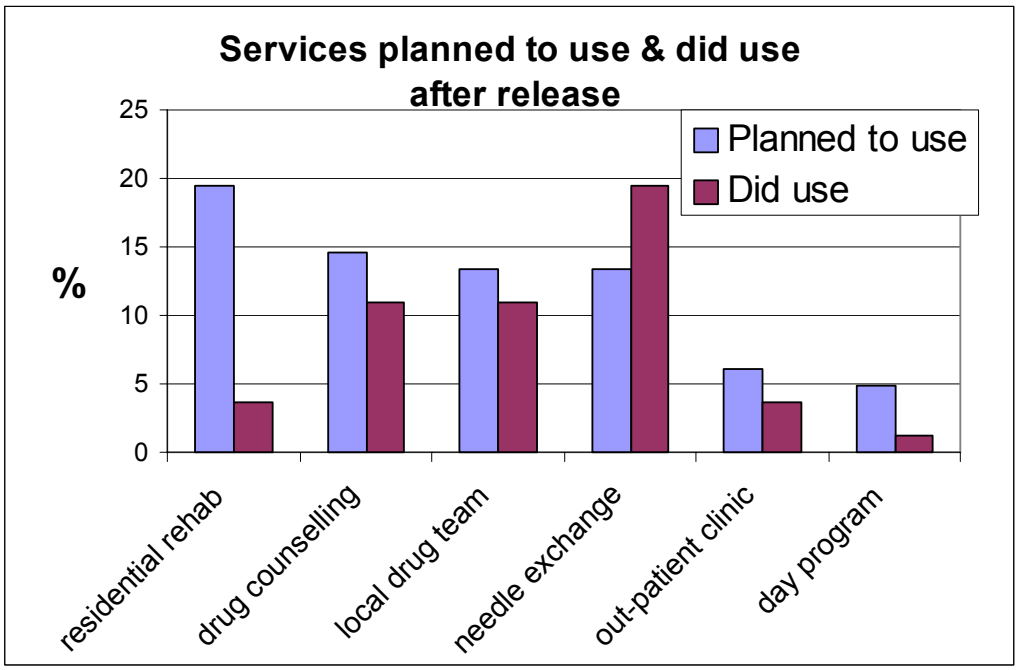


Chart 4: Prisoners' plans for voluntary aftercare.

9.4 Austria

9.4.1 Government position on drug use and addiction

In Austria, the official drug strategy is governed by the principle that "drug addiction and dependence are, above all, medical and/or social problems…"[33] In other words, in law, drug addiction is regarded as a disease. The aim is to rehabilitate the addicted offender through a balance of punishment and treatment to effect both re-socialisation and recovery from addiction. The Austrian strategy to tackle drug-related crime aims the full force of the law at drug dealers and organised drug rings, while offering rehabilitation opportunities to drug users.

In most cases, the law does not distinguish between different classes of drugs, as it does in the UK; the focus is on the quantity, rather than the type

[33] Ministry of Justice: Austria.

of drug a person possesses. The penalty for possession of drugs depends on the *purpose* of the possession: for personal use, or for dealing. Possession of a small amount of drugs indicative of individual use is unlikely to result in arrest. The police record the name of the individual but will not proceed further unless a crime has been committed. According to law, "the use of drugs as such is not part of the punishable acts relevant for the courts".[34] If an individual possesses large quantities with the intent of distribution, then the law does make a distinction between 'narcotic' (less harmful) and 'psychotropic' (more harmful) substances, with the latter demanding a longer sentence. However, the maximum penalty for possession with intent is three years. Convicted dealers can receive penalties of 1 to 20 years dependent on their leadership of, or participation in, criminal organisations or gangs.

9.4.2 Sentencing options

The principle of therapy instead of punishment has been legally possible since the 1980s.[35] Today, the measures to facilitate this possibility are well in place. If an offender is addicted to drugs, his or her case will be reviewed by a special 'drug judge'. The Austrian penal code allows for greater leeway in sentencing of drug-addicted offenders. Under The Austrian Drugs Act 1997 (Paragraph 39), rehabilitation and treatment may be offered to the offender if it is thought to be a more effective measure than imprisonment for those given sentences of 3 years or less. If the offender voluntarily agrees to undergo therapeutic treatment, the judge may suspend criminal action, temporarily dismiss the case, or temporarily suspend the execution of the sentence. The opinion of a health authority is required, on a case-by-case basis, to make a final determination on the need and viability of medical or therapeutic treatment and whether such treatment should be residential or out-patient.

Those who must serve a longer sentence in confinement may be sent to Wien-Favoriten, a prison dedicated to those with drug- or alcohol-related problems, or to special departments for drug-dependent offenders in other prisons.

In 1998, of those convicted of violation of the Narcotics Drug Act:

- 63% were imprisoned
- 30% had the sentence suspended
- 33% received a sentence.[36]

[34] Ibid.
[35] EMCDDA (1999) Austria: Report on the drug situation 1999.
[36] Haas, et al. *Report on the Drug Situation: Austria 1999*.

9.4.3 Schweizer Haus, Haddersdorf

Schweizer Haus is a residential drug-treatment centre on the outskirts of Vienna. The majority of clients are offenders who have been granted "Paragraph 39" (treatment instead of prison) by a 'drug judge'. A few of the 30 places are reserved for women who are still outside the criminal justice system.

While the overall aim of therapeutic treatment at Schweizer Haus is abstinence, it is recognised that some patients cannot achieve this without substitution. Ursule Daurer, of Schweizer Haus, confirms that they are "the only drug station where all patients are on methadone."

Schweizer Haus is owned by a private limited company but is financed in part by the Presbyterian Church. Places for offenders diverted from prison are paid for individually by the Ministry of Justice.

9.4.4 In-prison care

9.4.4.1 Favoriten, Vienna

In 1975, the Austrian Criminal Code was reformed to include measures for the treatment of addicts in penal institutions. The Wien-Favoriten prison was chosen to implement the new measures. After a three-year trial begun in 1972, Favoriten was permanently transformed from a normal detention centre into a treatment facility for drug-addicted offenders. Its main objective is to assist the prisoners in achieving abstinence and to prevent relapse and recidivism. At present its capacity is approximately 180 prisoners including 30 females.

There are two categories of prisoners in Favoriten: those who were committed to the centre by the court, and those who applied voluntarily to be admitted, or transferred from another prison.

On average, up to 60 guards and 20 members of the therapeutic team work in Favoriten. Some specialists work only part-time. The 1998 team make-up was as follows:

- 8 psychologists
- 1 therapeutic trainer
- 4 social workers
- 2 psychiatrists
- 1 former drug user with therapeutic training

- 1 internist specialising in diseases concomitant with drug addiction
- 1 general practitioner.

The prison doctor confirmed that 75% of prisoners come into Favoriten infected with Hepatitis C and 35% with Hepatitis B.

All staff members are trained in several therapeutic methods including gestalt therapy, conversational therapy, psychodrama, and behavioural therapy. Other services offered include HIV prevention, substitution treatment, labour training, adventure activities and art.

Group therapy sessions take place three times a week. Participation in this basic programme is obligatory for all prisoners. Prisoners can also request individual therapy sessions, although budgetary constraints restrict the number of sessions and therapists available.

While all prisoners are required to work, not enough jobs are available. Prisoners without work complained of long periods of boredom.

The wards are organised in shared-living groups where aspects of daily life such as cooking, cleaning and socialising are organised by the prisoners of the group. The cells are small, but prisoners are free to move around the ward at certain times.

Observed urine drug-testing is carried out on a weekly basis.

Prisoners clearly preferred Favoriten over other prisons; others are sceptical of its rehabilitative benefits. A spokesman for the Austrian Ministry of Justice worried that an entire prison dedicated to substance misusers might not provide the best environment for them as "[It places] too many addicts all together." The prisoners, he felt, would reinforce each other's beliefs and create a powerful subculture within the prison.

Another common criticism of Favoriten is that it attracts prisoners whose main motivation is to have an easy time in prison, not to address their drug problems. Favoriten staff and prisoners admit that some may be there for 'an easy life'. In discussion groups, most said they weren't bothered that this was happening; in private, in individual interviews, many more expressed frustration that the less serious prisoners disrupted group therapy sessions and ridiculed those who were genuinely trying to change.

Pre-release

Six months before the end of their confinement, the Favoriten inmates are given a first taste of freedom. For three months they may work in external (but prison-controlled) jobs near the centre. The last three-month stage of

their sentence takes place in Freigang, the 'release house'. From here they are assisted in finding a real job in the outside world and encouraged to take more and more responsibility for creating a drug-free life for themselves outside of the prison. At first they are required to return to 'Freigang' every evening, but as time progresses, if they adapt successfully, they are then given progressively more and more freedom to stay out. Many retain their jobs after final release. However, in 1998 (the last year for which statistics are available) up to 30% of prisoners had serious problems coping with the programme and had to be returned to confinement.

Evaluation of the release programme
In 1997, according to an evaluation based on data/information from internal documentation as well as from two theses, the prevention of relapse during the release phase of the sentence was successful for 29 out of 62 clients; and in 1998 37 of 66 clients reported a successful transition to a drug-free outside life. [37]

Relaxed confinement
Offenders sentenced to a short period of confinement who have external jobs are often permitted to continue in employment and return to Favoriten in the evening. External care and therapy programmes are thus continued throughout the sentence.

9.4.5 Aftercare

If, after final release, further therapy or medical assistance is necessary, the individual can receive continued care through the probation service agencies. If the inmate is still addicted at the end of his term, he will be encouraged to seek continued care with probation assistance centres or independent organisations. Some prisons, such as Stein, offer continued ambulant consulting to former prisoners.[38]

9.4.5.1 Change

Change (formerly 'Club Change') is an agency of the probation service, funded by the Probation and Social Work Office. It does, however, accept clients from outside the probation system who are paid for by the social welfare service. The staff consists of a full-time manager and social worker, plus 12 part-timers who work as freelance counsellors, social workers,

[37] This evaluation was referenced in Haas et al. *Report on the drug situation 1999: Austria*. There it was indicated that a copy could be found on the EDDRA website database. Unfortunately this database contains only abstracts with no date or publication information on the studies.
[38] Dr. Heinz Zobl. (1995) *In Drug Out In Prisons.*

probation officers and psychotherapists. There is also a doctor who sees clients on suspended sentences who have to be checked every two months. The doctor then forwards his report to the judges.

The main focus of Change is the out-patient therapy treatment of drug-addicted offenders, either on release from prison or who have received suspended conditional sentences. A range of therapeutic methods is offered, including creation therapy, family therapy, music therapy and so forth.

The only information about each client passed to the judges relates to attendance, health, and results of drug testing. All information obtained in counselling sessions is strictly confidential, except in cases of confession of murder or intent to harm.

Therapists from Change also conduct group or single therapy sessions in prisons by invitation. The prisons themselves pay for this service. Uschi Truls from Change thought that in-prison therapy was not always successful:

> *"Sometimes it is hard to do therapy in prison, because there are no proper rules or it is not quiet enough, or the officer is outside so it is hard for the people to talk there."*

According to one counsellor at Change, prisoners who receive therapy in prison are not stereotyped or victimised by other inmates or guards: rather they are seen as lucky or privileged. "It is hard for the addicted prisoners to make it happen that they get therapy."

Occasionally, prisoners will be allowed day-release to attend therapy sessions at Change. If the prisoner has a long sentence and is not trusted, a prison officer may accompany him to Change.

9.4.5.2 Wobes employment project

Wobes is a programme that trains and provides work for unemployed and hard-to-employ people in Vienna, some of whom are ex-offenders or graduates of rehabilitation programmes such as Schweizer Haus.

Starting as an employment project in 1988, it has since 1996 become a socio-economic business, financially supported by the Austria social welfare department and the European Social Fund. Wobes is a sister company in the same partnership as Schweizer Haus, so the collaboration between the two agencies is strong.

The Wobes programme seeks to counteract the downward spirals of long-term unemployment leading to debts, alcohol and drug abuse, increasing

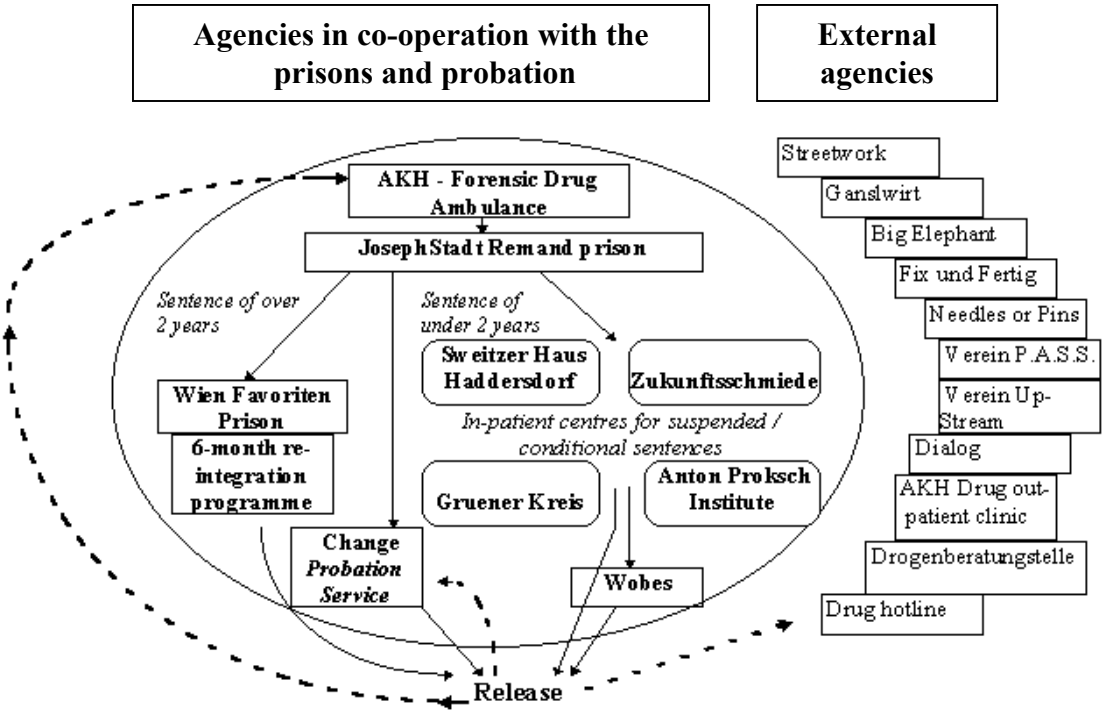
crime, and social disorientation. Low self-esteem and lack of motivation produce a "loser syndrome." The long-term unemployed are also unlikely to value punctuality, and to perceive their own potential resources and work opportunities.

The target group are people who have been unemployed for a variety of reasons, which may include previous conviction, excessive debts, drug addiction, homelessness / housing problems, continued addiction after therapy, inexperience, and lack of qualifications. Those who are excluded from the programme are acute addicts without a certificate from a therapist and/or without substitution, and people with a variety of psychological problems, such as violent tendencies and aggression, or noticeable lack of motivation.

Initially as trainees and temporary workers, the unemployed learn skills related to house repair, such as carpentry, painting and decorating, tiling, and general renovation, as well as transportation and storage. Each individual is assessed separately, and then undergoes a two-month probationary period followed by up to a year's semi-protected training period. The supervisors give constant support and continual reassessment. The programme aims to obtain and retain at least 30 positions for men and women, including 7 trainers, and 4 to 6 convicts on day release, and to obtain 51% permanent contracts on the free labour market. The goal is to achieve competition and placement ability, social competence, individual stability, and liaisons with other therapeutic enterprises and social- work institutions.

9.4.6 Co-ordination of services

The treatment of drug users in penal institutions is managed according to the "Wiener Organisationmodell." Continuity of treatment is ensured via a network of care agencies [See diagram below]. Liaison counsellors, psychologists and doctors, who apportion their time between institutions, maintain the chain of personal continuous care for each individual. The patient may obtain treatment from the Forensic Drug Ambulance both before and after release.



9.4.7 External agencies

A key aim of Vienna's Drug Policy Programme (Drogenkoordination), adopted in 1999, is the social inclusion of formerly marginalized drug users. The programme maintains an extensive network of medical and social services that support the four pillars of the policy: prevention, health-related measures, social measures, and public safety.

9.4.7.1 Ganslwirt

Ganslwirt is an outreach agency in Vienna, which encompasses street work with drug users, a needle exchange service, a day centre and a night station and an outpatient medical clinic. Drop-in clients can also receive crisis intervention or withdrawal counselling, as well as other forms of psychotherapeutic assistance.

> *"The day centre is a place where a drug user can rest from the scene, you know. They are working, the social workers, they do crisis intervention, psychosocial relationship and care. Then harm reduction, substitution and safe sex counselling, withdrawal and therapy*

arrangement counselling, they can have a warm meal and take a shower, they can do their laundry."

Hans Haltmeyer reported that, based on questionnaires he had collected, 50% of all Ganslwirt clients have been in prison at some point in their lives. To assist those who have been released or are awaiting trial, a legal counsellor from Favoriten prison comes once a week to Ganslwirt.

When a Ganslwirt client is incarcerated, he or she can continue the relation with the centre while in prison. Two social workers from Ganslwirt are dedicated to the care of incarcerated clients. The social workers represent a link between prison and the outside world and offer practical support such as continuation of rent payments, contact with the judge or legal counsel, and establishing contact with rehabilitation institutions. Thanks to donations by clients themselves, Ganslwirt can also make small amounts of money available to prisoners who make a written request.

A female inmate at Favoriten confirmed the good standing Ganslwirt has among drug users:

"Everybody knows about them. They do help you. Even when you are in here you can write to them and they can send you money."

The same organisation also runs a social employment project called 'Fix und Fertig' that offers drug addicts job-skills training and employment in either home renovation or silk screening.

9.4.7.2 DIALOG

DIALOG, a facility for drug-addicted people, is led by the City of Vienna's Drug Commissioner, Alexander David, MD. DIALOG employs a team of social workers, psychotherapists, physicians and honorary associates. Within its main framework of abstinence-oriented therapy, services offered include:

- advisory activity
- individual treatment / single psychotherapy
- maintenance treatment
- group therapy
- dance therapy
- gymnastics and self-defence for women.

9.4.7.3 Needles or Pins

'Needles or Pins' is a DIALOG project in cooperation with national and international partners, funded by the European Social Fund, the Austrian Labour Market Service and the Municipality of Vienna. The project's aims concentrated on the re-integration of drug users into the labour market and/or the educational system. It also assists current problematic users to stabilise their use and remain employed.

An evaluation showed that Needles or Pins is an important transition service for drug users. For 20 clients (= 40%), jobs could be arranged after participation in the programme; 4 (= 8%) were referred to in-patient therapy. [39]

9.4.8 Health insurance

In order to obtain state assistance for medical care, an unemployed or destitute person must make a formal application. Drug-users lives are often too chaotic to arrange these types of appointments. The result is that they are left with no means of paying for medical care and have to fall back on outreach agencies such as Ganslwirt. Much effort goes into arranging for proper medical insurance for these people. We were told of one case in which a woman on parole who had psychological problems managed to get a hospital bed by giving a false social security number, only to be returned to prison for fraud.

9.4.9 Drug scene in Vienna

Drug dealers in Vienna tend to concentrate around Karlsplatz and in the clubs, as I was told by an inmate in Favoriten and two patients at Schweizer Haus. Two clubs – Arena and Flex – were mentioned as 'good venues' for dealing and experimenting. "You don't have to go looking for dealers", one young former dealer said, "they come up to you and ask you if you need anything."

The interviews revealed some of the dealers' 'tricks of the trade': a common practice, especially among immigrant dealers, is to roll the product up in small balls of cling-film and carry them in the mouth. "Some of them can't even talk because their mouth is full of balls!" laughed an informant. "Then, if the police come, they just swallow them." According to this young man, police tactics to prevent this destruction of evidence often involved half-strangling the suspect before he could swallow the stash and forcibly removing the contents of his mouth.

[39] EDDRA

Cannabis is widely available, I was told, and often smoked openly. A shop in the 7th District, 'Bush Planet', sells cannabis seeds (which are not illegal to possess) and complete growing kits for enthusiasts.

After cannabis, Ecstasy is the most popular drug with young people, especially with fans of the 'techno-party' scene. Vienna was host to the 'Check It!' project that offered free analysis of drugs in clubs. In 1998, analysis of 370 samples demonstrated that only 37% contained MDMA (the chemical components of Ecstasy), or the variants MDE or MDA; 20% contained other amphetamines.

Drug-related deaths have been steadily declining for the past three years,[40] as has HIV prevalence. Levels of Hepatitis B and C among drug users remain high.

9.4.9.1 Policing the drug scene

Possession of small amounts of any drug, is not likely to result in more than a caution, or *Anzeige* from the police. The inmates and patients I spoke to were aware that the caution would result in closer surveillance. "They have your name and they will watch you," explained one young woman who had received several such police warnings.

The police do raid the clubs. Some of the 'targeting' of dealers is considered to be controversial and racially biased.[41] In 1999, 100 West African dealers were rounded up in a single raid.

9.4.10 Information dissemination / education

"Vienna is a small city," explained Hans Haltmeyer of Ganslwirt, "everybody knows about Streetwork and Ganslwirt". Official figures on registered drug addicts seem to support this, as over three-quarters of addicts are in therapy. There is a fairly strong network between the therapy centres, prisons, hospitals and social welfare agencies that work together to make sure that drug users in need of assistance don't fall through the cracks. Ganslwirt does distribute some flyers and booklets, but not necessarily in prisons. Their information about services is delivered face-to-face via counsellors and other social workers.

[40] Haas, S et al. *Report on the Drug Situation: Austria 1999*.
[41] 'Austrian police: brutal and racist.' March 25, 2000. London: *The Independent*

9.5 Netherlands

9.5.1 Government position on drug use and addiction

In Dutch drugs law, a distinction is made between hard drugs that are perceived to carry an unacceptable risk to health, and 'hemp products' such as cannabis and hashish. The possession and trade of any drug is punishable, but, under the guidelines issued by the Public Prosecutions department, the sale of small quantities of cannabis products (under 5 grammes) will not be prosecuted provided the vendor complies with the strict AHOJ-G criteria.[42]

Possession of small amounts of any drug for personal use is considered to be low-priority and is rarely prosecuted.

In the Netherlands, as in many countries, a small proportion of hard-drug users is responsible for a disproportionate amount of crime and public nuisance. The Trimbos Institute estimates that 20% of drug users commit the majority of all crimes.[43]

Dutch drug policy is the joint responsibility of the Minister of Health, Welfare and Sport (VWS), and the Minister of Justice. In 1993, a new government committee was formed to combat the nuisance caused by the trade and use of illegal drugs. The Steering Committee for the Reduction of Nuisance (SVO) combines the efforts of the VWS, the Home Affairs Ministry (responsible for the police), and the Ministry of Justice. Working with the SVO since 1996 is the new Inter-administrative Task Force on Public Safety and the Care of Addicts, whose main objective is to tackle the problem of drug-related nuisance in the cities.

9.5.2 Coerced care

Like other countries, the Netherlands has been frustrated by the repetitive criminal behaviour of a small group of drug-using offenders. Prison alone has no effect on the hard core of this group. The majority have served numerous sentences, but have never received treatment for their drug problems. Usually the problem is the length of the sentence. Small crimes

[42] No advertising; no hard drug sales; no causing a nuisance; no sales to persons under 18; no sales of quantities over 5 grammes.
[43] Trimbos Institute. *Drugs Nuisance Policy*

earn small sentences. As the Director of Brijder stichting, a central drug treatment agency in Alkmaar said:

> *"Prisoners with short sentences are more difficult to deal with. You hardly can do anything. It is too short a time to build up their plans. You can hope that they will contact addiction care in their own town but they may not."*
> —Wilhelm van de Brugge, Director, Brijder stichting

To solve the problem of persistent drug-using offenders, the drug-treatment agencies in the Haarlem district brokered a deal with the police and the public prosecutor. They generated a list of the top 25 persistent offenders who were known to be drug users. All police districts agreed to contact each other if one of these known offenders was arrested. The prosecutor, in turn, agreed to combine as many small sentences as he could into one long one, which would give the treatment system the time to work on the offender's drug problems.

9.5.2.1 SOV

As seen above, the idea of a compulsory sentence combined with treatment for persistent offenders has, unofficially, already been tried on a smaller scale in the Netherlands. In September 1995, the government unveiled its new 'Drugs Policy in the Netherlands' that initiated an experiment in compulsory care for drug-using persistent offenders. A much larger effort, SOV, is now underway in Rotterdam and will begin soon in Utrecht.

The acronym SOV stands for Strafrechtelijke Opvang Verslaafden, which is Dutch for "Order under the criminal law for the care of addicts". The programme applies to males between the ages of 18 and 35 who have long-standing addictions to hard drugs and who have demonstrated little ability to function in the normal law-abiding community. Such a person becomes a candidate for the SOV programme if he has been remanded for a non-minor offence and has been sentenced for similar offences at least 3 times in the preceding 2 years. If these criteria apply, he can be sentenced to the much longer penalty of two years at the SOV facility.

In 1998, Peter de Vrijer, a policy advisor on the Directorate General Prevention Youth and Sanctions policy at the Ministry of Justice, gave an outline of the new program at the Harm Reduction Conference. He then estimated that in Holland there were about 16,000 hard drug users, among whom there were about 6,000 repeat offenders. The SOV target group - around 2600 - forms the hard core of this group. 250 to 300 repeat offenders in Rotterdam had been arrested for an average of 9 crimes a year,

but had committed far more. They had also added to the drug 'nuisance.' But it is not just the string of thefts of cars, car radios, burglaries, etc., that concerned Mr de Vrijer, but also 'the total impact of drug addiction': drug dealing on the streets, the public use of drugs, discarded needles, public places being taken over; the corruption and the decay. He also warned that hard drug users, through their poor health and vulnerability to infectious diseases, represent a danger of contagion to others.

This programme takes addicted serial offenders from remand, through a special prison-cum-treatment centre, and continues contact with them when they leave at the other end, into rehabilitation, housing, work, and a changed life. Its subjects are people who have been in prison before, many times, who need help kicking the crime habit and the drug habit, and who have perhaps failed in other treatment facilities.

Because of this long-term effect on the local communities within the city, the SOV programme involves the city itself in the solution. When SOV is passed into law, it will be able to impose a much longer sentence on these addicted repeat offenders, but unlike their repeated short prison terms, the sentence will include a good chance of rehabilitation.

Placement in the SOV prison / treatment centre is compulsory: participation in the programme is not. So the first phase involves motivating the prisoner to participate in the programme. There will be a time in the 'closed setting' (up to two years), followed by a gradual freedom from supervision in the open setting. But even in the closed setting, the prisoner will go through a process that will allow frequent and early periods outside the walls. As de Vrijer said:

> *"The aim of the measure is more than just repression. The ultimate goal is reintegration, connecting up to society."*

Dr Astrid Bödeker has long experience working with addicts, as well as with prisoners. She now works within the SOV centre under construction in Utrecht. She explained the impetus for the development of this radically new programme:

> *"Since the 70s, in Holland we are busy trying to find a way of helping people with addiction problems. ... What we try to change is the whole life-style ... the addiction, the criminality, the poor social system ....the criminality is also related to the fact that they don't have any money and they don't know how to make money the legal way."*

There is a need, she said, to teach alternatives to the criminal life-style. For this, the staff must consider whether the clients need other treatment or education. Dr Bödeker explained that standards of progress with this group

of clients are different. For example, many clients have little self-control and must be taught, in small steps, the principles of delayed gratification "which will be 5 minutes at first, and then maybe an hour; you know, little steps."

While urine testing will be routine, relapse into drug use is not a cue for ejection from the programme. Patients are gradually taken out of the centre and re-introduced into the outside world. If they relapse, this will be considered an opportunity for self-understanding. Dr Bödeker would tell the patient:

> *"The outside is where you have to practise, and give the preparation, not only looking from the inside through the walls. So we take you out, and if you fall back, if you have a relapse, that should lead to treatment, to step over the relapse, see what are your cues and triggers, to find out what's your problem, and start all over again."*

Dr Bödeker also explained that in the second 'open' phase, in co-operation with agencies and organisations in the city, the SOV staff would help the client to take charge of his future. As incentive for full participation in the treatment, clients are told:

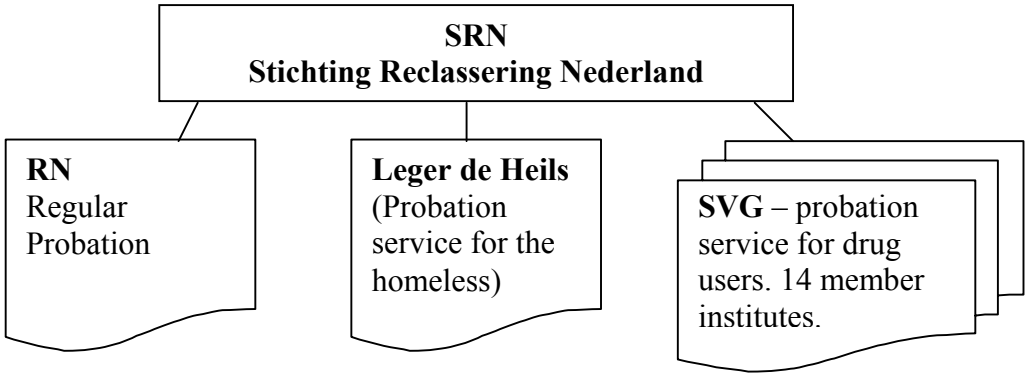
> *"We will see to it that you get a house, that your finances are taken care of, that you will have an education here inside the prison. If you say 'yes' to everything, we will make sure that when you come out, you will have something in your hands, and not just the same street again"*

She stressed the importance of involving the client's family and visitors in the rehabilitation process where possible. She also speculated that the open phase should be somewhat open-ended, so that clients who relapse later can always come back for further contact with their caseworker.

Dr Bödeker would like for there to be always room for 'graduates' of the programme to return whenever they feel the need for a rest, or for help. If this transpires, it may go a long way towards reducing drug-related nuisance on the streets of Utrecht.

9.5.3 Probation

For the last 100 years, the Dutch probation service has been decentralised. Under a Ministry of Justice umbrella, probation is handled by three separate organisations, each specialising in a different type of offender (see diagram below). The RN probation group handles the bulk of offenders; the Leger de Heils organisation serves offenders who are also homeless; and the GGZN -- SVG (hereafter SVG) is the national association of probation services for drug users.



Organisation of the Dutch Probation Service

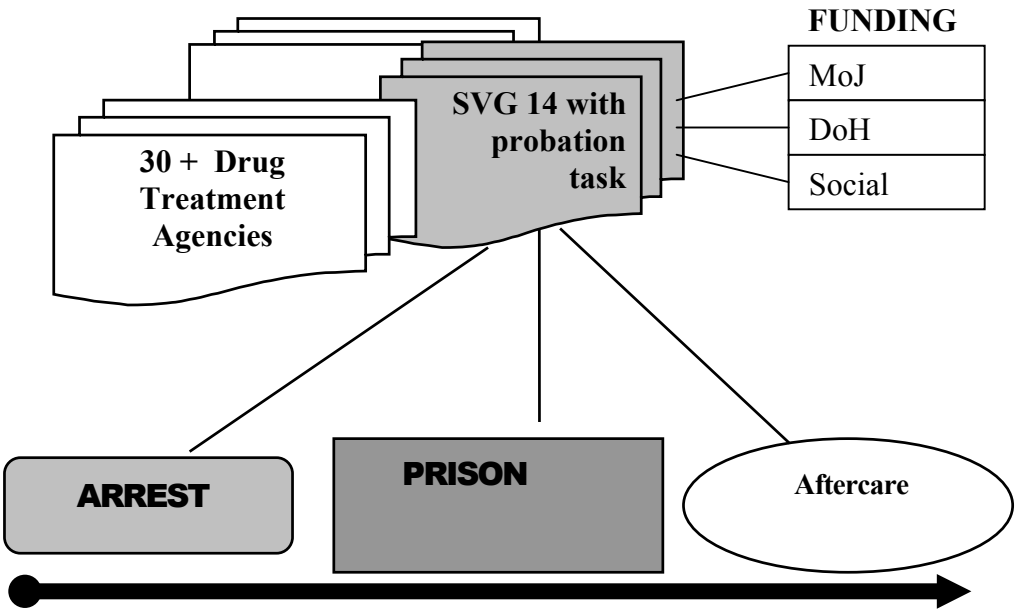
This unique structure rests on the philosophy that all offenders are not equal. The needs of drug users and the homeless cannot be met by traditional probation services. The list of offenders served by specialised probation organisations could soon be expanded to include those with psychiatric problems who, it is felt, need an even greater degree of specialist help.

Drug-treatment services for all drug users come under one organisation (SVG), making a greater diversity of treatment accessible to all. Each of the 14 member institutes has a probation task in addition to their normal provision of drug services to the general public.

Funds for the probation department of these agencies are allocated by the Ministry of Justice in proportion to the need in that area. In some drug treatment agencies, offenders account for most of the client base, in other agencies, for not more than 10%. Probation drug workers make first contact with a client soon after arrest; they also have a visible presence in prison and can maintain contact throughout an offender's sentence.

Most drug-treatment services aim to develop a long-term strategy for each prisoner that may begin in prison, but continues after release. Because the drug services provided to prisoners are managed by external agencies, continuity of treatment is possible. The centralisation of drug services also means that offenders can move between treatment modalities with greater ease without worrying about re-applying for funding at every turn.

The Ministry of Justice provides funding for in-prison treatment; aftercare (or suspended-sentence treatment) is funded by the Department of Health. But it was emphasised that this is not the client's worry; it is up to the drug-treatment agency to ensure that each phase of treatment is paid for.



Drug treatment probation task

9.5.4 Problems

The SRN organisational structure is not without difficulty. To maintain funding, each partner (RN, SVG, Leger de Heils) must show an appropriate output of clients. This pressure often leads to the inappropriate assignment of clients to services. For example, to meet their quotas, the Leger de Heils organisation may treat drug users who are not homeless, or RN may not pass on drug-using offenders to SVG. Relations between the partners are not always amiable. Tensions began to increase further 2 years ago by the joint management and location-sharing of the RN, a subsidiary, with the SRN, the umbrella organisation. The other two partners, SVG and Leger de Heils feel this merger gives one of three subsidiaries a privileged position and an unfair advantage.

Two examples of drug treatment agencies with a probation task are provided below.

9.5.5 Aftercare

9.5.5.1 Centrum Malieban, Utrecht.

The Centrum Maliebaan is part of GAVO, a organisational structure that formalises co-operation between the police, the public prosecutor and Centrum Maliebaan, the drug treatment agency for the province of Utrecht. GAVO is the Dutch abbreviation for "Integrated Approach to Addiction and Criminal Nuisance".

Centrum Maliebaan offers help to the drug-user, as well as to people from his or her environment such as family, parents, or partners. The core functions of the agency are to offer medical assistance, rehabilitation, general consultation, prevention and education.

Probation drug workers from Centrum Maliebaan are sent to police stations to make first contact with arrestees. Within prisons, they assist prisoners with release planning. Many options are available. The policy is to find the lowest threshold of treatment necessary in the first instance.

If the prisoner has managed well with in-prison drug treatment, a weekly visit to the centre after release may be all that is required. The ambulatory centre also assists clients with housing, employment, benefit and other financial issues and offers a methadone maintenance programme.

The assisted living schemes help those who have completed other forms of treatment but need continued support with daily structure.

Part-time rehabilitation programmes are also available for those who have greater independence. The Blue House offers residential treatment for problematic drug users with a long history of addiction that requires intensive treatment.

If the client lacks motivation, or basic cognitive or personal skills, he or she can be transferred to the 'Motivation Centre', a 3-month residential programme that motivates and prepares a drug-user for further treatment.

Sometimes, the first necessary step is to the detoxification clinic's 4-week programme.

9.5.5.2 Brijder Stichting, Alkmaar

In Alkmaar, Brijder stichting is the central drug treatment agency.

Olav Makkinje, a probation drugs worker, maintains an office within the regional prison. Prisoners can see him at any time during their sentence. They do not have to go through the guards in order to manage their own in-prison treatment or release planning: they can go straight to Olav.

Like the Centrum Maliebaan, Brijder stichting encompasses a myriad of options for offenders on release or on conditional sentence (Article 43) and non-offending drug users. Examples include:

1. The Assisted Living houses in Alkmaar allow ex-offenders with past drug problems to blend in to communities in a supportive, semi-supervised environment.

2. The Baansingel day centre offers work training and holistic support for drug users with the aim of complete social re-integration. Approximately 20% come from prison. Clients can receive personal instruction in metalwork, art, carpentry, boat building, bicycle repair and other activities. Support is also offered through counselling and practical assistance with debts and relationships. The Baansingel staff is comprised of a few full-time workers and interns doing university degrees in social work. Client follow-up through the last ten years points to a 60% success rate. As Ton de Boer, one of the centre's staff, explained: *"60% of Baansingel clients achieve the type of lifestyle they want."*

3. Ambulatory clinics offering probation counselling, methadone maintenance and needle exchange also come under the Brijder stichting umbrella. Drug users on release can receive specialised counselling as well as medical help.

Thea Andriessen, a drugs probation worker at the Brijder stichting Ambulatory clinic in Alkmaar, considered it imperative that drug users be seen by specialist probation services. If not, she felt it would be impossible to properly diagnose and treat their problems. All drug use is not alike, she explained. Many of her clients have a long history of addiction that, after in-depth interviews, is revealed to be the result of self-medication for physical or psychological disturbances. For example, many stimulant users have undiagnosed Attention Deficit Hyperactivity Disorder (ADHD). She cited research claiming that 60% of ADHD sufferers can become addicted to Speed or cocaine. Substituting drugs such as Ritalin can radically alter the drug user's life for the better. In order to make an accurate diagnosis, drug users who show signs of ADHD-related addiction should be seen by a psychiatrist. As a specialised probation worker, Thea Andiessen, and others like her, are able to spot these signs and arrange relevant appointments.

9.5.6 Prisoner rehabilitation centres

9.5.6.1 Piet Roordakliniek

The Piet Roordakliniek is one of two experimental 'forensic clinics', or residential rehabilitation centres in the Netherlands. The centre's 25 places are open to offenders who obtain the pre-trial diversion – that is, 'treatment instead of prison' – and to those on conditional release from prison. The target group is offenders whose crime is directly related to drug addiction.

Piet Roordakliniek operates on the principle that successful rehabilitation depends on the treatment of all addictive behaviours: both addiction to drugs and addiction to crime. The clinic's manager said that it is common for ex-offenders to relapse into crime before starting to use drugs again.

The centre has a very strict policy on drug or alcohol use during the programme. If clients test positive for drug or alcohol use they are sent away, but are allowed back after a certain period of time. Most staff disagree with this hard line. Many would like to see alternatives to ejection from the programme, as it usually results in the client seeking out a dealer and slipping back to square one.

In justifying rehabilitation centres exclusively for prisoners, the centre's staff point to a difference between regular drug users and prison drug users. The regular drug users, they explained, are often manipulative, but they use subtle, interpersonal means; the prison drug user, by contrast, has learned a different set of survival skills. Ex-prisoners tend to be tougher, more aggressive, and concerned about maintaining a 'macho' image.

9.6 Sweden

In size, Sweden is the third largest country in Western Europe after France and Spain, yet its population hovers around only 9 million – about that of greater London. Sweden's advanced social-welfare system accounts for the bulk of government expenditure. Unemployment rose during the early 1990's from 1.6% to nearly 8% but is now, we were told, around 3%. 40% of all employed people work for the public sector.[44]

9.6.1 Government position on drug use and addiction

An increase in the severity of drug legislation came about in the late 1980s, partly in response to an increase in drug use.[45] New laws included provision for the "coercive treatment of addicts". This forcible treatment for drug addiction, even in the absence of a criminal offence, is allowable under Swedish law if it is determined that the individual is a risk to him or herself or the community.

In 1988, the dominant prohibitionist approach was made clear when "personal illicit use of narcotic drugs" became a criminal offence. The penalty for ingestion of an illegal drug was raised in 1993 to six months of imprisonment.[46]

Swedish law makes no distinction between 'hard' or 'soft' drugs. The penalty for possession or trafficking depends on the quantity of the drug, not the type.

9.6.2 Sentencing options

Every attempt is made by the courts to keep sentences as short as possible. 30% of a year's receptions into prison are serving 2 months or less; 65% are serving 6 months or less. Those serving sentences of less than 12 months are worst placed for aftercare planning, as they are not subject to probationary supervision.

[44] World Drug Report (1997) UNDCP
[45] Ibid.
[46] National Council for Crime Prevention: Sweden (1997)

Section 34 of the Prison Treatment Act allows prisoners with drug problems to serve their sentence in the community if they are participating in a treatment programme.

9.6.3 Prisons – general information

In 1998, receptions into prisons totalled 9,500 for the country. 5,000 of these were classified as drug misusers, 1,600 of whom were identified as serious misusers. In 1998, 2,200 sentence prisoners took part in various drug treatment programmes, and 1,100 remand prisoners participated in informational or educational programmes.[47]

During prison terms, efforts at 'normalisation' are maintained. Regular contacts with outside agencies and with family are encouraged. Some prison officials complained that this can hamper efforts to prevent drug smuggling into prisons, but on the whole, the benefits to prisoners were thought to outweigh the drug threat.

9.6.4 In-prison care

9.6.4.1 Österåker prison

Located 30 km outside of Stockholm, Österåker prison has a 20-year history as a treatment prison for drug abusers. Within the established framework of a therapeutic community, various methods of treatment have been attempted and evaluated. Most have focused on applied behavioural change: wards that emphasised role playing and cognitive training appeared to have the best success as measured by recidivism rates. A Stockholm University study in 1996 found that prisoners who completed the Österåker programme had lower rates of recidivism than drug abusers from any other residential treatment centre.[48]

Two elements are necessary for admission to Österåker: a documented lengthy dependence on drugs, and sincere motivation to change. Prisoners are allowed greater physical freedom, but must also accept greater responsibility and stricter controls on behaviour. Violence, threats or even conversation about crime can lead to expulsion from the programme. In addition, prisoners must provide a sample of urine for drug testing every morning. The prisoners are nude and directly observed during this process, so opportunities for cheating are almost non-existent.

[47] Swedish prison and probation administration
[48] Berggren, O. et al. (1999)

The Österåker administrators understand that maintaining behavioural change is only possible if multiple aspects of the prisoner's life are stabilised. This means that treatment must address not only attitudes, feelings and cravings, but also practical matters such as housing, work, family relationships, friends and the social setting into which the prisoner will be released. As C. Åke Fabring of the Ministry of Justice explains:

> *"Multimodality ... has also been a major theoretical underpinning. Change is not easy, and if it is not correlated with whole sets of attitudes, family network and friends, feelings and social arrangements, it is likely to disappear once the 'campaign effect' is over."*

Due to funding cuts, many of the innovative in-prison drug-treatment programmes have been eliminated due to staff cuts of nearly 50%. For example, the Cognitive Skills programme developed in Canada by Ross and Fabiano, although a proven success, uses too many resources per prisoner to be affordable. Another programme to suffer cuts is the Aggression Replacement therapy. Mr Farbring acknowledged that this was a much-needed programme but most prisons could not afford the tutor.

The most common method now used in Österåker and other prisons is talk therapy and social planning. 6 to 10 months before the end of their sentence, most prisoners are placed in treatment institutions or with foster families. Selection of these placements begins as long as a year prior to release.

9.6.5 Aftercare

9.6.5.1 Treatment centres

Prisoners who still have problems with drugs, or are at high risk for relapse, normally go from prison to residential treatment centres. The selection of a centre begins at least one year before release and is a co-operative effort between the prisoner, social services, the probation service and the centre itself. Often the prisoner will be allowed to visit the centre and be interviewed in prison by members of staff.

9.6.5.2 Björka

As a drug-rehabilitation centre, Björka is state-of-the art. It takes approximately 45 to 50 clients a year from Österåker and other prisons. The centre can house 21 clients at any one time. The ratio of staff to clients is 1:2. Thanks to the investment of its founder, the centre has no lack of funds. As long as a former prisoner is still serving his sentence, his stay at Björka will be funded by the prison and probation service. Thereafter, it becomes

the responsibility of the social services to continue payment if the individual is not considered competent to be discharged. Director Peter Irvell said that they have, on several occasions, kept individuals on without payment for several weeks.

Incoming clients begin with a 3-month course of therapy, usually a combination of 12-step programmes and cognitive-skills development focusing on drug and alcohol abuse. Also on offer are programmes on gambling, aggression and other psychosocial problems. In phase two, clients begin training and education in fields that will improve their chances of finding employment.

The clients are under obligation to remain drug and alcohol-free. This is enforced through random testing of urine and breath. Relapse is not tolerated at all, and clients are returned to prison if they fail a test.

Björka's success stories are numerous and their former client reunions are apparently huge and happy occasions.

Mr Irvell considered that Björka 's success was due to a confluence of several elements:

- Good relations with the authorities
- High ambitions for clients
- Adequate funding (1 million crowns available)

The biggest obstacle to success, he feels, is the negative attitude of many prison wardens towards drug users, which prevents many potential clients from "being heard or being taken seriously". He criticised the Swedish system of training and selection of guards that allows prejudiced individuals to have power over the lives of others.

The Björka centre has plans to take non-offending clients on an ambulant basis as of November -- offering therapy group sessions twice a week.

Peter Irvell's dream would be that all prisons be modelled on the Björka centre.

9.6.6 Innovative programmes

9.6.6.1 KrAMI

KrAMI is a collaboration between the prison and probation service, the social welfare department, and the employment department.

If they qualify, offenders between the ages of 18 and 40 can come to KrAMI even before they have completed the usually mandatory two-thirds of a sentence. A personal plan is arranged for them for the next year. It offers the offender a full programme of job-skills training combined with practical 'life skills' courses, counselling for substance-misuse problems, and group work.

'Pupils', as they are called, attend the centre every day between 9 am and 5 pm. An intake group of 12 offenders will usually stay together for the entire year.

Richard Göransson of the KrAMI centre in Stockholm said it was very important for release planning to start at the earliest possible date. This is important not just for practical reasons, but for mental preparation as well. The earlier an offender has contact with KrAMI, the more realistic he or she will be during the sentence. Prisoners have plenty of time to daydream about how their lives will be when they are released. Very rarely does this daydreaming involve realistic goals or practical steps. Göransson will tell a potential pupil: "You have to begin to imagine yourself in a responsible life position." He also warns them that:

"The day you are released from prison is the day your problems start."

KrAMI's aim is to help offenders develop ambition and realistic dreams, and then give them the skills and confidence to achieve them.

After the pupil has found suitable employment, he or she can still come back to the KrAMI centre for counselling and advice. KrAMI will also mediate between the ex-offender and the employer in the case of disputes or problems, if either side wishes.

KrAMI claims a success rate – that is, ex-offenders into permanent jobs – of 54%. Although many do not achieve the goal of a job, they do manage, in most cases, to take responsible control of their lives.

The incentive for employers to hire ex-offenders is great. The Swedish government recompenses 80% of the employee's salary in the first year and keeps up the compensation to the employer, in decreasing amounts, for five years.

The KrAMI project was evaluated in 1993. Since good results were obtained, funding and expansion has continued.[49]

[49] Lindberg O (1993)

9.6.6.2 Foster Families

An innovative form of aftercare for released prisoners in Sweden is their placement in homes of specially selected families. The idea is to integrate the individual back into a new community where he or she will have the support of a new and stable social network. Usually these placements are in rural areas -- on farms or in small towns. The families are well compensated for their care of the prisoner. Prisoners at Österåker thought that the average pay was around 1000 Crowns per day. Consequently, it seemed that there is great incentive to be evaluated and accepted as a foster family and obtain a license.

Mr Farbring thought that the results of family placements from Österåker prison were generally successful, but that there are often difficulties and there have been cases of abuse of the system. In the past there were a few cases when the foster family itself included former prisoners who encouraged their charge to smoke cannabis, and also cases in which the prisoner simply absconded. Nonetheless, programme inspectors, probation service officers, treatment providers and the prisoners themselves all agreed that family placements are, on the whole, a superb method of re-integration into society for former drug addicts. For many, it offers a chance to live within a stable and drug-free environment where they can continue to receive support for psychological and practical troubles.

Part 10: Conclusion

An opinion common to many who work directly or indirectly with drug users or criminal justice is that the 'War on Drugs' is a war on drug users. Prisons can be redefined as prisoner-of-war camps where thousands of users are punished for their dependency on a politically charged substance.

The campaign for proper aftercare for drug-using offenders is not intended to absolve criminals of responsibility for their crimes; it is intended to restore to drug users – in or out of prison – the right to treatment for their problems. It is also intended to restore hope to communities – whose taxes finance the prison and social welfare systems – that something can be done about the level of drug-related crime. If the same drug user has been to prison 20 times for the same crime, are communities being served by the prison system? If the released prisoner is still a drug user, has the sentence achieved anything?

Many countries in this study have already shifted sides in the war. The heavy artillery has been re-aimed at the dealer; the war chest re-opened for treatment of the user. From examination of four countries, it is apparent that lasting rehabilitation for drug users, and lasting peace for communities, depend on treaties being signed between the agencies for criminal justice, social welfare, healthcare, and drug-treatment.

In countries where the prison and probation system is divorced from drug-treatment efforts, the prisoner is always 'someone else's responsibility'. If the person is released with an addiction to drugs, he is the health system's problem; if he commits a crime and is re-arrested, he is the prison's problem. The cycle repeats ad infinitum. But in countries where a merger has occurred between the treatment and punishment tracks, greater success is seen in reducing both recidivism and relapse.

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