

# Evaluation of the Scottish Prison Service Transitional Care Initiative

**Substance Misuse Research**

# **Evaluation of the Scottish Prison Service Transitional Care Initiative**

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## **Executive Summary**

### **Introduction**

In June 2000 the Scottish Prison Service (SPS) launched a revised drug strategy aimed at, among other things, effectively managing the transition between prison and the community. Transitional Care was introduced by SPS in 2001 to support short-term prisoners (that is, those serving less than 4 years) and remand prisoners with an identified substance misuse problem.

The main aim of Transitional Care was to facilitate access to pre-existing community services based on an individual's assessed needs. This was done through the provision of support during a 12-week period immediately following a prisoner's return to the community. The Transitional Care arrangements were provided by Cranstoun Drug Services under contract to SPS.

A research team from the University of Stirling and TNS Social Research was commissioned to evaluate the operation and effectiveness of the Transitional Care initiative. A combination of quantitative and qualitative research methods was employed in this study. This included the analysis of Transitional Care monitoring data; surveys of prisoners four and seven months following release; in-depth interviews with ex-prisoners in three areas of the country with different demographic characteristics and varying arrangements for the delivery of Transitional Care; and interviews with prison and community based staff associated with Transitional Care. Interviews with prisoners included both those who had attended Transitional Care on release from prison and those who had not.

### **The organisation of Transitional Care services**

#### **Prior to release**

Prison-based Cranstoun caseworkers were responsible for conducting assessments on all short-term and remand prisoners to identify the needs of individuals with substance misuse problems and to co-ordinate service provision. The Common Addictions Assessment Recording Tool (CAART) was employed to assess prisoners and to develop a care plan, though it was found by caseworkers to be cumbersome to administer and ill-suited to particular groups of prisoners (such as young offenders and women) who were considered to have different needs. Caseworkers believed that the resulting care plans were resource- rather than needs-led.

There were differences between prisons in the extent to which Transitional Care casework was co-ordinated with other service provision. Additionally, some penal establishments were able to allow caseworkers and Transitional Care staff greater access to prisoners than others. Both of these factors, along with caseloads, impacted upon the ability of caseworkers to engage with prisoners prior to their release.

Most prisoners assessed as requiring Transitional Care were reported by caseworkers to have agreed to being referred to the service. In these cases caseworkers liaised with community-based Transitional care workers in sub-contracted agencies. The extent to which Transitional Care workers attended pre-release case conferences appeared to vary across the country. More generally, pre-release contact was influenced by the emphasis placed by the agency on this aspect of the work and the accessibility of prisoners in individual establishments. Pre-release contact was, however, universally regarded as important not least as a means of encouraging take-up of the service once the prisoner returned to the community.

Remand prisoners presented particular challenges because of the brevity and uncertainty of their period of incarceration and because many were of no fixed abode on release

(courts will often remand an accused to custody because they have no fixed address in the community). Amendments made to the Transitional Care initiative – which reflected its evolutionary nature - included the introduction of Crisis Transitional Care aimed at those who were expected to be incarcerated for 31 days or less. Other important changes included amendments to the CAART assessment tool to reduce the administrative burden and the re-focusing of Transitional Care upon a narrower range of needs (addiction and housing) to reflect the introduction of Link Centres to bring together external service provision to facilitate throughcare within all prison establishments.

### **Following release**

Transitional Care services in the community were provided by a range of non-statutory agencies that were sub-contracted by Cranstoun Drug Services. Given that the focus of these services differed Transitional Care workers had a varied range of previous work experiences and qualifications. Most were based in local communities with the exception of Transitional Care staff employed by Cranstoun who were based in HMP Dumfries and who undertook both casework and work following release.

The organisational and management arrangements for Transitional Care were complex, requiring relevant training and ongoing contact and negotiation between the relevant parties. Concerns about the quality of sub-contracted provision resulted in a re-configuration of staffing to better meet identified need. Targets and expectations were constantly under review and it was acknowledged that initial targets for the service had not been realistic.

The Transitional Care workers were expected to provide support to ex-prisoners by offering three appointments in the 12-week period following release aimed at referring them to existing community-based services. Transitional Care workers believed that contact with prisoners prior to release impacted upon their subsequent engagement with the service. They also suggested, however, that the take-up of Transitional Care could be enhanced through adopting a more proactive approach once prisoners were released (for example, meeting clients at the prison gate or escorting them to appointments).

The system of three appointments within 12 weeks was regarded by workers as insufficient to address complex needs and to ensure that ex-prisoners were effectively linked into services as opposed to simply being referred on. Instead, it was suggested that clients needed more intensive support in first week following release. It was also proposed that appointments should be based on need rather than being fixed to three.

Substance misuse and housing were the services most often said to be requested by Transitional Care clients. However, the range of services available varied across the country (tending to be less extensive in more rural areas) and where they were available there were often lengthy waiting lists. This applied both to drug services (including access to substitute prescribing) and to accommodation. It was rare for ex-prisoners to be offered anything other than transitory accommodation (such as a hostel or Bed and Breakfast) within the 12-week post-release period. The ability of Transitional Care workers to link ex-prisoners effectively to these and other services was also hampered by lack of understanding of the Transitional Care and some hostility on the part of other agencies, such as social work services and Drug Action Teams, who felt that they had not been adequately consulted prior to the initiative being established.

### **Engagement with Transitional Care**

Monitoring data were available in respect of 4794 prisoners who 'signed up' to Transitional Care while in prison. The mean age of ex-prisoners on release who signed up to Transitional Care was 28.4 years and 90 per cent of the sample was male. Most prisoners (95%) were unemployed when they received their prison sentence and many

(35%) were recorded as being of no fixed abode. Ex-prisoners were most commonly returning to Glasgow City (24%), Tayside (10%), Lanarkshire (10%), Ayrshire (9%) and Grampian (9%).

Twenty-eight per cent of prisoners were recorded as having attended their first Transitional Care appointment on release, 15 per cent attended a second appointment and 8 per cent attended a third appointment. Survey and interview responses indicated that those who attended Transitional Care appointments were positive about the service they received.

Attendance rates at first appointment were similar for men and women, but ex-prisoners under 21 years of age were least likely to attend. Consistent with staff perceptions that they were more difficult to engage with, and despite staff efforts to make contact with them on the day of release, attendance rates were lower among those who were of no fixed abode.

Sixty-four per cent of those interviewed 4 months after release said they had met their Transitional Care worker while they were still in prison. There was, however, no evidence – either from monitoring data or the survey – that attendance at a pre-release case conference or other pre-release contact with prisoners increased the take-up of Transitional Care. That said, geographically, the highest attendance rate at first appointment was in Dumfries and Galloway, where the same Transitional Care workers provided a service in the prison and in the community.

Arrest or return to custody accounted for most instances of non-attendance where the reason was recorded in the monitoring database (though in most cases reasons were not recorded because they were not known). Survey responses by ex-prisoners indicated that the most common reason for non-attendance was not receiving an appointment to see the Transitional Care worker following release. Ex-prisoners who had not seen their worker prior to release were more likely to give 'not receiving an appointment' as a reason for non-attendance, suggesting that mechanisms for engaging clients could be improved.

## **Effectiveness of Transitional Care**

The Cranstoun monitoring data indicated that health (drug and alcohol) (63%) and housing needs (58%) were most common among those who attended at least one appointment, followed by benefits/financial needs (34%), education/training (26%) and employment (22%). Women were more likely than men to have identified housing needs while men were more likely to have needs identified in relation to employment. Compared with those aged 25 years or older, younger prisoners were more likely to be identified as having needs related to education and employment. A very similar pattern of needs was identified from the 4-month ex-prisoner survey data. Seven months after release housing was the most commonly identified need (51% of respondents) followed by education, training or employment (42%).

The effectiveness of the Transitional Care initiative depended on the extent to which it facilitated ex-prisoners' access to community services. Within 12 weeks following release, action to meet identified needs (usually making an appointment with a relevant agency) had been taken in between 51 per cent and 69 per cent of cases, depending upon the specific action required. However there was no evidence of different levels of unmet need between those who attended Transitional Care appointments and those who did not.

There were no differences in drug use, injecting behaviour, alcohol use and offending among survey respondents who attended Transitional Care and those who did not. There was a significant reduction in mean scores on the Cristo Inventory over successive appointments, which would suggest an improvement in psychological and

social well-being among those attending Transitional Care. However, the number of cases was comparatively small and in the absence of an appropriate comparison group it is not possible to attribute changes to Transitional Care.

Ex-prisoners were generally positive about their experience of Transitional Care, valuing the advice they received, the friendly and courteous approach of the workers and, in particular, the assistance they received in negotiating bureaucratic processes to access the services they required. Some, however, were critical of Transitional Care for raising expectations with respect to access to services in the community that could not subsequently be fulfilled.

## **Conclusions**

A number of factors appeared to have impacted upon the operation and effectiveness of the Transitional Care Initiative. Some were external to the initiative but nevertheless had implications for its operation while others were intrinsic to it. They included the impact of arrest on outstanding charges (including gate arrest) on the ability to take up Transitional Care, the complex management and staffing structure and the amount of administration that was required. The operation of Transitional Care was also constrained by the availability and accessibility of services in the community.

It appears that Transitional Care was reasonably effective at linking clients with services as indicated by the survey and monitoring data. However the extent to which it linked them with services they would not in any case have accessed by some other means was unclear and there were no apparent differences in short-term outcomes among those who attended Transitional Care and those who did not. It is therefore difficult to conclude how effective Transitional Care was in this respect in comparison with the services that existed before it was introduced. Those who attended appointments were positive about the workers and the service they received. However, the take-up rate of initial appointments was comparatively low, especially among young offenders and those of no fixed abode, suggesting that the process for engaging ex-prisoners may need to be improved and the appropriateness of the model for certain groups of ex-prisoners reviewed.



## Chapter 1: Introduction and Background

Attempts to reduce the social, political and economic problems associated with substance misuse have led to a growing recognition of the need for a co-ordinated response (Scottish Office 1999; Scottish Executive 2000, 2001). While all areas of society have a role to play in tackling substance misuse, the criminal justice system is of particular significance. The Scottish Prison Service (SPS) has been clearly identified as presenting an opportunity to identify substance misusers and to provide a resource for reducing and/or ending problem substance use (Ministerial Drugs Task Force, 1994; Scottish Affairs Committee, 1994; Scottish Prison Service 1994, 2000; Scottish Office, 1999). Many prisoners with substance abuse problems may not have had any prior contact with treatment services before receiving a custodial sentence and levels of substance use among prisoners are high. For example, in October 2000, 75% of prisoners tested positive for drugs on entry to prisons (Scottish Prison Service, 2000) though data provided by SPS suggest that this figure had reduced to 66% by 2002/3.

Subsequently the Scottish Executive and the SPS have acknowledged the importance of bringing substance users into contact with services during their period of imprisonment and substantial resources have been directed towards the provision of treatment and support services in custody. The SPS launched its revised drug strategy in June 2000 aiming to keep drugs out of prisons, to bring prisoners into drug treatment, to keep them in contact with treatment services and to effectively manage the transition between prison and communities<sup>1</sup>.

It has been acknowledged that for services to operate effectively in reducing drug-related harm, it is essential that these provisions continue following release from prison. The transition from prison to the community can be difficult for prisoners, particularly for those who have received some form of treatment within prison and who may be drug free when released. Treatment received in prison may be jeopardised on release unless community-based support is made available. Many ex-prisoners return to the communities from which they originally came, and to the same problems they faced prior to imprisonment. Their resolve not to use drugs on release may disappear quickly. Relapse may result in a return to drug use and to drug-related crime. Furthermore, those who resume drug use on return to the community may be at risk of overdose given their reduced tolerance to drugs. Structured after-care provision can help reduce the likelihood of relapse though, as recent research in England and Wales has demonstrated, the provision of effective throughcare services is a complex task (Burrows et al., 2001).<sup>2</sup>

The SPS Drugs Strategy (Scottish Prison Service, 2000) set out one of its key objectives as being to increase the proportion of identified substance misusers taking part in successful Transitional Care after release from prison. In 2000, with the support of the Scottish Executive, the SPS was able to expand drug treatment resources in prisons and to establish improved services to facilitate offenders' transition between prison and the community. In particular, continuity of provision was to be introduced for short-term and remand prisoners (Scottish Executive 2001). The Transitional Care arrangements were designed to assist SPS to meet this key objective<sup>3</sup>.

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<sup>1</sup> Previous research suggests that the supports available to prisoners upon release may be more important, in terms of reducing recidivism, than services that are provided to them while in prison (Haines, 1990).

<sup>2</sup> Research into social work services to the criminal justice system in Scotland (McIvor and Barry, 1998) found that community-based throughcare was the least well developed form of provision. The difficulties involved in providing effective post-release services to ex-prisoners have also been documented by Maguire et al. (1996).

<sup>3</sup> This reflects the development of policies in England and Wales where the Prison Service launched the CARAT (Counselling, Assessment, Referral, Advice and Throughcare) service for prisoners with drug problems in April 1999.

## The Transitional Care Initiative

The Transitional Care initiative was established to alleviate problems associated with the uneven provision of services throughout the penal estate and to co-ordinate and enhance ex-prisoners' access to community based services on their release from prison. The main aim of Transitional Care was to facilitate access to pre-existing community services based on an individual's assessed needs. Support was provided during a 12-week period immediately following their return to the community. Transitional Care aimed to bridge the gap between prison and a return to the community, a period which is crucial in terms of establishing and maintaining contact with appropriate support services for individuals leaving custody.

Transitional Care was voluntary on the part of prisoners. Transitional Care arrangements were designed to support prisoners with an identified drug problem and intended to substantially expand existing provision for short-term and remand prisoners. Long-term prisoners (those who receive a custodial sentence of four years or more) were already catered for through the provisions of the Sentence Management System<sup>4</sup> (Scottish Prison Service, 2001). Transitional Care therefore focused upon remand prisoners and those serving sentences of less than four years.

The Transitional Care service was provided by Cranstoun Drug Services under contract to SPS. Prison-based caseworkers employed by Cranstoun were responsible for conducting prison-based assessments that identified the key needs of individuals and for co-ordinating service provision while the prisoner was in custody. They were also responsible for liaising with community-based Transitional Care workers and, for those prisoners who chose to participate in Transitional Care, facilitating case conferences prior to their release. Community-based Transitional Care services were provided by Cranstoun and by a range of sub-contracted voluntary agencies operating in the drug and criminal justice fields who, by offering ex-prisoners three appointments over a period of 12 weeks following their release, aimed to enable ex-prisoners to access relevant services on their liberation.

Transitional Care was introduced on a phased basis. Some areas began to provide a service in January 2002 and most schemes were operational by April 2002. However, Transitional Care was an evolving service and throughout the course of this evaluation aspects of the service were modified in the light on ongoing experience. This means that many of the issues identified at earlier stages of the research were subsequently addressed through operational changes, which are highlighted at relevant points in this report. It also means that ascribing outcomes to specific aspects of Transitional Care is not possible since features of the service changed over time. It should also be noted that the Transitional Care initiative formally ended in July 2005 with the introduction of a new national Throughcare Addiction Service (TAS) for prisoners with drug problems in Scotland. This development is being taken forward as part of a wider range of throughcare services for priority groups being developed by the Tripartite Group comprising representatives of the Scottish Executive, The Scottish Prison Service and the Association of Directors of Social Work. While the findings of this research can no longer shape the Transitional Care initiative per se, they can nonetheless inform current and future developments in throughcare for prisoners with drug problems.

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<sup>4</sup> This will include statutory supervision by the local authority social work department following release (in some cases with an additional requirement that ex-prisoners access substance misuse treatment services). Short-term prisoners, by contrast, will not normally be subject to statutory supervision in the community following a custodial sentence, though they may access social work services on a voluntary basis in the 12 months after their release.

## Objectives of the evaluation

The principal aim of the research was to evaluate the effectiveness of the Transitional Care arrangements in facilitating access to pre-existing community services based on an individual's assessed need. The evaluation therefore included an analysis of the process and outcomes of Transitional Care and the identification of potential areas where practice may be improved. The specific objectives of the study were to:

- examine the operation and appropriateness of the assessment process
- consider the effectiveness and efficiency of the referral procedure
- identify and assess the role of key workers
- analyse the characteristics of those who opt out and of those who continue to utilise Transitional Care
- identify stages in the Transitional Care process where individuals are dropping out
- examine the level of non-completion and consider how this can be minimised
- examine the effectiveness of Transitional Care arrangements
- compare outcomes between those who complete Transitional Care and those who do not and between different groups of ex-prisoners in respect of whom services are provided (e.g. young offenders and women)
- analyse key aspects of service delivery in order to assess their contribution to the effectiveness of Transitional Care.

The Scottish Executive, SPS and the Inspectorate of Prisons for Scotland have regularly drawn attention to the increase in substance abuse among young prisoners and women prisoners. Successive reports have highlighted the need to provide focused interventions for young people (Scottish Office, 1999; Scottish Executive, 2001) and women prisoners (Scottish Office 1998; HM Inspectorate of Prisons for Scotland, 2001). There is a clearly identified need to enhance prevention and early intervention for these groups, community disposals and provisions, and effectively coordinated aftercare (Scottish Executive, 2001; Ministerial Group on Women's Offending, 2002). While Transitional Care was focused on the needs of the individual, the evaluation process also examined how the service impacted on the experiences of young offenders and women.

## Organisation of the report

The remainder of this report is organised into five chapters. Chapter Two describes the methods used in the evaluation while Chapter Three focuses on the organisation of Transitional Care services. Chapter Four considers ex-prisoners' engagement with Transitional Care while Chapter Five examines the effectiveness of Transitional Care in linking clients into services and achieving other outcomes. The main findings and conclusions are presented in Chapter Six.



## **Chapter 2: Methodology**

### **Introduction**

A combination of quantitative and qualitative research methods was employed in this study. This included the analysis of Transitional Care monitoring data; surveys of prisoners four and seven months following release; in-depth interviews with ex-prisoners in three case study areas; and interviews with prison and community based staff associated with Transitional Care.

### **Analysis of monitoring data**

Monitoring data collected by Cranstoun between October 2002 and April 2004 was analysed to obtain a profile of identified needs of ex-prisoners, their engagement with Transitional Care services and the extent to which links were being made with relevant community-based services. The community-based Transitional Care workers recorded the monitoring data in Transitional Care Action Plans and Logs that were returned to Cranstoun Drug Service Head Office to be entered into an Access database 12 weeks after ex-prisoners' release. The log was completed for those clients who were assessed by Cranstoun. Clients were assessed at either their case conference prior to release from prison, or at their first appointment with Transitional Care on release. This meant that the log was completed for both those clients who attended an appointment with a Transitional Care worker, as well as for those who did not attend Transitional Care on their release from prison.

Between October 2002 and April 2004 information on clients' living arrangements, employment status, ethnicity, local authority area, penal establishment and their needs in relation to six key domains was collected by Transitional Care staff via the Action Plan and monitoring log. The domains of need initially identified were:

- health generally and in relation to drug and alcohol use
- housing
- benefits and finance
- education and training
- employment
- social issues in relation to family members, children and diversionary activity programmes.

However, since Transitional Care was an evolving service its focus was subsequently revised to prevent overlap with and duplication of other services. The monitoring log was consequently amended to take account of the reduced number of domains that provided the focus for Transitional Care.

The electronic formatting of the log proved problematic in conversion to a statistical analysis software package (SPSS). This resulted in a number of incomplete cases being omitted from the final data set. The resultant sample consisted of 4794 cases, 292 of whom were repeat attenders. However, there appeared to be inconsistencies in how the logs were completed by different sub-contracted agencies (see also Cranstoun Drug Services, 2003), making some data difficult to interpret. Moreover changes to the design of the monitoring log over time, reflecting its adaptation to the evolving service, meant that some data were available only for a sub-sample of cases. For example, whether or not clients had received a case conference while in prison was only recorded from October 2003. Further significant revisions were introduced from May 2004. The

action plan and monitoring log became more concise with a number of sections omitted, including the key domains on benefits and finance, education and training, employment and social issues<sup>5</sup>. Because this produced a distinctively different data set, analysis has concentrated upon the data collected in the 'first phase' of Transitional Care until April 2004.

The design of the log did not allow a breakdown of needs in relation to the first, second, third or fourth appointment, preventing any assessment of whether a client had the same or different needs over the course of appointments. It should also be noted in this report that the term 'action achieved'<sup>6</sup> is used in relation to the needs of ex-prisoners and the extent to which they have been met. This means only that an appointment to attend an existing community service provider had been given to the client within the 12-week time frame. It does not necessarily mean that the client had met a representative from that service during that 12-week period following release nor that they would be actively supported by that service.

### **Analysis of changes in Christo scores**

The Transitional Care action plan and log also recorded the client's Christo Inventory scores at each appointment. The Christo Inventory is an audit/evaluation tool completed by the Transitional Care workers that gives a professional indication of a client's drug and/or alcohol use through assigning scores in relation to involvement with crime, drug/alcohol use, general health, psychological well being, living situation, occupational activities and support. The lower the score the less severe the client's problems would appear to be in relation to their drug and/or alcohol use. For evaluative purposes the analysis of Christo Inventory scores has to be limited to those clients who attend at least two appointments. In the present study, Christo score were compared over subsequent appointments for those who attended three Transitional Care appointments. The relevant data were available in respect of 292 ex-prisoners.

### **Professional interviews**

Semi-structured interviews were conducted in spring 2003 with thirty-seven staff involved in the Transitional Care initiative. The interviews explored respondents' views about the operation of Transitional Care in its first 12-18 months with a view, partly, to identifying practical issues that might need to be addressed to improve the effectiveness of the service. For this reason interviews with staff not only elicited data pertaining directly to the research aims but also elicited data on issues that were considered important by the staff involved. The sample consisted of:

Ten case workers employed by Cranstoun Drug services and responsible for implementing Transitional Care assessments for all short term and remand prisoners identified as having substance misuse issues. These caseworkers were selected from five prison establishments.

Fourteen Transitional Care workers employed by sub-contracted agencies: APEX, SACRO, Drugs Action, Dundee Cyrenians, PARC, Realise Community Care Project, Molendinar Drug Service and Cumbernauld and Lanarkshire Counselling services. These workers were responsible for implementing the Transitional Care Plan for clients within a 12-week period after liberation. One or two workers from each agency were included.

Seven Managers of the sub-contracted agencies.

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<sup>5</sup> Leaving health and housing as areas for assessment and action.

<sup>6</sup> This is one of the categories which Transitional Care workers were required to complete on the monitoring log.

Five senior personnel from Cranstoun Drug Services and the Scottish Prison Service Addiction Services employed to operationalise Transitional Care.

The interviews, mostly lasting between 30 and 70 minutes, were tape recorded and fully transcribed. Prior to analysis all interviews were coded and made non-identifiable to protect the identity of respondents.

In addition, information was sought, in autumn 2002, from each of the local Transitional Care schemes about organisational arrangements and service provision. Twenty forms designed to elicit relevant information were completed: 6 by telephone interview with a researcher and 14 by workers themselves.

## **Survey of ex-prisoners following release**

A survey of prisoners at four and seven months post-release was undertaken by TNS Social Research<sup>7</sup>. The cohort of prisoners was recruited from those leaving prison over a period of approximately 15 months from November/December 2002 to the end of March 2004. Fieldwork was completed for the four-month survey between March 2003 and August 2004, and for the seven-month survey between July 2003 and December 2004.

### **Recruitment**

While in prison, at the point at which they were offered Transitional Care, prisoners were asked whether they would also be willing to take part in the research. Those consenting signed a consent form and were asked to provide contact details of where they could be contacted post-release. The difficulties of maintaining contact with a 'chaotic' sample of substance misusers and offenders are well known. For this reason, in addition to the address and phone number of the place the prisoner thought they would be staying post-release, we asked for one further address and two further telephone numbers of relatives or friends through whom they might be contactable. However, the quality and amount of contact details proved to be variable. Most prisoners provided one address and telephone number at best. As an incentive to take part and to thank them for their time, respondents who completed an interview or questionnaire were sent a £10 postal order.

### **Four-month quantitative interviews**

Around 16 weeks post-release, prisoners were contacted by trained interviewers from TNS Social Research. Where possible, interviews were conducted over the telephone, but where no telephone number was available or telephone contact could not be made for some other reason, attempts were made to conduct the interview face-to-face in the respondent's home. In most cases, where an interview was not obtained, it was because no contact was made.

The interview was designed to take around 20-25 minutes to complete. However, in most cases, interviewers found that it took around 30-40 minutes because respondents were keen to talk and to provide additional details of their experiences and difficulties since leaving prison. The main topics covered were:

- experience and perceptions of the Transitional Care service
- needs on leaving prison (housing, education/training/employment, benefits or money, health/substance use, issues to do with partner/children/family)
- current health
- substance use since leaving prison

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<sup>7</sup> Formerly NFO System Three Social Research.

- offending behaviour since leaving prison
- current accommodation and economic activity.

The questionnaire was designed by the research team and adapted slightly following two series of pilot interviews. Most of the questions were closed (with a small number of 'other'/open-ended questions). Questions on health symptoms, substance use and offending were adapted from the Maudsley Addiction Profile instrument for treatment outcome research.<sup>8</sup>

### **Seven-month quantitative interviews**

At around seven months post-release, prisoners were sent a self-completion questionnaire. The questionnaire was sent to all contact addresses available for the prisoner – obtained from the original consent form or from additional contact information obtained at the four-month interview stage. The covering letter made clear that only one questionnaire need be completed and any duplicates received were discarded by the researchers.

The questionnaire was designed to provide data on outcomes comparable with that obtained at the four-month stage. It covered:

- current needs (housing, education/training/employment, benefits or money, health/substance use, issues to do with partner/children/family)
- current health
- current substance use
- current offending behaviour
- current accommodation and economic activity.

The questionnaire was essentially a slightly shorter and simplified version of the four-month questionnaire. As with the four-month questionnaire, the seven-month questionnaire was designed by the research team and adapted slightly following a series of pilot interviews.

Prisoners were sent seven-month questionnaires regardless of whether an interview had been successfully obtained at the four-month stage. This means that for some of the sample we have data for both the four-month and seven-month stages, for some we have four-month data only and for some we have seven-month data only (Table 1). Whether or not the prisoner attended any Transitional Care appointments post-release was based on monitoring data from Cranstoun. Where this was not available<sup>9</sup>, the data were based on the prisoner's self-report at the four-month interview. The characteristics of the sample are shown in Tables 1 – 3 in the Appendix.

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<sup>8</sup> Marsden J, Gossop G, Stewart D, Best D, Farrell M, Lehmann P, Edwards C and Strang J. 1998. The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome. *Addiction* 93 (12): 1857-167.

<sup>9</sup> There were 83 cases where there was no record of the individual in the Cranstoun monitoring data.



<b>Table 1. Quantitative Sample Numbers</b>				
	<b>Attended TC</b>	<b>Did not attend TC</b>	<b>Not known if attended TC</b>	<b>Total</b>
4mth data only	28	70	0	<b>98</b>
7mth data only	24	72	49	<b>145</b>
4mth and 7mth data	21	56	0	<b>77</b>
Total 4mth sample	49	126	0	<b>175</b>
Total 7mth sample	45	128	49	<b>222</b>

### **Response rates**

A total of 698 contacts were issued to interviewers for the four-month interviews. Interviews were successfully achieved with 175 individuals, representing a response rate of 25%. The vast majority of the unsuccessful interviews were because we failed to make any contact with the individual (n=435, 62%). Only 3 (0.4%) individuals were contacted but refused to take part. In two cases (0.3%), someone else in the household refused permission to speak to the respondent and refused to pass on a message. In seven cases (1%), a relative informed us that the individual had died of an overdose. In 76 cases (11%) we were informed by a friend or relative that the individual was in prison or in custody (in addition, a proportion of the 435 with whom we failed to make any contact are likely to have been in prison/custody).

Seven month questionnaires were sent to 667 individuals (fewer than the number of four month contacts because we were not able to send questionnaires to those from whom we only had a telephone number but no address). We received 222 completed questionnaires, representing a response rate of 33%.

Three categories of ex-prisoner emerged from the fieldwork:

- those who declined contact with Cranstoun staff on release
- those who had contact (however brief) with Cranstoun staff on release
- those who expected to be contacted by Cranstoun staff on release, but heard nothing.

### **Levels of analysis**

Much of the analysis has been based on comparisons between those who attended Transitional Care appointments and those who did not, at three different levels:

- Differences at the four-month stage between those who attended Transitional Care and those who did not. This analysis is based on the 4 month data only (n=175 for all respondents, n=49 for those attending Transitional Care, n=126 those not attending Transitional Care).
- Differences at the seven-month stage between those who attended Transitional Care and those who did not. This analysis is based on the 7 month data only (n=222 for all respondents, n=45 for those attending Transitional Care, n=128 those not attending Transitional Care. There were 49 cases where attendance was unknown).

- Where we have both four-month and seven-month data for an individual (n=77), any change between the two stages has been analysed to identify any differences between those who attended (n=21) and did not attend (n=56).

### **Caveats**

Because of the relatively small number of quantitative interviews and the fact that 83 of the total 320 cases could not be linked to Cranstoun monitoring data (required, for example, for information on geography, nature of assessed needs on release, number of appointments attended) there is little analysis of sub-groups. Much of the sub-group analysis has therefore had to be based simply on whether the respondent had any contact with the Transitional Care service post-release. Further, those who did not attend any Transitional Care appointments cannot be seen as a 'control group' - they may well have different characteristics from those who did attend. There is no analysis by sex because there were only 14 females in the four month data and 23 in the seven month data. Only 10 of the four month sample and 15 of the seven month sample were non-white, so there is no analysis by ethnicity. Neither is there any regional analysis (the highest number of cases from any area was 18, in Highland), nor any analysis by the establishment the individual was liberated from (the highest number from any one establishment was 24 from Polmont Young Offenders' Institution).

Moreover, those interviewed may not be fully representative of all those who signed up for Transitional Care. It is likely that those able to provide better contact details, and with whom we subsequently managed to make contact, were in a more stable situation and were perhaps the less 'difficult' cases. This may overstate how effective the service might be for the whole of the target population.

### **In-depth qualitative interviews**

In-depth interviews were conducted with ex-prisoners in three local authority areas to provide a more detailed assessment of the use and perceived effectiveness of Transitional Care services. The purpose of the interviews with ex-prisoners was to elicit their views about Transitional Care services and to identify any problems they had faced since their return to the community. The sample of ex-prisoners was recruited from the population returning to each area, all of whom had Transitional Care assessments conducted while in prison. This included both those who had made use of the Transitional Care service on their return to the community, those who wanted to but could not and those who had not wanted to. This allowed an exploration of the reasons why individuals drop out of Transitional Care arrangements and an examination of the experiences of those who remained in contact with the service. Interviews were conducted after the 12 week Transitional Care period, offering respondents the opportunity, where appropriate, to reflect upon their experiences of Transitional Care and its immediate consequences.

The in-depth interview sample was drawn from three areas representing different socio-geographic characteristics and different arrangements for the provision of Transitional Care. To minimise difficulties in contacting respondents, the sample was drawn from among those ex-prisoners who had participated in the questionnaire survey. Contact details were identified and potential respondents were contacted by letter and/or telephone and invited to attend for interview at a location suitable for them (for example local agency office, café or to coincide with an agency appointment). If the individual was known to be in custody, arrangements were made to interview them there. In addition to pursuing contact details, Transitional Care staff were invited to assist in the identification of suitable respondents. Thirty seven respondents participated in the in-depth qualitative interviews. Almost two thirds came from Glasgow (see Table 2) and most (23/37) were 21 years of age or older. Despite attempts to boost the numbers of young offenders and women, only two women were successfully recruited into the sample (out of a total of 7 'possible' cases for whom contact data were available).

<b>Table 2. Breakdown of Interviewees by Local Authority</b>					
<b>No. of respondents</b>	<b>Glasgow</b>	<b>Dumfries &amp; Galloway</b>	<b>Fife</b>	<b>Misc*</b>	<b>Total</b>
Adult offenders	16	3	4	-	23
Young offenders	4	1	3	6	14

*The sample of young male offenders was boosted by drawing on respondents in Aberdeen City (1), Clackmannanshire (1), Midlothian (1), North Ayrshire (2) and Stirlingshire (1).*

Twenty-two respondents were interviewed in the community<sup>10</sup>, nine were interviewed in prison and six were interviewed over the phone.

The in-depth interviews explored the following issues:

- difficulties encountered since leaving prison
- relevance of the Transitional Care services accessed
- accessibility of the Transitional Care services accessed
- effectiveness of the Transitional Care services accessed
- perceived gaps in service provision
- further offending and drug use and how it compares with the period before their last prison sentence
- perceived impact of Transitional Care services on offending and drug use
- likelihood of continuing to access relevant services in the longer term.

In the case of clients who had dropped out of Transitional Care services, the interviews also explored their reasons for ceasing to make use of the service and their use of other services since being released from prison. All interviews were tape-recorded with the permission of respondents and identifying information was removed from the subsequent transcripts.

The majority of respondents were released from prison between December 2003 and March 2004, with almost half of these being released in February 2004. With the exception of five interviews undertaken in the winter of 2003/04, all interviews were conducted in June and July 2004. Thus, the vast majority of respondents were interviewed at least four months following release. Thirty-one of the sample had been convicted (one had been recalled from parole), whilst the remaining six had been on remand. Lengths of sentence varied from one month to approximately three years. The four Dumfries and Galloway respondents were held in HMP Dumfries, the seven Fife respondents were held in Low Moss, Saughton, Perth and Polmont, and the 20 Glasgow respondents were held in Barlinnie, Polmont, Cornton Vale and Greenock. Being under 21 years of age, all the respondents from the other local authorities were held in Polmont.

Even in the qualitative interviews there tended to be little detailed discussion regarding Cranstoun or Transitional Care arrangements at interview, not least because most respondents seemingly had no direct contact with Transitional Care on release from prison. Only seven had apparently received a service on release while 15 had declined

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<sup>10</sup> Most of these respondents were interviewed in their own home.

the offer of a service and 15 indicated that they received no further contact from Transitional Care workers on leaving prison. Many respondents found it difficult to recall what services were offered to and taken up by them, partly because of the time that had elapsed since they left prison or because they experienced lapses of memory or concentration as a result of being on drugs at the time of interview. For illustrative purposes brief cases studies are presented as an Appendix to this report.

## **Chapter 3: Organisation of Transitional Care Services**

### **Introduction**

This chapter focuses on the organisation of Transitional Care, with particular emphasis upon the arrangements for providing a 12-week period of post-release support in the community. As indicated in the introductory section of the report, the evaluation of the Transitional Care initiative was concerned principally with the services provided to prisoners in the 12-week period immediately following release. However, the effectiveness of Transitional Care was likely to be influenced by the assessments and referrals undertaken in prison. For this reason we begin with a discussion of the prison-based element of the Transitional Care process drawing upon analysis of documentary material and interviews conducted with professionals based in prisons and in the community. It should be noted that the present Chapter draws essentially upon qualitative data, reflecting the perspectives of the various stakeholders involved in its operation. Subsequent Chapters (Four and Five) examine the operation of Transitional Care using, in addition, quantitative information derived from monitoring and survey data.

### **The prison-based element of Transitional Care**

#### **The aims of prison-based work**

The broad aim of casework provision within the prisons was to assess the needs of all prisoners serving less than four years with substance misuse issues and to co-ordinate the referral process based on those assessed needs. Cranstoun Drug Services were brought in specifically to bring more substance misusing prisoners into contact with prison-based addiction services, to link clients to community-based Transitional Care services and to free up prison staff to deliver addiction related services. The way in which these aims were pursued was through the assessment and referral process.

The prison-based Cranstoun caseworkers were responsible for conducting assessments on all short term and remand prisoners to identify the key needs of individuals with substance misuse issues and for co-ordinating service provision for those individuals. If clients had previously been in contact with community agencies, the caseworker would liaise with those agencies to promote information sharing and joint planning.

#### **Assessment**

The Common Addictions Assessment Recording Tool (CAART) was the main tool used for recording client information and assessing clients' needs. It was intended to be the main source from which a client's care plan was derived. It was also the main source from which a client's care would be co-ordinated. It was held in and formed part of the client's case management file (CMF) to be discussed by the caseworker with a member of the Addictions team and actioned as appropriate. Where the required interventions were not available, this should be discussed with the Addictions team and noted in the CMF.

The CAART tool was perceived by caseworkers to be a general and brief tool. Most caseworkers reported using the space on the form for additional notes to record information that would not otherwise be elicited. However some questioned the merits of doing so partly because they were sceptical as to whether this would be used to identify (and address) gaps in service provision and partly because of a concern to safeguard the confidentiality of sensitive information.

Many caseworkers found the process of completing the CAART to be repetitive and believed that it had obvious 'gaps'. Some of those 'gaps' related to the inability of the tool to address the specific needs of particular groups such as young offenders or women. Two specific complaints about the CAART concerned the number of client signatures required (up to six) and the amount of paperwork and administrative workload that the assessments generated. Caseworkers reported that for every assessment undertaken (usually lasting around 60 minutes) there was at least an hour and often an hour and a half of subsequent administration.

Although Transitional Care workers did not carry out the actual assessments they nevertheless had views about the assessment tool and the assessment process. There was a feeling that this model did not necessarily lend itself to identifying the needs of women and young or first time offenders. The Transitional Care workers also believed that the caseworkers were under a great deal of pressure to meet their targets with respect to the numbers of assessments they had to complete and that the emphasis on targets led to a focus on quantity rather than quality in the assessment process. Transitional Care workers shared the view with caseworkers that clients were over-assessed as a result of different agencies working in prison carrying out their own assessments.

The CAART was in part designed to identify gaps in service provision. However, many caseworkers expressed concern about whether the resulting care plan was resource or needs led and had doubts about how adequately and systematically this information would be used to effect changes in the programmes and services offered in prisons. The scope of prison based interventions, programmes and external agencies providing services was not uniform, with some establishments appearing 'better off' in this regard than others. Some of the caseworkers believed that referral to programmes and other services was influenced more by availability than by clients' needs. Several voiced concern about the lack of counselling available and expressed the view that many clients were 'assessed to death': in addition to undergoing assessment by the caseworker they were also assessed by other external agencies working in the prisons and by programme providers. Many reported that programmes were difficult to access, largely as a result of their infrequency, which meant that they were often not available within the time frame of clients' sentences.

While Transitional Care was intended to provide a much-needed resource for women and young people, it was evident to most managers that this was not happening in practice. The difficulties in engaging with women suggested to many managers that a different system was required to identify women's needs (CAART was not able to identify 'deeper' needs or experiences of trauma) and to provide a different service. Sub-contracted managers in Glasgow agencies indicated that the service which had previously been provided for women (Turnaround) had been perceived very positively and this may have adversely affected relationships with Transitional Care. However, Cranstoun managers believed the service needed to be marketed more effectively in Cornton Vale and plans had been put in place to 'sell the service' within the prison. Nevertheless, as we shall see, the take-up of Transitional Care by women was in practice similar to the take-up by men.

The process of referral and assessment appeared to be significantly affected by the caseworkers' physical location within the prison and by the existing lines of communication. It was also reported by caseworkers as being influenced by the established level of collaboration between the Cranstoun team and SPS personnel (particularly the Addictions team and the Drug Strategy co-ordinator), by their relationship with other external agencies operating within the prisons and by their level of access to prisoners. The assessment process was reported as operating more smoothly where more positive, co-operative relationships had been developed.

Generally those teams who were integrated within Throughcare Centres or within Addictions teams found the assessment process less problematic: lines of communication were more open and more regular, and communication with other agencies better. Those teams who were located separately from the other agencies and SPS staff had more difficulties with communication and the process of assessment and referral. Access to prisoners varied from establishment to establishment but where there was better access, the caseworkers reported being less pressurised and appeared more productive in terms of the quantity and quality of client interaction. This was because less time was spent negotiating access to prisoners, freeing workers up to devote themselves to the task at hand.

One of the aims of the caseworkers was to meet with clients once a month to review and monitor their progress and to undertake one-to-one work such as motivational interviewing, relapse prevention and harm reduction incorporated into these sessions. Some teams endeavoured to see clients once a month but these were teams who had better access to prisoners and lower numbers. More usually, caseworkers suggested that convicted clients were, for the most part, seen two or three times during their sentence unless they were deemed vulnerable or to have complex and high needs, in which case they would be seen more often. If clients participated in prison programmes or were serving long sentences their case was usually 'suspended' and a further assessment undertaken when they completed their programmes or were nearing the end of their sentence. Workers acknowledged that the assessments could provide a good basis for motivational and relapse prevention work, but this required both initiative and time. Many of the workers reported feeling under tremendous pressure to meet assessment targets at the expense of therapeutic interventions. As a consequence, some reported feeling deskilled and disempowered by what was perceived as an 'admin job'. On the other hand, some caseworkers also believed that there was a lack of basic drugs knowledge within many of the casework teams.

Caseworkers reported a fairly low rate of refusals by clients to being referred to Transitional Care. It was estimated that between 10-20% of clients refused to be referred. Caseworkers reported that when clients did refuse, it was usually because they did not perceive themselves to have a need for Transitional Care, they were already receiving support from community agencies or they wanted a specific service that could be accessed more directly through a social work referral. It was suggested by caseworkers that that Cornton Vale and Polmont had a higher rate of refusal than other prisons. The caseworkers reported that most women were already linked into existing service provision (most often social work), though analysis of the monitoring data (see Chapter Five) suggested that women were as likely to participate in Transitional Care as men. In the case of young offenders, many already had a social worker (as a result of having been on supervision as an adult or having been looked after as a child) or felt that their drug use was not so problematic as to require any further intervention or support. Analysis of the monitoring data confirmed a lower take-up of Transitional Care in the community by young offenders (see Chapter Four).

### **Referral to Transitional Care**

It was expected that referrals by caseworkers to Transitional Care would, where possible, be made 28 days prior to the prisoner's release, though where a prisoner was incarcerated only for a short time, the assessment could start on admission. The timing of caseworker assessments was to enable Transitional Care workers to conduct a case conference and a pre-release meeting with the client to discuss and agree their care plan. These meetings were aimed at confirming that the client's assessed needs were still pertinent. The case conference also provided an opportunity for the Transitional Care worker to meet the client prior to release since it was believed that face-to-face interaction between Transitional Care workers and prisoners would increase the likelihood of the client attending Transitional Care appointments on release. The pre

release meeting additionally provided an opportunity for the Transitional Care worker to inform prisoners of what steps had been taken to facilitate access to the services they were identified as needing on release. An appointment should also be made for the first post-release meeting - preferably with an agreed time and location - and this should take place within 5 working days of the clients' release.

Most Transitional Care workers pointed out that clients' needs change throughout their sentence and particularly on release. Many felt that as a result of their incarceration, clients were often idealistic about what their needs would be on release. For this reason it was important for the case workers to be able to spend more time with clients working through these issues and for Transitional Care workers to participate in case conferences and pre-release meetings.

In order to inform clients of local services and to establish contact as early as possible, Transitional Care workers stated that they would visit clients in prison, and/or attend case conferences where possible. All respondents noted that they would attend a high number of case conferences for individuals who had been referred to the Transitional Care service, reporting that they attended between 50-100% of referrals (and averaging approximately 80% of referred cases). The case conferences that were not attended by workers from local Transitional Care schemes were said to be those where workers had not been given sufficient notice, or where clients had been released before the details of the referral had been passed to local schemes. One worker indicated that they anticipated problems in attending case conferences if the number of referrals increased, due to the time and resources which would be required to maintain high levels of attendance.

The caseworkers suggested that the 'better' Transitional Care agencies were those who attended as many case conferences as possible, who provided feedback on clients, who were knowledgeable and who were practical about making clients' arrangements. Conversely some caseworkers believed that some agencies were less inclined to make the effort to attend case conferences and appeared not to be particularly knowledgeable about existing resources. That said, caseworkers acknowledged that the Transitional Care agencies often had long distances to travel to attend case conferences. They also recognised that it was more practical to send one member of the Transitional Care team to cover all the case conferences held on a particular day even if this meant that clients may not meet their allocated worker.

### **Case conferences**

There was clearly a definitional issue regarding what constituted a case conference and what was marked as a case conference or a pre-release meeting on the monitoring logs. The terms seemed to be used interchangeably by staff across the spectrum of Transitional Care: for instance reference was made to 'a pre release case conference', while another worker explained that 'we do the case conference as a pre release meeting, we wouldn't have time to do both'. This in part may account for the apparent inconsistencies that were identified in the monitoring logs.

It was clear that most agencies and workers therein endeavoured to attend case conferences with as many convicted clients as they possibly could. Moreover most were under the impression that they were near to or surpassing their contract target of 80% (for convicted clients only). Those Transitional Care agencies receiving high numbers of remand referrals were likely to have a lower proportion of case conferences because of the practical difficulties involved in arranging case conferences with remand clients.

The majority of Transitional Care workers felt that the more they could engage with the client prior to release, the greater the likelihood that the client would attend for the first post-release appointment. The case conference was seen as particularly important,



partly because it provided an opportunity to obtain the client's signed consent to participate in Transitional Care.

Case conferences were also viewed by caseworkers as a crucial element in the referral process. A number of the caseworkers felt that the effectiveness of the case conference could be enhanced if the community-based Transitional Care worker had more time to see the Case Management File (CMF) and there was more scope for liaison work prior to meeting with the client. Caseworkers also suggested that the take-up of Transitional Care would be improved if Transitional Care workers could see clients more often prior to release though they recognised that this had to be balanced against the meeting of targets. Indeed, caseworkers themselves did have the time to facilitate enhanced levels of contact between clients and Transitional Care staff without this impacting upon the time available to undertake assessments. This meant that if Transitional Care agencies wanted to see a client other than for a case conference, they had to make the necessary arrangements through the agents' visits system. Pre-release meetings between clients and Transitional Care workers were viewed by caseworkers as desirable but not practical within the current system.

The type and amount of contact Transitional Care workers could have with prisoners prior to release varied from agency to agency and from establishment to establishment. Some agencies placed more emphasis on pre-release work than did others and some establishments were more flexible than others with respect to access to prisoners. For example, some workers stated that to achieve their targets it was not feasible for them to visit any prisons other than those in their locale.

Other Transitional Care agencies tried to get to the national establishments (Polmont, Cornton Vale) as well as to their local establishments, though this often meant sending a member of the team rather than the actual person who would be working with the client:

"There's quite a few prisons far away, so we'd do a day for Cornton Vale and Polmont for travelling reasons. It's not always possible to go in and look at six files before you see the clients, it would be nice to see the care plan before we go but. We introduce the team rather than the person, it's not ideal."

Access to and within the various establishments also varied:

"Before we could go into the halls, guys would come over and speak to you and finding out about us but now with the Throughcare Centre we're only seeing the guys getting brought to us."

"We don't have case conferences with clients, we don't have the facilities, we can't go into the halls either, so we go through the agents visits system."

### **Pre release meetings**

Transitional Care workers observed that visiting a client more than once prior to their liberation would put additional pressure on the caseworkers if the latter were required to devote time to making the necessary practical arrangements. Access to conduct pre-release meetings was consequently arranged through the agents visits system, making it more time-consuming for Transitional Care staff. The time, distance and budget implications of undertaking pre-release meetings also had to be taken into account. As one Transitional Care worker explained:

"We do just the one meet, the case conference, no pre-release meeting and that's a budget issue, travelling costs."

That said, the majority of Transitional Care workers saw the benefits of pre-release meetings.

"It's important to do pre release meetings otherwise people are just numbers you've never met and you're just sending out letters."

"It would be good to go back face to face and say I've done this or that, 'cos a letter is just a bit of paper, but to go back and reassure them and saying I'll meet you here at a certain time would be good for the prisoners."

"If someone has high needs we'll go in and do a pre release, so we endeavour to see all once and as many as possible twice."

The extent to which agencies undertook pre-release meetings was variable. Some appeared to undertake as many as possible, some undertook them more occasionally and opportunistically while others did not, it seems, undertake them at all.

### **Pre release information**

Transitional Care workers would receive a copy of the care plan when a referral was made. They could also have access to the client's CMF while visiting clients prior to release although most found that in practice there were few opportunities to scrutinise this information. Opportunities were constrained by the fact that both the caseworker and the Transitional Care worker were not always present at case conferences and by restrictions on time available to spend at prison establishments.

A few Transitional Care workers stated that it was quite common that they did not see the client's care plan prior to their release. However, it would appear that most of the time Transitional Care workers did have sight of the client's care plan either through it having been forwarded with the referral documents or being made available at the time of the case conference.

Nevertheless some workers found the quality of information in the care plan to be insufficient to action some of the client's needs:

"We get referrals regularly that say 'needs housing support'.. but you don't know why - is it that they're barred from housing, they've got rent arrears?"

### **Remand clients**

There was wide consensus among Transitional Care workers that at least one meeting with the client was essential prior to release in order that they might establish what the client's needs were and could begin the process of facilitating appropriate support. The fact that referrals for Transitional Care were made 21 days prior to the prisoner's release facilitated the convening of case conferences for convicted clients. Some Transitional Care workers stated, however, that referrals often did not come 21 days in advance of the release date and that this problem was particularly acute with remand clients. Even where referrals were made to Transitional Care in a timely fashion, many community agencies would not accept referrals for or give appointments to clients who were still in prison or who were of no fixed abode (NFA). This meant that Transitional Care workers often found themselves having to wait until the client's day of liberation or until s/he was allocated a hostel or B&B place before they could action much of the care plan.

Caseworkers and Transitional Care workers associated with one establishment (Barlinnie) reported that Cranstoun had requested that case conferences and pre-release meetings were not offered to remand clients. Remand clients in this establishment were rarely seen more than once by caseworkers - for assessment - and they found it almost impossible to arrange further meetings prior to release. This was very much related to

the brevity and/or uncertainty of the period of incarceration, with the result that remand clients would often be released before the caseworkers could inform their colleagues in the Transitional Care schemes.

More generally, referrals to Transitional Care for remand clients could rarely be made 28 days prior to release. Often this meant that Transitional Care workers were informed about a referral only a day or two before release and in some cases only after the client had been released. When this occurred, the client would usually only have the telephone number of the Transitional Care scheme or, on occasions, the name and address of the Transitional Care worker or agency. The onus was on the client to contact Transitional Care, despite their having had no prior contact with the agency or the individual worker. The ability of the Transitional Care workers to follow up clients was reported to be further constrained by the fact that a significant number of remand clients were NFA on release from prison, in which case workers would endeavour to meet the client on the day of release.

"Most of the ones from Barlinnie are remand so you don't see them before they come out. Most of the ones that don't turn up are the Glasgow ones, the remands. We would see them before and we have in the past but Barlinnie don't want us to do that, they just want us to send an appointment for them on release."

"Remands, they may be needing help with benefits, registering with a GP, looking for a meth script, but you never see that person. .... It was decided we were not going to see the remands unless the guy was no fixed abode."

The absence of a case conference meant that the client might not have had an opportunity to provide their signed consent to participate in Transitional Care. This sometimes resulted in situations such as the one described below:

"The ones we don't see in case conference might phone up and say they're in crisis, but we can't contact anyone till we've met them and got their consent signed. They've been given your name and number in gaol and told to contact us if they need help, they do and I have to say well I can't help you till I see you, that's a bit of a stickler".

## **Changes to the prison-based element of Transitional Care**

Subsequent to the conduct of the professional interviews, a number of important changes were introduced into the prison-based element of Transitional Care aimed at addressing some of the key areas of difficulty identified in the early stages of the initiative. These included:

- changes to the CAART assessment tool were introduced in April/May 2003 to make the assessment easier to conduct and to reduce the amount of administration. From April 2004 further changes were introduced, including the removal of the Christo scale, which would further reduce the time required for administration.

From April 2004 Caseworkers became involved in the induction process for all short-term prisoners, delivering a Harm Reduction Awareness session and taking direct referrals from prisoners who were expected to be incarcerated for 31 days or less. Under this new model of Crisis Transitional Care, the induction sessions took place within seven days of incarceration and would be followed in relevant cases by a full CAART assessment and intervention plan. The changes put Cranstoun caseworkers in a better position to assess remand prisoners and enabled them to make better use of a range of skills:

- from April 2004 Transitional Care become more narrowly focused on addiction and housing and would be encompassed within the Link Centres that were being established within all prison establishments. The Link Centre would be staffed by multidisciplinary teams and would address some of the integration/duplication issues that had been identified by caseworkers
- at a more general level, the Scottish Prison Service's focus on abstinence and detox was changed to encompass Harm Reduction, stabilisation, maintenance, abstinence and detox.

## **Community-based Transitional Care**

### **Organisational arrangements**

As indicated in Chapter One, Transitional Care services in the community were provided by a range of agencies that were sub-contracted by Cranstoun Drug Services. For management purposes, the schemes were organised into two sectors reflecting the parts of the country that they covered (North-east and South-west). Tables 3 and 4 indicate the areas covered by local Transitional Care schemes, identify the service-provider and the focus of the agencies' service provision and show the staff how much staff time was allocated to the Transitional Care service. These data relate to the initial Transitional Care arrangements and were amended following a review of community-based service provision by Cranstoun Drug Services in 2003.

**Table 3. Initial Arrangements for Transitional Care Provision – North East Sector**

<b>Area</b>	<b>Geographical Area Covered</b>	<b>Service-Provider</b>	<b>Other/Services Provided</b>	<b>No. of Workers</b>	<b>Time Allocated to TC</b>
Highland	Highland Region	SACRO	Supported Accommodation	2	1 Full-time 1x 14.25%
Grampian	Aberdeen City Aberdeenshire Moray	Drugs Action	Helpline, Counselling, Support and information, Needle Exchange, Specialist Drug Services	4	Equivalent to 2 Full-time posts
Tayside	Dundee City Angus Perth & Kinross	Cyrenians	Homelessness Support Hostel Accommodation	1 Senior 3 Workers	Approx. 0.1 WTE
Edinburgh City	Edinburgh Fife (Kirkcaldy)	Apex	Employment Support	2 workers (+1 vacant post)	All Full-time TC
Lothian	West Lothian East Lothian Mid-Lothian	SACRO	Throughcare Supported Accom. Bail - alcohol project Youth Justice Team	1.5 workers	Full-time TC
Fife	East, Central & West Fife	APEX	Employment Support	2 workers	1 Full-time TC 1 Part-time TC
Borders	Scottish Borders	Cranstoun Drug Services	Assessments/Case Work within All Scottish Prisons	1	Maximum of 2 days Per week to TC
Dumfries & Galloway	All of Dumfries and Galloway	Cranstoun Drug Services	Casework within Dumfries Prison (and all Scottish Prisons)	1	Approx 50% of Time to TC

**Table 4. Initial Arrangements for Transitional care provision – South West**

<b>Area</b>	<b>Geographical Area Covered</b>	<b>Service-Provider</b>	<b>Other/Services Provided</b>	<b>No. of Workers</b>	<b>Time Allocated to TC</b>
Ayrshire	North Ayrshire South Ayrshire East Ayrshire	SACRO	Youth Reparation and Mediation; Bail Service; Youth Justice	3 Full-time workers	Full-time TC
East Dunbartonshire	Kirkintilloch Lenzie Lennoxtown	SACRO	Youth Justice Service	1 Worker (Shared with West Dunbartonshire)	Full-time TC
West Dunbartonshire	Dunbarton Clydebank	SACRO	Youth Justice Service	1	Full-time TC
Renfrewshire	Johnstone Paisley Renfrew	SACRO	Youth Justice Service	1.5	Full-time TC
East Renfrewshire	Barrhead Newtonmearns etc	SACRO	Youth Justice Service	0.5	Full-time TC
Inverclyde	Greenock Port-Glasgow etc	SACRO	Youth Justice Service	1 Worker	Full-time TC
South Lanarkshire	South Lanarkshire	SACRO	Mediation and Reparation Youth Justice Bail support	0.5 worker	Part-time
North Lanarkshire and Forth Valley	Stirling Falkirk Clackmannanshire North Lanarkshire	CLCS	Drug & Alcohol Support Service	2 Workers	All Full-time TC
Glasgow City	City of Glasgow	Molendinar	Support Group Clinic, Counselling Needle Exchange	1 Worker	Full-time
	Greater Glasgow	Parc	Drug Counselling: Relapse and Prevention; Day Programme	1 Worker	Full-time TC
	City of Glasgow	Realise	Daycare	1 Worker	Full-time TC

Local schemes became fully operational in providing a Transitional Care service at slightly different times. Some areas began to provide a service in January 2002 (Lothian, Highland, Renfrewshire and Inverclyde) and most schemes were in place by April 2002. However CLCS did not begin providing Transitional Care to North Lanarkshire and the Forth Valley until 1<sup>st</sup> June 2002 while PARC was fully operational by 27 June 2002.

In all local schemes the Transitional Care workers' posts were new posts, although in Tayside the senior post was a secondment, while two posts were secondments in Grampian (alongside two new posts). In Highland, an already existing part-time post was adapted to a Transitional Care post. In some cases, workers had been appointed to Transitional Care posts from within the service-providing agency, having applied for the newly created posts of Transitional Care worker with new contractual arrangements. Transitional Care workers had a varied range of previous work experiences and qualifications. They had considerable experience in a number of related professions including: social work (6), mental health (3), drug and alcohol services (15), nursing (2), housing and homelessness support (8), prison service (4), other institutional care (3), work with offenders (3) and counselling (3)<sup>11</sup>.

In the majority of cases, Transitional Care staff were based in local communities, and were provided with accommodation in the offices of the agency service-provider. The exception to this was Cranstoun staff, both of whom were located in Dumfries prison and saw most of their clients as caseworkers. Given the wide geographical areas covered by the scheme, workers met ex-prisoners in a variety of locations. Where possible, contact was arranged in agency offices (if they were central to the locality), but this was not always possible. Frequently meetings were held in community centres, drug projects, council offices, job centres, housing agencies/hostels and health centres. In a few cases, meetings took place at the clients' home address. Local schemes would continue to provide services in prison to individual clients who were re-imprisoned.

Local Transitional Care services received referrals from a wide range of prison establishments. Individuals who were referred to local schemes were those who were going to be released into the local area and accordingly it was possible that referrals to local schemes could come from any prison in Scotland. The exception to this was Kilmarnock prison which did not initially have a Transitional Care caseworker located in the prison and which appeared to make all referrals to the local Ayrshire scheme in the first instance. Workers in Ayrshire were often required to visit clients in HMP Kilmarnock and to provide information and advice to prisoners there.

An audit of Transitional Care services was carried out by Cranstoun in early 2003, focusing upon the operation of the initiative between January and March 2003 (Cranstoun Drug Services, 2003). The resulting report identified a number of operational issues. These included a lower than anticipated level of referrals to Transitional Care, variations across areas in attendance at case conferences and in the take-up of Transitional Care and variations across areas with respect to the development of links with other relevant agencies. The audit also resulted in a reconfiguration of the staffing of the Transitional Care initiative to better meet demand (with some areas receiving an increase in staffing and others a decrease) and in the termination of the contract with one agency that was considered not to have met the required standards. As part of the re-configuration, service provision to Glasgow and Dunbartonshire was combined, the level of management of Transitional Care by Cranstoun was increased and systems were put in place for all referrals to Transitional Care to be channelled through a Transitional Care Co-ordinator located at HM Prison Barlinnie. Previously, caseworkers in individual establishments liaised directly with the Transitional Care providers in the communities into which prisoners would be released.

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<sup>11</sup> Some workers had experience in more than one area.

## Management structures

As a result of the contractual framework for the provision of Transitional Care, the organisational arrangements were inevitably complex. Both groups of service delivery staff – the caseworkers in prisons and the Transitional Care workers in the community – were accountable both to the organisation that employs them and to the organisation by whom they had been subcontracted to provide Transitional Care.

There was ongoing contact between sub-contracted agencies and Cranstoun. Regular meetings took place with Cranstoun Area Managers and sub-contracted Service Managers. Training and conferences provided opportunities for workers and managers to meet at regular intervals, enabling discussion between agencies, Cranstoun and SPS. Agency Managers noted that as well as using formal channels for communication, they were also able to contact individuals within Cranstoun on a more informal level to discuss issues as they arose. Contact with Cranstoun was viewed positively by sub-contracted agency managers.

“There has been good communication, a lot of clarity, this doesn’t look like an easy contract for Cranstoun considering it is national and I have to say I think they’ve handled it really well.”

Some staff suggested that the arrangements for Transitional Care – with prison based caseworkers undertaking the assessments and referring in most prisons to Transitional Care workers located within existing agencies in the community – felt somewhat disjointed. Some suggested that continuity of service might be improved through the use of mixed teams working within the prisons, with some staff undertaking assessments while others focused on the co-ordination of the referral process and maintained contact with clients when they returned to the community. Whilst such an arrangement might facilitate the co-ordination of services provided by external agencies in prisons and in the community, it would only be feasible for those clients being released locally: for others it is difficult to envisage how services could be provided other than through arrangements similar to those that actually pertained.

Cranstoun managers indicated that there had been problems with some of the sub-contracted services in terms of the quality of service provided. However, they also recognised that there had been problems in the initial structure of the service. Cranstoun managers believed it would be helpful if they had more direct oversight of the operation of individual agencies. SPS did not have direct contact with agencies, however agencies could be ‘spot-checked’ by the SPS Contract Manager. SPS had established close working relationships with Cranstoun and there was reported to be considerable communication in relation to contract compliance between SPS and Service Managers in Cranstoun.

While agencies considered it to be generally helpful that Cranstoun took on the role of negotiator with SPS, it was also noted that it would be useful if agencies were able to inform SPS of the ‘real situation’ in the community, in relation to resources for example. For the subcontracted agencies, uncertainty about contract renewal and future developments in Transitional Care provision was compounded by uncertainty about long-term plans for criminal justice in the context of proposals that had been put forward for the creation of a ‘single agency’ bringing together prison and community-based services. How this might have affected services such as Transitional Care was unclear.

## Training

Cranstoun and the Scottish Prison Service were the key agencies involved in the development and organisation of Transitional Care. Some of the sub-contracted agencies considered the regular workshops, which their staff attended, as providing opportunities to input into the ongoing development of Transitional Care. One manager suggested that



while workshops were useful for bringing workers together they could be structured more effectively. More generally, however, the induction and training provided by Cranstoun was considered to be useful and thorough by all sub-contracted agencies. Many of the agencies provided training to their workers in addition to that provided by Cranstoun.

The vast majority of Transitional Care staff felt adequately trained to do their work, but some felt overqualified. They felt they could access adequate training through both Cranstoun and their own agency. The only training issue that arose for both caseworkers and Transitional Care workers was with respect to the drugs knowledge and related expertise possessed by some of the caseworkers. This, it was suggested, had occasionally resulted in some lack of clarity regarding identified needs.

### **Targets and resources**

There appeared to be a significant amount of pressure on agencies to meet targets that were set, although these had been revised since the inception of Transitional Care. The initial targets were described by one SPS Manager as '*fairly unrealistic*'. They had not taken into account the number of clients who did not want to take up Transitional Care, not did they consider the people who were in and out of prison so quickly that they were not being included. However, targets and expectations were constantly being reviewed as the service developed.

Several workers indicated that the low number of referrals during the first year of operation of Transitional Care was causing them some concern being much lower than expected, particularly when considered alongside the low number of clients who were actually attending for Transitional Care services. However, for some workers the high volume of clients was a major issue - particularly given the lack of administrative support available to workers - as was the disparate nature of service-provision.

### **Responding to clients following release**

The Transitional Care worker was expected to provide facilitating support for the client for a 12-week period after release. The aim of this support was to ensure that the client was linked effectively to community service providers who could address the client's assessed needs. The Transitional Care worker should endeavour to accompany the client to the first appointment with each relevant agency, unless s/he is already an existing client of that agency. If the client was attending independently the Transitional Care worker would endeavour to check whether the client attended the appointment given. All but one of the ex-prisoners who had contact with Transitional Care following release reported that they were seen within a week (including two on the same day as they were released). The other suggested that he had waited one month after release before being given a Transitional Care appointment.

The Transitional Care worker was expected, within 10 working days of a referral, to confirm with the named person in the community agency to which the client has been referred that the client has had their needs addressed or is still in contact with the agency. Where contact had not been maintained the Transitional Care worker should take follow up actions such as telephone calls, letters etc. to re-establish contact with the client, with these actions documented in the client's file.

At the end of the client's contact with the Transitional Care service a report (monitoring log) would be completed and returned to the caseworker in the establishment from which the client was released. The CMF would be updated accordingly and the monitoring log returned to Cranstoun central office. The end of the client's contact was defined as being when the client contact was lost and could not be renewed; the client's needs in relation to the care plan had been met; the 12-week maximum contact period had been reached; the client had been readmitted to prison; or the client had died.

The monitoring system overall was recognised as problematic with a lack of consistency in the ways in which information was recorded:

"We need to have better guidelines on how people complete the paperwork because some agencies are completing it differently, some people are getting forms signed at different stages than others."

SPS and Cranstoun recognised that the monitoring by sub-contracted agencies had to be given increased priority after the initial emphasis on getting the casework aspect of the service right at the beginning of the initiative.

The issue of the paperwork associated with Transitional Care (the monitoring logs) was raised consistently. The monitoring log is a substantial 9 page booklet that takes the worker through a number of key areas – Health, housing, benefits/finance, education and training, employment, social issues. They are also required to complete the Christo inventory and an appointment log at the end. In each key area the worker has to document what services the client has been offered, has had made available and has achieved at each appointment. The Transitional Care workers complained that the log was repetitive, inflexible and unrepresentative of the work undertaken with clients.

"I don't like the logs they're cumbersome, the paper work could be cut right down. All these tick boxes – what are the reasons? Is it just for stats. There's no guidelines on how the paperwork should be done. Is it all down to numbers and contacts? Is this really what it's about?"

"I don't think it captures the work going on, it's bums on seats stuff, it will record if and how often clients are seen but it's basic figures, its not going to evaluate the quality of the service."

Most of the Transitional Care workers believed that the quality and quantity of contact they had with clients prior to release impacted on whether clients turned up for their first appointment. However that was only one factor that they felt impacted on a client's engagement with Transitional Care. The main issue for the vast majority of Transitional Care workers was their ability to meet their clients' needs in terms of facilitating access to service provision. Many of them also suggested that how community-based agencies responded to clients impacted on their take up of Transitional Care.

Most Transitional Care workers felt that the sooner they could meet the client the better. They believed that clients' take-up of Transitional Care could be improved, if they were able to meet clients at the prison gate and take them to their first appointment, if they could meet clients on their own 'territory' and if they could facilitate access to the support services they required.

It appeared that the majority of agencies attempted to see clients who were NFA on the day of release and other clients within 72 hours. Most also endeavoured to accompany clients to their first appointment. However the manner in which this was done varied from agency to agency: occasionally an agency would transport clients in their cars; or undertake home visits; or on a rare occasion undertake a gate pick-up for a particularly vulnerable client while most others could not. The agencies' working philosophies and the prior experience of workers had an apparent impact in terms of how, where and when staff interacted with clients. Newer, less experienced staff had a preference for being office-based on the basis that this was in the interests of their health and safety.

"Our availability, where we can see people, I mean if we can see people right outside their door they are more likely to turn up than if they have to travel. If you can see someone on the day of release or the day after."

"We pick them up or offer them an appointment on the day of release, make sure they're accommodated. If you expect somebody who's got low literacy skills, poor social skills, chaotic drug behaviour to come to you and seek a service, well that's just not the client group we work with."

"We try and do gate pick-ups for vulnerable clients but distance means we can't do it for most. Nobody NFA comes out without an appointment on the day of release and for the others its 72 hours. We do take people in our cars, we go and see clients in their own homes, that's the way we work although if we had not met pre-release I would not be happy to do a home visit for the first meeting."

"At the start we were trying to meet people at the job centre but people weren't turning up, so what we've started doing is if we've met the person and feel comfortable we first visit at their house and that's working better. Like we use our cars too and that makes life easier - 'cos rather than me standing waiting and him not turning up for appointments, we go to them. It's not taking anything away from them because if they didn't want to see you they wouldn't answer the door or tell you and I've had that. It makes life easier all round."

Some staff, on the other hand, who had previous experience of providing community-based services acknowledged that there were other ways of working that may be more productive and that may increase client uptake, but reported being prevented from doing so by the agency's rules. Those who could not undertake home visits or have clients in their car found it necessary to arrange meeting places. This had proved problematic, particularly outside of the big towns and cities.

"Getting access to clients in areas where they can see us, often they need to travel to see us, we've got offices we can use in bigger towns but we can't set up interview space in a mass of small towns and that means they have to get a bus and that's going to cost them."

"I think a client needs a service where they can sit down and talk to us. I don't think just catching them jumping out from behind a pillar at the benefits office saying 'hi how you doing' is actually an appointment but Cranstoun are quite keen for us to do this."

It was acknowledged by managers that the costs of interviewing clients in the community had not been built into the service, and in some areas travel costs were considerably underestimated. While SPS considered this to be Cranstoun's responsibility, Cranstoun managers were clear that this was an issue for sub-contracted agencies, who had been advised to ensure that travel costs would be accounted for. Funding was not available to reimburse clients who had to travel to access services, a particular problem in rural areas.

This illustrates an underlying question of whether the Transitional Care agencies perceived their staff as office-based workers or community outreach workers. It also begs the question whether it was more productive to work with clients on their 'territory' or to ask clients to attend office-based appointments. Some Transitional Care workers believed that taking the services to the client rather than asking/expecting the client to come to them did increase take up. For instance, some clients were reluctant to go to the Transitional Care office because it was in an area that they wanted to avoid. Moreover the Transitional Care workers who were able to operate in this way felt that clients were more likely to engage not only with the Transitional Care service, but with the services that Transitional Care was referring them to. There was a perception that it was not only more practical to work in this way but, because it allowed the client to

engage on their own terms and increased take up, it diffused the worker's position of authority:

"If I refuse to meet you in your home, in the local community centre, your local café and say you must come to my office – who is that alienating? It's putting up barriers that needn't be there. Whereas if I send appointments and wait for them to come to the office, they default, I'll no see them."

"I know like different agencies go to people's homes and that would maybe increase the figures, better places to meet, places convenient to them. If we could pick them up at the gate and get them the services they need. If we could get more appointments made, go down with them, be more active than right here's a GP, more hands on but when its just 'advise to present' they (client) are sitting there saying 'well I could have done that myself.'"

While the low attendance at appointments in the community was a concern for all, it was evident that this issue was being examined by Cranstoun and SPS. Sub-contracted agency managers believed that more pre-release meetings, more proactive contact with clients in the community such as gate pick-ups, and accessible central meeting places would increase client attendance rates.

### **Facilitating support in the 12-week post-release period**

Many Transitional Care workers felt that they were in a better position to mediate, diffuse and advocate for clients if they accompanied them to as many appointments as possible. However, they often found that the three appointment system did not lend itself to that way of working.

"Be less of a referral agency and more of a supporting agency. Be more welfare, go out to them take them places give them support more. The number game to be played less."

"I think the advocacy side, you can mediate and advocate for them in their appointments 'cos they have poor social skills, they're not good at dealing with stuff, so it helps them to build on those and help establish a relationship with them. You know it's about being the bridge between two people as opposed to being the bridge between services 'cos if that was the case the Cranstoun workers could just fill out a form."

Indeed the issue of how often Transitional Care workers were able to meet clients within the 12-week period was consistently raised. Many of workers felt that three appointments was often just not enough to facilitate access to services and to support the client through this period of transition. Most of the Transitional Care workers believed that there should be more flexibility to meet clients according to their needs rather than according to contract specification. However it must be said that because in most areas the number of referrals had been considerably lower than expected, most Transitional Care agencies had been able to meet with clients over and above the minimum three appointments. They had therefore been able to work with more 'vulnerable' clients more intensively in the beginning of the 12-week period when their needs were highest.

There were a number of interrelated issues that consistently arose regarding the 12-week post-release period. The main difficulty identified was that of being able to facilitate access to community services within this 12-week period, especially if the aim of 'effectively linking' clients with existing services was intended to mean more than

simply referring clients on. Workers suggested that it was difficult to ensure that community agencies were actively supporting clients within 12 weeks:

"I don't think our role is floating support and although we can't get people supported by services in the 12-week period."

"The 12 week period is fine for some but many tend to have very complex needs and I think they are going to have to look at extending the 12 week period. I think it's inappropriate that someone could be told that their help has stopped because they've reached a certain date in the month, I just can't get my head round that. There has to be a cut off point it should either be extended or the government will have to tackle the waiting lists. And \*\*\*\*\* [agency] is apparently quite good compared to other places. In theory I think Transitional Care is fantastic but they have to tailor the contract to reality, we are catching some but the majority need longer."

"12 weeks is just too short, especially if a prescribing agency waiting list is 13 weeks, you will not be able to do anything else with that client until they've got the script. They are focussed on only the house or the script and if they've not got that sorted, the chance of you being able to do anything is slim to none."

The majority of Transitional Care workers felt that the 12-week period should be extended though how long it should be extended for varied depending on how long clients had to wait to receive active support from community agencies. Many considered it unprofessional and inappropriate to leave clients 'in limbo', having been referred to but not yet being seen by an allocated worker and being still in need of support.

There were one or two Transitional Care staff who felt that the 12 week post-release period **was** adequate but they were based in areas where the most requested services provided active support through housing support workers and outreach drug workers within the 12 week period.

### **Services required following release**

This brings us to the services most needed and/or requested by Transitional Care clients. Overwhelmingly clients were reported to be in need of support with housing and drug problems. Given the large numbers of Transitional Care clients leaving prison with no fixed abode and, perhaps more obviously, drug problems, their support needs from the community service providers working in these areas were high.

All agencies indicated that they would contact a wide range of services for Transitional Care clients. Local services provided a range of provisions which were available to Transitional Care clients relating to: accommodation support, addiction/drugs and alcohol support, benefits, healthcare, blood testing, employment and training, relationship advice, day care and counselling/relapse prevention. All Transitional Care service providers indicated that they would link clients with services providing support with housing/accommodation and drug/alcohol services.

The range of drug services provided in local areas was broad, with a number of service-providers operating alongside local GPs and other health-care services. Thus clients were generally able to access prescribing services and/or broader support services through Community Drug Problem Services and/or local drug/alcohol agencies and substance misuse teams.

Perceived gaps in services varied across areas. For example while most workers indicated that a range of drug services were operational, this was not the case in

Dumfries and Galloway. Several workers indicated that services were available, although there may be gaps at times (e.g. in Borders, Tayside). However in such cases the main problem that workers were experiencing was linking people into services. Similarly, it was noted that drug services were operating, but it was the lengthy waiting lists which were causing problems for Transitional Care (Tayside, Lothian, Edinburgh, North Lanarkshire, Forth Valley, Renfrewshire, Ayrshire, Glasgow, South Lanarkshire, Grampian). As one worker noted, the

"main problem is not in terms of gaps, but in the capacity of existing services to meet demand".

Lack of accommodation was identified as a major problem (Edinburgh, East Dunbartonshire, West Dunbartonshire, Dumfries and Galloway, Ayrshire, Mid Lothian, Highland, Glasgow) particularly as the local authority had no legal obligation to house individuals released from prison. It was noted that there is a lack of support for drug users on the streets, with housing and prescribing identified as the key requirements for stability. Problems with accessing GPs who will prescribe was also identified as a problem for workers in Glasgow. Lack of residential rehabilitation spaces was noted by workers in the Borders and Glasgow.

Anger-management was identified as a gap in service-provision in North Lanarkshire, the Forth Valley, and South Lanarkshire as clients were requesting this service which could only be accessed through social work. Services for clients over the age of 25 was identified as a problem in Ayrshire, where services catered more effectively for younger clients, despite the fact that older clients may be more ready to deal with substance-use problems.

One worker noted that there were geographical gaps in service provision (Glasgow) as some Social Inclusion Partnerships (SIPs) would not provide funding outwith their area. Workers (South Lanarkshire and Highland) noted that there were gaps in services which offered clients day services, alongside drug support. In Highland, it was noted that more 'localisation' of services was required.

Only one of the managerial respondents believed that there were adequate resources in the community to meet the needs of Transitional Care clients. Other managers indicated that while some geographical areas were better resourced than others, there was a general problem with access to services, notably accommodation and support for drug problems. While employment and training were key areas which Transitional Care was intended to provide help with, some agencies believed that this was over-emphasised and it was the more basic needs which individuals required support in obtaining:

"People are being offered appointments and that's the good bit, but they are being offered appointments for waiting lists, which is the bad bit because at the end of 12 weeks some of these people will still be sitting on waiting lists and that means the advocacy role is gone and we don't know after that whether they uptake that service or not, so that's frustrating".

"It means that what we're doing is dropping clients just when they most need a little bit of support to get them into the service and that was supposed to be the purpose of Transitional Care and yet we drop them when they're most vulnerable sometimes."

The lack of existing programmes to deal with re-offending behaviour was noted by managers. It was suggested that a centralised drop-in service where individuals could access a range of services on release from prison might go some way towards addressing perceived gaps in existing services and the difficulties that clients were reported to experience when moving between them.

## Drug services

There were two main kinds of drug support that clients seemed in need of: substitute prescribing and counselling/support for their drug related issues. Both of these seemed to be problematic to access within the 12-week period and often for much longer.

Many workers identified areas of good practice (Turning Point Outreach Service, Signpost) indicating that services were effective and efficient, although there was variation between and within regions. It was also noted that it would benefit clients to have access to a wider range of services (including those with a more client-centred approach) and that more services were needed for clients who were not using (Renfrewshire). One worker indicated the

"difficulty with accessing support for those who are clean - same waiting list for assessment whether client requires methadone substitution, naltroxine or purely support - can take weeks".

Workers in Glasgow, Fife, Dumfries and Galloway mentioned the lack of counselling services which again limited the 'treatment' options available to clients:

"Counselling services are lacking. Most services seem to offer clinics/activities but not a comprehensive counselling service. Social work can take up to 3 months to allocate a counsellor".

Workers in rural areas such as Highland, indicated that more services were required throughout the region to minimise the travel required.

The perception of the Transitional Care workers was that in most areas - the exceptions being the more mixed rural/small town areas such as Grampian, Ayrshire, Dumfries and Galloway and the Borders - there were enough drug agencies. However, their ability to deal with the volume of potential work undermined not only their ability to take clients on but also their capacity to offer interactional support. The waiting list for substitute prescribing was said by Transitional Care workers to vary from six or seven weeks to more than a year.

In many areas, workers indicated that drug services had lengthy waiting lists for assessment and referrals (Lothian, Tayside, Edinburgh, North Lanarkshire, Forth Valley, Renfrewshire, Ayrshire, Glasgow, South Lanarkshire, Highland) which meant that clients could wait for considerable periods of time before being given a place with services. In some cases, the waiting lists (up to 11 months in one Tayside service, 13 weeks in Edinburgh, up to 18-24 months in Grampian) meant that clients on Transitional Care were unable to access services during the 12 week Transitional Care period, or that clients were waiting for considerable periods of time to access services.

It appeared that in the areas that had outreach workers, community workers working with GPs' clients were able to access substitute prescribing services more quickly, often within 14 weeks (Edinburgh, Mid, East and West Lothian, West Dumbartonshire). It appeared that in those areas with centralised prescribing agencies and little or no outreach, and little or no community or GP liaison work, the waiting lists were more than four months, sometimes eight months (Ayrshire) and in a couple of areas more than a year (Aberdeen, Tayside). This obviously impacts hugely on Transitional Care: if clients are unable to access the services they need through Transitional Care they are unlikely to use the service in the first place or if they go through the system again.

Waiting lists also operated for access to GPs who were prepared to prescribe and for dispensing chemists in some areas. Prescribing services, according to one respondent:

"have strict contracts which can be very inflexible to individual needs".

One worker noted that existing services were:

"fine but everyone has their waiting lists of assessments. Clients have to access social workers first for funding".

The waiting lists for counselling and/or general drug support appeared similar. In some areas the drug support and/or counselling went hand in hand with prescribing services while in others they appeared to be completely separate. Many of the Transitional Care workers were of the opinion that even if the client received an allocated worker and a substitute prescription, the amount of counselling and/or support that complemented it was woefully inadequate. This was particularly the case in areas that offered a more centralised prescribing service (such as Glasgow, Tayside and Aberdeen):

"Getting on the waiting list, a year for an appointment for assessment, it's a year before they're given any help at all. Maybe they are assessed within the year but they're not given any help."

This sometimes meant that clients were being returned to prison before they could access services:

"The biggest one we come across is people looking for scripts. They were coming back in before they were getting a service. They were going out and getting assessed in about 3 weeks but there was no space at the doctors and they ended up back in crisis, started using again and ended up coming back (to prison). They were holding it together for two or three weeks and then talking to their mates that had been in two months before and still not getting a service so they were away back to their old habits. I'm not making excuses for them but they weren't getting a service."

Moreover in some areas substitute prescribing agencies removed those who were imprisoned from their waiting lists. In effect this could mean a Transitional Care client being assessed by a substitute prescribing agency within the 12 week period, being put on their waiting list for treatment, beginning to use drugs illicitly again, being re-incarcerated and being taken off the waiting list, only to start the whole process over again on release.

The waiting lists for active support from drug services appeared to be a constant problem. Transitional Care workers were often frustrated by not being given a specific appointment date for their clients and not knowing when a 'closed' waiting list would be re-opened<sup>12</sup>. Many of the Transitional Care workers pointed out that although addiction services claimed not to have waiting lists this was only partly true. A duty worker would often see clients within 24 hours but thereafter clients may have to wait weeks or months before being allocated a key worker, or given active support. The Transitional Care workers perceived this situation to result from insufficient capacity to deal with the volume of clients who needed support from an addiction service.

Related to this, many Transitional Care workers perceived there to be a number of gaps in services. For example, drug counselling and general supportive one-to-one counselling was often requested but was difficult to access. Some felt that there was a lack of group-based programmes, including groupwork but also more practically-orientated interventions such as those that focused on life skills or activities. A few suggested that these services should be offered locally, within drop-in centres, which were also reported to be scarce. A number of workers specifically mentioned anger management as a service that they often felt their clients were in need of but that was

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<sup>12</sup> The Bridge project in Ayr was reported to have 'closed' its waiting list around the time of interviewing



rarely available. In general Transitional Care workers believed that what was required was 'real' services that were adequately staffed.

### **Housing services**

Housing was also an area that was problematic for many clients in receipt of Transitional Care, with their accommodation status impacting upon their ability to access drug treatment services and vice versa:

"The most important thing for the people we pick up are their housing and the addiction services, but we can't tie them into services until they are accommodated."

This meant that accommodation had to be the first priority for the vast majority of clients. Many of the workers mentioned how the changes made to the housing legislation in 2002 had improved clients' access to emergency accommodation. However clients rarely wanted to go into hostel accommodation since hostels often had a significant proportion of residents who had substance misuse issues. For clients released from prison, returning to a situation in which problematic drug use was endemic was unappealing. B&Bs were seen as the 'next step up' but as presenting similar problems:

"The main problem related to their offending is their drug use, until you get that sorted they are going back into the system over and over again and this brings it back to the waiting lists. Another thing is the lack of safe secure housing, supported temporary accommodation. Sending someone to a hostel or a B&B where drugs are rife is not ideal, so we need more half way houses and supported accommodation."

This raised a related issue in that if services were inaccessible, this could limit the perception that Transitional Care had something to offer:

"If things go well they tend to turn up again, like if you can get them a B&B instead of a hostel. ... if they turn up and they get put back in a hostel, nothing has changed, they've had someone there to sit and talk with but nothing has changed - if you are not able to do anything for them they are unlikely to turn up again. If they stand to gain something they will link in to that contact but the services just don't work quickly enough."

Unfortunately despite these changes, all the Transitional Care workers reported that the housing departments had little or no housing stock available. It was rare to find Transitional Care workers who referred to housing departments that could offer supported accommodation and/or tenancies within the 12-week period. However it was not always appropriate to put someone with complex needs, including substance misuse issues, straight into a tenancy even if there was one available. This was in part because there was a reported lack of housing support workers:

"Housing is a big one. We have a really good housing officer and we had three or four who got tenancies straight from prison but it didn't work. One had absolutely no furniture and had been sleeping on floor boards for 5 days before he got in touch. Another didn't pick up the keys, another did but didn't move in and the other moved in successfully. Nobody will go to a bare flat and agencies can't help them overnight. If somebody gets out at 8 am they can't be settled in by 8 pm that night. If you are setting them up with a tenancy - why set them up to fail? Why not look at the bigger picture and say this guy will need support."

The issues of what kinds of service provision clients needed and requested, the waiting lists for such services and the perceived gaps in provision were the most consistent and perhaps most significant issues that the Transitional Care workers raised. Transitional

Care workers felt that in some ways they were unable to facilitate access to services for clients because clients were simply 'advised to present'. This meant that they would be seen by a duty worker, who would take basic details and ask them to return for a 'proper' appointment at a later date.

Many workers also expressed concern that some of their younger, more vulnerable clients were only being offered hostel places and often preferred to sleep rough. Despite Transitional Care workers enjoying good working relationships with housing agencies, there was a lack of available supported accommodation that could be accessed quickly.

### **The role of other agencies**

Obtaining information from other agencies was often problematic. It was noted that community based services outwith Transitional Care did not always understand its objectives. Indeed there had been some hostility towards Transitional Care. This appeared to be based on a lack of understanding of the advocacy role that Transitional Care workers were expected to provide, and that they were referring clients onto services - not drawing them into their own organisation.

Social work services had also apparently raised concerns about the potential increase in their workload that could arise from Transitional Care:

"One of the great anxieties about Transitional Care, particularly from the local authorities was, and I actually had letters there that evidence this from fairly senior people in social work, you're going to create a need that we can't meet. Well absolutely not. We're not creating any need. What we're doing is identifying needs that are already in existence...That said however, there never were sufficient resources or sufficient range of service in the community to start with."

Managers suggested that there was a need to publicise the aims and objectives of Transitional Care to other agencies. There was some hostility towards Transitional Care sub-contractors due to other agencies misunderstanding of how they operated and their roles and responsibilities within the remit of Transitional Care. Early lack of consultation with statutory services was said to have led to a lack of co-operation, particularly from social work departments.

"I think that the problems with it initially were that there had been no real consultation with the statutory agencies who were dealing with this, if you like the social work departments who were vehemently opposed to this system being introduced because they had no ownership of it."

"Local authorities have not welcomed this service with open arms and I think that's been very shortsighted of them. There has been open hostility and resentment at the fact that we've chosen voluntary sector agencies to partner the subcontracting and I have a suspicion that their (SW) proposal for their throughcare service for all prisoners is a direct response to them not getting the contracts locally to do this at local level."

Transitional Care workers perceived the main communication difficulties to be the lack of co-ordination within and between prison and community services. This was often about the communication between agencies in prisons and agencies in the community which in some cases involved the same agency working in both environments. With a number of agencies working in the prison, duplication of effort was said sometimes to occur. Transitional Care workers sometimes found that the agencies to which they were referring clients had already received a referral from another agency working in the prison. There appeared no system for co-ordinating who clients saw whilst in prison and

what referrals were made by the other agencies working there. This raises a question about whether Cranstoun should have had the remit to co-ordinate referrals only to Transitional Care or the overall co-ordination of referrals and service provision between prison and the community.

Agencies reported often having experienced difficulties engaging with SPS as a whole. This was acknowledged by SPS respondents who indicated that different governors attached different levels of importance to Transitional Care, something which was reflected in practice. Availability of resources for addiction work, and co-ordination of this work, was not uniform throughout SPS.

As one agency manager noted, all the referrals came from Cranstoun so sub-contracted agencies could only respond to the referrals that come to them. There was some indication that the passing of information from prison caseworkers to Transitional Care workers was not always as effective as hoped, but this was an element of provision that was starting to improve as the service developed. As one SPS respondent observed, "the dedication of Cranstoun and our Transitional Care partners has been immense".

## Summary

Prison-based Cranstoun caseworkers were responsible for conducting assessments on all short-term and remand prisoners to identify the needs of individuals with substance misuse problems and to co-ordinate service provision. The Common Addictions Assessment Recording Tool (CAART) was employed to assess prisoners and to develop a care plan, though it was found to be cumbersome to administer and ill-suited to particular groups of prisoners and caseworkers believed that the resulting care plans were resource- rather than needs-led.

There were differences between prisons in the extent to which casework was co-ordinated with other service provision and in the ease of access to prisoners, both of which, along with caseloads, impacted upon the ability of caseworkers to engage with prisoners prior to their release.

Most prisoners were reported to have agreed to being referred to Transitional Care. In these cases caseworkers liaised with community-based Transitional care workers in sub-contracted agencies. The extent to which Transitional Care workers attended pre-release case conferences appeared to vary across the country. More generally, pre-release contact was influenced by the emphasis placed by the agency on this aspect of the work and the accessibility of prisoners in individual establishments. Pre-release contact was, however, universally regarded as important not least as a means of encouraging take-up of the service once the prisoner returned to the community.

Remand prisoners presented particularly challenges because of the brevity and uncertainty of their period of incarceration and because many would be of no fixed abode on release. Amendments made to the Transitional Care initiative – which reflected its evolutionary nature - included the introduction of Crisis Transitional Care aimed at those who were expected to be incarcerated for 31 days or less. Other important changes included amendments to the CAART assessment tool to reduce the administrative burden and the re-focusing of Transitional Care upon a narrower range of needs (addiction and housing) to reflect the introduction of Link Centres within all prison establishments.

Transitional care services in the community were provided by a range of non-statutory agencies that were sub-contracted by Cranstoun Drug Services, which meant that Transitional Care workers had a varied range of previous work experiences and qualifications. Most were based in local communities with the exception of Transitional Care staff employed by Cranstoun who were based in HMP Dumfries and who undertook both casework and work following release.

The organisational and management arrangements for Transitional Care were complex, requiring relevant training and ongoing contact and negotiation between the relevant parties. Concerns about the quality of sub-contracted provision resulted in a re-configuration of staffing to better meet identified need. Targets and expectations were constantly under review and it was acknowledged that initial targets for the service had not been realistic.

The Transitional Care workers were expected to provide facilitating support to ex-prisoners by offering three appointments in the 12-week period following release aimed at referring them to existing community-based services. Although Transitional Care workers believed that contact with prisoners prior to release impacted upon their subsequent engagement with the service, they also suggested that the take-up of Transitional care could be enhanced through adopting a more proactive approach.

The system of three appointments within 12 weeks was regarded by workers as too inflexible to address complex needs and to ensure that ex-prisoners were effectively linked into services as opposed to simply being referred on.

Substance misuse and housing were the services most often said to be requested by Transitional Care clients. However, the range of services available varied across the country (tending to be less extensive in more rural areas) and even where they were available there were often length waiting lists. This applied both to drug services and to accommodation. It was rare for ex-prisoners to be offered anything other than transitory accommodation within the 12-week post-release period. The ability of Transitional Care workers to link ex-prisoners effectively to resources was also hampered by lack of understanding of and in some cases hostility towards the initiative on the part of other agencies.

## Chapter 4: Engaging with Transitional Care

### Introduction

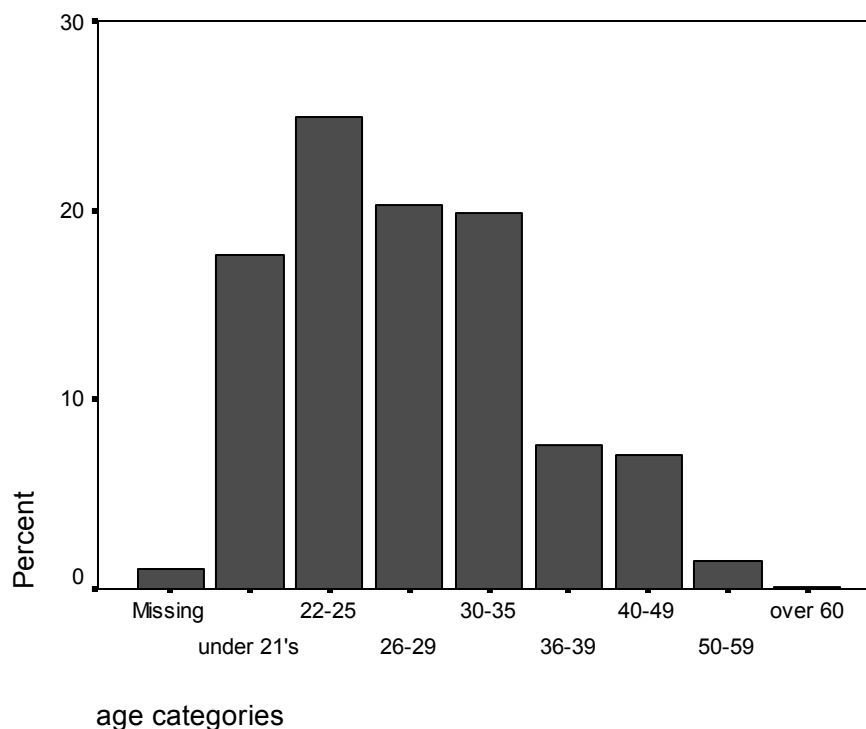
The previous chapter provided an overview and professionals' perspectives on the organisational and operational arrangements for Transitional Care. This chapter examines the extent to which ex-prisoners engaged with Transitional Care by taking up the offer of up to three appointments following their release and considers the perceived barriers to accessing Transitional Care. First, however, an overview of the characteristics of ex-prisoners referred to Transitional Care is presented.

### The characteristics of prisoners referred to Transitional Care

#### Sex and age

Monitoring data were available in respect of 4794 ex-prisoners for whom a Transitional Care monitoring log had been completed<sup>13</sup>. This included 4231 men (90%) and 478 women (10%). The sample varied in age from 16 to 79 years, with a mean of 28.4 years. The proportions of ex-prisoners in different age groups within this range is illustrated in Figure 1.

**Figure 1: Age of Those Referred to Transitional Care**



<sup>13</sup> The amount of missing data differed across variables. Percentages are based on the numbers of cases for which the relevant data were available.

## Ethnicity

The ethnicity of ex-prisoners was recorded in 4091 cases. Preliminary analysis suggested that 86% of the sample was white, which appears low in relation to the known ethnic composition of the Scottish prison population. For example, in 2003 ethnic minority groups represented only 2% of the total prison population (including persons awaiting deportation who would not be eligible for Transitional Care) (Scottish Executive, 2004). Further inspection of the data indicated that only 11 ex-prisoners were identified as being black, Asian or Chinese while 559 cases had their ethnicity recorded as 'other'. It is assumed that the 'other' category was being used when the ethnicity of the ex-prisoner was unknown. With these cases removed, almost 100% of ex-prisoners were identified as being white. Clearly, the very small number of ex-prisoners of known ethnic minority status prevents any further analysis of take-up of Transitional Care and ex-prisoners' needs by ethnicity.

## Employment

The employment status of ex-prisoners prior to imprisonment was recorded in 1998 cases. As Table 5 indicates, the majority of prisoners (95%) were unemployed when they received their custodial sentence and in most cases had been unemployed for more than one year.

<b>Employment status</b>	<b>Number of cases</b>	<b>Percentage</b>
Never employed	689	34%
Unemployed > 1 year	980	49%
Unemployed < 1 year	237	12%
Employed	70	4%
Full-time education	6	<1%
Other	16	<1%

## Living situation

Information about who the ex-prisoner was living with before being imprisoned was recorded in 2252 cases. Around two-thirds of the sample were living alone or with parents (Table 6). The percentage of ex-prisoners who were living with children appears very low. It is assumed that this reflects the categories included on the monitoring form, the design of which did not enable ex-prisoners to be recorded as living **both** with dependant children **and** with other adults and that those recorded as living with dependent children were living with children **alone**.

<b>Who Living With</b>	<b>Number of Cases</b>	<b>Percentage</b>
Living alone	927	41%
Parents	628	28%
Partner/spouse	423	19%
Dependent children	30	1%
Other	244	11%

The type of accommodation to which ex-prisoners expected to return was known in 2968 cases. The relevant data are summarised in Table7. More than one third were recorded as being of no fixed abode. However, others – for example those living in hostels or with friends – were also likely to be returning to temporary living arrangements. As shall be seen, this high level of housing insecurity is reflected in the high level of identified

housing needs among those who took up the offer of Transitional Care. This is also evident from other studies (e.g. Reid-Howie Associates Ltd, 2004).

Women were slightly, though not significantly, more likely than men to be returning to local authority housing (45% compared with 38% of men) but the percentages of men and women who were described as being of no fixed abode were similar (35% and 31%). Accommodation status appeared to be unrelated to age: for example the percentages recorded as being of no fixed abode were similar for those under 25 years of age and those aged 25 year or older (34% and 35% respectively).

<b>Type of Accommodation</b>	<b>Number of Cases</b>	<b>Percentage</b>
Local authority	1141	38%
NFA	1031	35%
Hostel	216	7%
Friends	209	7%
Private rented	147	5%
Owner-occupier	66	2%
Residential rehab	6	<1%

### **Region to which returning**

Details of the regions of Scotland to which ex-prisoners were returning were available in 2868 cases (Table 8). The most common destinations on release were Glasgow City, Tayside, Lanarkshire and Ayrshire. Despite Edinburgh being the second largest city in Scotland, a relatively low percentage of ex-prisoners were planning to return there on release.

<b>Destination</b>	<b>Number of Cases</b>	<b>Percentage</b>
Glasgow City	683	24%
Tayside	287	10%
Lanarkshire	282	10%
Ayrshire	265	9%
Grampian	255	9%
Edinburgh City	166	6%
Forth Valley	155	5%
Highland	147	5%
Renfrewshire	143	5%
Dumfries and Galloway	132	5%
Fife	114	4%
Lothians	86	3%
Dunbartonshire	83	3%
Inverclyde	62	2%
Borders	8	<1%

## Transitional Care service provider

The agency responsible for providing Transitional Care in the area to which ex-prisoners were returning was recorded in 2897 cases (Table 9). Transitional Care was being provided in just under one half of all cases by two agencies – SACRO and Cranstoun.

<b>Table 9. Transitional Care Service Providers on Release</b>		
<b>Transitional Care Agency</b>	<b>Number of Cases</b>	<b>Percentage</b>
SACRO	1005	35%
Cranstoun	403	14%
Cyrenians	280	10%
Molendinar	278	10%
Apex	277	10%
CLCS	212	7%
Drugs Action	171	6%
Realise	140	5%
PARC	116	4%
Other	15	<1%

## Take-up of Transitional Care

Interviews with Transitional Care staff and scrutiny of the Cranstoun audit of Transitional Care conducted in 2003 suggested that the take-up of the service was relatively low. Further information about the take-up of Transitional Care was provided through the monitoring data collected by Cranstoun and through the survey interviews conducted by TNS. The latter additionally explored the reasons for not taking up the offer of Transitional Care, as did the in-depth interviews conducted with 37 ex-prisoners.

## Contact with prisoners prior to release

The Transitional Care worker who would be working with the client in the community was expected to attend at least one pre-release case conference with the client. It was believed that this face-to-face contact would increase the likelihood of the client attending appointments post-release. In practice, these meetings did not always happen. In some cases, remand prisoners had been released before a meeting could be arranged. In other cases, Transitional Care agencies sent just one member of their team to attend case conferences in prisons at some geographical distance - so the client may not have met the worker to whom they were assigned upon release.

Of the respondents interviewed at the four-month stage, 64% said they had met their Transitional Care worker while they were still in prison, 23% said they had not and 13% did not know/could not remember. There is clearly a possibility that some respondents may forget having seen a Transitional Care worker, or be confused about who works for which agency. Of the 47 individuals who claimed to have seen a Transitional Care worker post-release, nine are shown in the Cranstoun monitoring data as not having attended any appointments. Of the 123 who said they did not see a Transitional Care worker post-release, the monitoring data indicates that 10 did attend at least one appointment.<sup>14</sup>

Nine of the 37 respondents who participated in the qualitative interviews could not recall having received any publicity about Transitional Care whilst in prison, although the

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<sup>14</sup> Subsequent analysis by attendance/non attendance is based on the monitoring data, and only on self-report where this is unavailable.



majority remembered either seeing leaflets or posters or receiving a talk about the service as part of their induction process on admission. This publicity was seen as helpful at the time, but on reflection several suggested that it could be improved. Some respondents said they also talked about Transitional Care with other prisoners – indeed a couple of respondents said they strongly recommended it to other prisoners, whilst one mentioned discussing the possibility of Transitional Care with the prison social worker.

On the basis of the qualitative interviews, Polmont and Dumfries seemed to fare the best on the number of visits to prisoners by Transitional Care staff whilst Barlinnie prisoners recorded less visits overall. However, the number of visits obviously depended on the length of sentence, whether or not the visits were requested by prisoners or automatically initiated by caseworkers and whether the prisoner required or requested ongoing support. Furthermore different regimes were reported to operate in different prisons in relation to visits and access to prison-based services. For example, one man on remand recollected waiting two weeks for a caseworker to visit him after filling in a 'request form', whereas others could request such a visit at very short notice. Several respondents also suggested that the culture within particular prisons might not always have been conducive to visits from outside agencies.

The only qualitative interview respondents who thought they did not receive an assessment while in custody were two in Barlinnie and one in Low Moss. Otherwise, there did not seem to be any apparent differences in the type or frequency of contact between prisoners and Cranstoun caseworkers depending on which prison they were held in prior to release. Nor were there differences in respondents' perceptions of the quality of service provided according to where they were held.

There was, however, a lot of confusion amongst respondents about who exactly visited them in prison or who referred them to which agencies on release, as illustrated by the following quote:

"... the Straight Out Project, they helped me because they came to see me in prison and when I got out [Researcher: Was it Transitional Care that referred you to Straight Out?] No, I think they just visit any 16-25 year old that's getting out of prison in Renfrewshire area... I was supposed to be with SACRO as well but they just mostly do the same thing as the Straight Out Project. I couldn't be bothered going to all these places if I was just going to sit and say the same thing. Because that's what they were doing every week before I [was released], they were all coming down and telling me the same and asking me the same thing, I was like 'no!'."

A few respondents felt that their one-off visit from a caseworker did not constitute an assessment as such, but was seen more as a 'courtesy call'. For example, one respondent indicated that he was told to phone Cranstoun if he needed assistance on release; another told the caseworker that he did not need any help; a third implied that he was only seen to agree to participate in the research ("Just got to sign a bit of paper saying I would do this for a tenner and I said 'aye, no bother'"); and a fourth was told by the caseworker that he would return to assess his needs nearer to the date of his release but failed to do so:

"[The Cranstoun worker] didn't say much, no. Just asked if I had alcohol problems... He said he'd be back in touch but never got back in touch... He was gonna see me before I was released, but never."

It was a common view amongst the qualitative interview respondents that Cranstoun caseworkers did not fulfil their promises.

There seemed also to be a lot of confusion amongst prisoners about who was providing which service. Some suggested they were 'assessed' by several visitors. That said, the

vast majority thought that their assessment was realistic and helpful, not only in identifying their needs, but also in enabling them to talk through problems with somebody who seemed genuinely keen to help.

Complaints about assessment included the timing (too soon after admission to have got over initial withdrawal) and the fact that it was sometimes perceived to be service-rather than needs-led. For example:

"[Cranstoun] said they could try and do this and that [in relation to housing], but I was trying to explain to them I'm no interested in the housing. It's the drugs I need, I need help with the drugs... when I got the answer that I wasnae getting help with drugs, it kinda, I wasnae bothering... I told him about the drugs, eh, he was asking me about reading and writing and that's what was annoying me, I said I'm no here for reading and writing, I want help with drugs. I need help with drugs and that's what I thought it was all about. He was asking me stupid questions that I'm not interested in."

One respondent who had not had the opportunity to see a Transitional Care worker in prison expressed reluctance at having to provide information as part of the assessment for Transitional Care, only to have to repeat this again with another worker when released. Another respondent in an area where the Transitional Care workers were based in the prison, indicated that he found it beneficial to have met the worker in prison, and to have the opportunity to maintain that contact following his release. A third respondent who was in contact with a separate service (the Straight Out Project) had decided to maintain contact with this service on release rather than taking up Transitional Care. The importance of continuity appeared to be important for some respondents. As one respondent commented

"I put in to see them (Transitional Care) when I first came in and saw somebody two days before I got out, that was the first time I saw somebody".

### **Attendance at Transitional Care appointments**

Despite practical difficulties in collating accurate information on the percentage of clients attending first appointments from the monitoring data, when all the data files were merged it was found that 28% of ex-prisoners had attended their first Transitional Care appointment following release from custody. Attendance at subsequent appointments declined steeply, though more one half of those who attended a previous appointment attended the subsequent one (Table 10). These data were consistent with the survey finding that 27% of respondents said they had seen their Transitional Care worker at least once after release while 70% said they had not and 2% did not know/could not remember. While the take-up rate may not appear high, it is widely recognised that voluntary take-up rates of services by this client group are low. Whilst it is difficult to make a direct comparison with other studies, Burrows et al. (2001) found that only a third of prisoners had sought help from a drug service following release, with many of them making contact with a service they had been in contact with before being imprisoned, while Hickman et al (2004) estimated that between 16 and 22% of intravenous drug users in three English cities were receiving structured treatment.

	<b>Number of Cases (n=4001)</b>	<b>Percentage of Sample</b>
First appointment	1136	28%
Second appointment	610	15%
Third appointment	331	8%
Fourth appointment <sup>15</sup>	140	3%

The reasons for non-attendance at Transitional Care appointments recorded in the monitoring log are summarised in Table 11. In the majority of cases the reasons for non-attendance was not known, but this is not surprising given that the majority of clients referred to Transitional Care had no post-release contact. A return to custody and/or being arrested accounted for the majority of known reasons for non-attendance. Indeed, in total, being returned to custody or arrested accounted for 10%, 15%, 18% and 17% respectively of known non attendance over the four appointments included in the monitoring data. Being arrested or being returned to custody becomes particularly prominent after the first appointment. This finding would seem to support staff concerns that outstanding offences appeared to be a motivational barrier preventing some clients from engaging with the Transitional Care service.

<b>Reason</b>	<b>1<sup>st</sup> Appoint- ment</b>	<b>2<sup>nd</sup> Appoint- ment</b>	<b>3<sup>rd</sup> Appoint- ment</b>	<b>4<sup>th</sup> Appoint- ment</b>
Not known/no contact	84%	74%	73%	77%
Arrested	2%	7%	11%	5%
Returned to custody	8%	9%	7%	12%
College/work	<1%	1%	2%	0%
Moved area	1%	1%	3%	0%
No longer requires help	3%	4%	2%	2%

Many offenders who were offered Transitional Care had outstanding charges. This, it was suggested by staff, could influence their motivation to engage with services or could result in work undertaken by Transitional Care staff being 'undone' as a result of the client receiving a further custodial remand or prison sentence. There were reports of clients being liberated, engaging with services and making progress and then finding themselves in court some time later for an 'old' offence. Many staff therefore suggested that if a mechanism could be established for outstanding offences to be 'rolled up' and dealt with all at once, this could improve the motivation of some clients to engage with Transitional Care and the community-based services into which ex-prisoners were linked.

Further data on reasons for non-attendance were provided by the ex-prisoner survey. Of respondents in the quantitative survey sample, just over half (n=26 out of 48) of those who saw their worker post-release said they had attended all of the appointments made with them. The most common reasons for *not* attending appointments are shown in Table 12. The responses are from respondents who had not attended any appointments and those who had attended at least one, but not all appointments.

<sup>15</sup> Although Transitional Care was intended to consist of three appointments, up to four post-release appointments were recorded in the monitoring log.

Base: 149 (Those who did not attend any appointments and those who attended at least one but not all appointments)  
 Source: 4 month data

<b>Table 12. Reasons for Not Attending Transitional Care Appointments</b>	
	<b>% respondents</b>
Did not receive appointment	44
Something came up	10
Forgot about appointment	10
Could not get to place we were meeting	3
Sick/unwell	4
Was in prison/custody	2
Didn't think it would be useful	2

Although there was no difference in attendance between those who had met their worker pre-release and those who had not, those who had not met their Transitional Care worker prior to release were more likely to say their *reason* for not attending was that they had not received an appointment (n=21 out of 33 who had not met their worker compared with 34 out of 94 who had).

Some respondents indicated that despite having an appointment made for them to attend on release, continued drug use had deterred them from attending. For example, from the in-depth interviews, it was clear that in some cases, respondents left prison and were engaged in drug use immediately or very shortly after release. As a result, if appointments had been arranged to put them in contact with Transitional Care agencies or related services, the respondent considered there was little point attending if they had resumed their drug use.

However most of the 15 qualitative interview respondents who said that they heard nothing from Transitional Care after they were released said that they had been told while in prison that that a Transitional Care worker would ring them to arrange an appointment but that this had not happened. As one ex-prisoner commented,

“the last thing they said [was] they would contact me, but I’m still waitin”.

The fact that the single most common reason for non-attendance was simply not receiving an appointment (regardless of meeting the worker pre-release), suggests that the process for engaging the client at the outset needed to be improved.

For those who **declined** to attend Transitional Care on release, the main reason given was that they felt at the time of release that they no longer needed any help. Several qualitative interview respondents cited this as a reason for not pursuing the service:

“She [Transitional Care worker] was gonna help us get a job and that, but I ended up getting a job straight away when I got out... So I didnae get time to go in and see her... I just phoned her up and said ‘well, I’ve got such and such a job’... They are quite willing to help if you’re... it would be very useful for somebody that definitely need it. I just didnae happen to need it when I came oot but if somebody needed it, she’s good.”

## **Attendance and age**

There was found from the monitoring data to be an association between age and likelihood of attending an initial Transitional Care appointment. The mean age of those who attended appointments was higher than that of those who did not (29.3 compared with 28.0 years)<sup>16</sup>. Similarly, the percentage of those under 25 years of age who attended appointments was significantly lower than the percentage of those aged 25 years or more who did so (25% compared with 30%)<sup>17</sup>. The lowest attendance rate was found among those under 21 years of age (23%). The attendance rate increased with age, with 37% of those over 40 years of age attending their initial Transitional Care appointment. In line with the analysis of the monitoring data, the survey findings suggested that older respondents were more likely to attend. However, the number of older respondents was too small to allow any robust analysis of this issue.

These findings support staff perceptions that young people appeared less inclined to engage with the service and attend post release. Many staff felt that the 'model' of intervention was not the most appropriate for young people with substance misuse problems, for whom a more proactive and supportive approach might be required.

## **Attendance and gender**

From the monitoring data, attendance rates at first appointment amongst men and women were not significantly different at 28% and 31% respectively. This is contrary to the perception of Transitional Care staff that women were more reluctant to engage with the service.

## **Attendance and housing**

The relationship between anticipated accommodation status on release and attendance at initial Transitional Care appointments was examined using the monitoring data. It was found that those who were recorded as being of No Fixed Abode were significantly less likely to attend appointments (24%) than those who had local authority housing (43%) or who had other living arrangements (46%). This is consistent with the view expressed by staff that it was particularly difficult to engage those who had no fixed address with Transitional Care on release.

## **Attendance and participation in pre-release case conferences**

There was a perception on the part of staff that clients who received a pre-release meeting with an identified Transitional Care worker and who participated in a pre-release case conference were more likely to attend appointments in the community when released. In practice, however, this contact appeared to have little effect upon actual attendance rates. Examining the relationship between case conference and attendance at Transitional Care appointments was not, however, straightforward. First, the relevant information was not recorded on the monitoring log for much of the period under consideration, only being introduced in October 2003. Second, attendance at a case conference was not recorded as a discrete variable but rather was linked to identified needs. For example, it was possible to identify, from October 2003 onwards, whether ex-prisoners who were assessed as having particular needs had had a case conference in relation to each of these needs.

Comparing attendance rates according to whether or not a pre-release case conference had been convened produces somewhat different findings across different domains of need. In most domains (see Chapter Five) there was no apparent association between case conferences and subsequent attendance. However, a significant difference was

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<sup>16</sup>  $P < .001$

<sup>17</sup>  $p < .001$

found in the attendance rates of those with an identified health need who did and did not have case conferences. Contrary to the perceptions of staff, 45% who were recorded as having had a case conference attended their initial appointment compared with 54% of those who had not<sup>18</sup>. On the other hand, attendance was more likely among those with an assessed financial need/benefits need who had a case conference than among those who did not (51% compared with 45%)<sup>19</sup>.

These data would appear to suggest that the pre-release case conference has a less important role in encouraging the take-up of Transitional Care in the community than had previously been assumed. Indeed, an absence of association between participation in a case conference and engagement with Transitional Care was also found in the survey of ex-prisoners: those who had seen their worker in prison were no more likely to attend after release than those who had not seen their worker in prison. Yet, as we shall see, there was also evidence that the Transitional Care scheme that provided the greatest degree of continuity in terms of staff support in prison and in the community (Cranstoun in Dumfries and Galloway) also achieved the highest post-prison attendance rates. More generally, workers who had made themselves known to respondents while they were in prison and following release were viewed positively and proactive intervention was generally appreciated, particularly in relation to arranging appointments with welfare agencies. In one case, the support provided by the Transitional Care worker was viewed as the 'best thing' about Transitional Care:

"to me he is a very helpful person and he'll go out of his way to help you".

#### **Attendance and local authority area**

Table 13 summarises the attendance rate for first appointment by local authority area, the percentage of clients from each area and the Transitional Care partner operating in that area. As Table 13 illustrates, there were considerable differences between attendance rates across local authorities and Transitional Care providers. Six local authority areas had an attendance rate of over 40%. Dumfries & Galloway (Cranstoun) had the highest attendance rate, followed by West Dumbartonshire (SACRO), Inverclyde (SACRO), Dundee city (Cyrenians), North Ayrshire (SACRO) and Highland (SACRO).

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<sup>18</sup>  $p < .001$

<sup>19</sup>  $p < .05$

**Table 13. Attendance Rate by Area and Service Provider**

<b>Local Authority</b>	<b>Attendance Rate First Appointment</b>	<b>% Of All Clients Nationally</b>	<b>TC partner</b>
Dumfries & Galloway	69%	3%	Cranstoun
West Dunbartonshire	60%	2%	SACRO
Inverclyde	50%	2%	SACRO
Dundee city	47%	6%	Cyrenians
North Ayrshire	46%	3%	SACRO
Highland	41%	4%	SACRO
Fife	39%	4%	Apex
South Lanarkshire	38%	4%	SACRO
South Ayrshire	37%	2%	SACRO
East Ayrshire	36%	2%	SACRO
Perth & Kinross	28%	1%	Cyrenians
Renfrewshire	23%	3%	SACRO
Aberdeen city	22%	8%	Drugs Action
North Lanarkshire	21%	6%	CLCS
Glasgow city	20%	27%	Molendinar/Realise
Stirling	19%	2%	CLCS
West Lothian	17%	2%	SACRO
Aberdeenshire	14%	1%	Drugs Action
Edinburgh City	12%	9%	APEX
Falkirk	12%	3%	CLCS

All other local authority areas account for 1% or less of the total client numbers.

There would appear to have been some association between attendance rates and the geographical accessibility of the Transitional Care service. Many agencies which covered rural and semi-rural areas reported difficulties in finding suitable meeting places for client appointments. It was often the case that their office base was some distance away from potential clients. For example, SACRO had an office in Edinburgh but covered the East, Mid and West Lothian local authority area. This meant clients had to travel into Edinburgh or SACRO had to find a suitable meeting area nearer to the clients' home. Similarly, CLCS covered North Lanarkshire, Falkirk, Stirling and Clackmannanshire. CLCS had a low percentage of total clients and low attendance figures, however their figures for North Lanarkshire, where their office was based, were higher than for the other areas they covered. The Cyrenians, based in Dundee, also covered Angus and Perth and Kinross. Their attendance rates were higher in Dundee city than either of the other two areas.

Cranstoun workers covering Dumfries and Galloway and Borders also reported experiencing difficulty in finding suitable accessible meeting venues. However, while attendance rates for the Borders were very low, attendance rates for Dumfries and Galloway were high. Some areas, notably Glasgow, were also affected by a change of office accommodation for Transitional Care staff, which was thought to have affected the level of contact with prisoners on release. As one respondent explained:

"She said somebody would get in touch with you after a few months of coming out of prison... Cos they were starting up a [new] office somewhere... I never had any information. There was no phone number or anything like that. I didnae know where they were... All she told me was that they were starting an office down from [street name]. I went away doon there a few weeks ago. I went into the social work department... They said they're no in here."

Both pre-release and post-release accessibility of Transitional Care may impact on the uptake of service. In terms of pre-release accessibility, the level of informal contact with potential clients may be a relevant factor. Some penal establishments were able to allow caseworkers and Transitional Care staff greater access than others. Staff reported better access to prisoners in Dumfries, Greenock, Cornton Vale, Low Moss and Perth. Conversely, staff felt that in some penal establishments, for various reasons, formal or informal access to prisoners was more difficult to achieve: Aberdeen, Barlinnie and Edinburgh were all viewed in this way by caseworkers. For example, although the Throughcare Centre in Edinburgh was perceived to be advantageous for co-ordinating a prisoner's pre- and post- release care, it was also thought to have brought about a reduction in opportunities for informal access to prisoners in workshops or halls.

### Attendance and penal establishment

Table 14 shows the percentages of clients coming from different penal establishments and the attendance rate for first appointments. Attendance at first appointment varied considerably between establishments with some - such as Dumfries (61%), Kilmarnock (43%), Perth (42%), Greenock (37%) Inverness (37%) - all having higher than average rates of attendance at first appointment.

<b>Table 14. Attendance Rates by Prison Establishment</b>		
<b>Establishment</b>	<b>Attendance Rate First Appointment</b>	<b>% Of All Clients</b>
Dumfries	61%	4%
Kilmarnock	43%	4%
Perth	42%	10%
Greenock	37%	4%
Inverness	37%	5%
Low Moss	30%	12%
Cornton Vale	28%	7%
Polmont	24%	7%
Barlinnie	21%	27%
Glenochil	20%	1%
Aberdeen	19%	8%
Edinburgh	14%	10%

All other penal establishments account for 1% or less of the total client numbers.

Some prisons held prisoners from across Scotland (for example, Polmont, Cornton Vale) while others catered for a much more local population. It was suggested by staff that geographical distance impacted on the ability of Transitional Care staff to meet with prisoners prior to release and that this in turn could adversely affect attendance rates when prisoners were released. However, there was no evidence that attendance rates were lower among prisoners in establishments with a wider geographical catchment area. This, along with the case conference data, suggests that pre-release contact may be less important for engaging prisoners with Transitional Care than had previously been supposed.

Edinburgh is worthy of special mention as it is the second largest city and it appears to have had one of the lowest uptakes of Transitional Care. HM Prison Edinburgh has a largely local population, with the vast majority of prisoners coming from Edinburgh City followed by West Lothian, Mid Lothian, Fife and East Lothian. The staff working across Edinburgh and the Lothians reported difficulties in accessing clients both prior to and following release – possibly because many prisoners accessed pre-release services via the well-established Throughcare Centre - and this may have impacted on attendance at Transitional Care.



## Summary

Monitoring data were available in respect of 4794 prisoners who 'signed up' to Transitional Care while in prison. The mean age of ex-prisoners on release was 28.4 years and 90% of the sample was male. Most prisoners (95%) were unemployed when they received their prison sentence and many (35%) were recorded as being of no fixed abode. Ex-prisoners were most commonly returning to Glasgow City (24%), Tayside (10%), Lanarkshire (10%), Ayrshire (9%) and Grampian (9%).

Twenty-eight per cent of prisoners were recorded as having attended their first Transitional Care appointment on release, 15% attended a second appointment and 8% attended a third appointment. Survey and interview responses indicated that those who attended Transitional Care appointments were positive about the service they received.

Attendance rates at first appointment were similar for men and women, but ex-prisoners under 21 years of age were least likely to attend and, consistent with staff perceptions that they were more difficult to engage with Transitional Care, attendance rates were lower among those who were of no fixed abode.

Sixty-four per cent of those interviewed at 4 months said they had met their Transitional Care worker while they were still in prison. There was, however, no evidence – either from monitoring data or the survey – that attendance at a pre-release case conference increased the take-up of Transitional Care. However, geographically, the highest attendance rate at first appointment was in Dumfries and Galloway, where the same Transitional Care workers provided a service in the prison and in the community.

Arrest or return to custody accounted for most instances of non-attendance where the reason was recorded in the monitoring database. Those surveyed indicated that the single most common reason given for non-attendance was not receiving an appointment while in custody or following release. Ex-prisoners who had not seen their worker prior to release were more likely to give 'not receiving an appointment' as a reason for non-attendance, suggesting that mechanisms for engaging clients could be improved.



## **Chapter 5: Effectiveness of Transitional Care**

### **Introduction**

The key outcome by which the effectiveness of the Transitional Care initiative is to be evaluated is the extent to which it facilitates access to pre-existing community services, based on an individual's assessed needs. This chapter examines how successful the Transitional Care initiative was in this respect and whether this translated into more distal outcomes such as reduced drug use and offending and improved health. First, however, the needs of prisoners on release are discussed prior to considering the extent to which they had been met.

### **Ex-prisoners' identified needs**

In order to assess whether or not Transitional Care was making a difference, respondents at the four-month stage were asked about their needs since leaving prison and respondents at the seven-month stage were asked about current needs. They were asked whether they needed help or advice in the following five areas:

- Housing.
- Education, training or employment.
- Benefits or money.
- Health, or drug or alcohol use.
- Issues to do with partners, children or other family members.

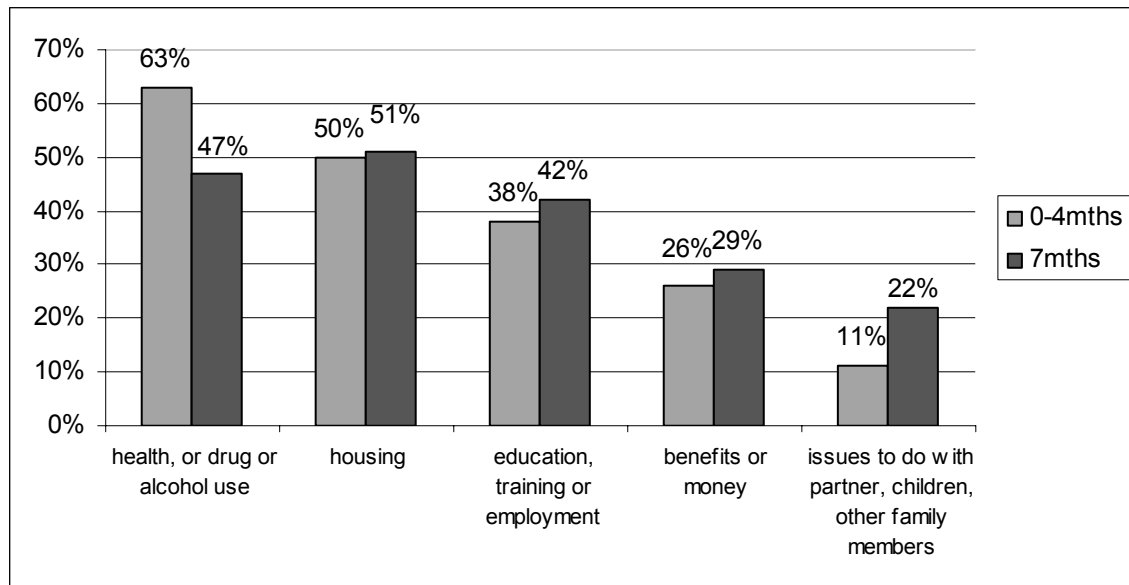
These specific areas were chosen because they fitted with the domains covered by the assessment tool used by caseworkers and Transitional Care workers to assess clients' needs. Where respondents indicated a need in a particular area, they were also asked what particular help or advice they thought they needed (mainly in terms of links with services).

### **Areas of need**

The areas in which survey respondents most commonly said they needed help or advice are shown in Figure 2.

**Figure 2: Areas in Which Respondents Said They Had Needed Help or Advice**

Bases: 175 for 4-mth data (all respondents), 222 for 7-mth data (all respondents)  
Source: 4mth and 7mth data



Not surprisingly, given that these individuals were all identified as substance misusers, the most frequently mentioned issue at the four-month stage was help in relation to health, drug or alcohol misuse (and, more specifically, “an appointment with a drugs agency or information on a drop in centre” and “an appointment with a GP”). Housing was mentioned by half the respondents at the four-month stage and was the most common need at the seven-month stage. The most common needs in this area were “an appointment with the housing officer” and “your name on the council waiting list”. This backs up the perception of caseworkers and Transitional Care staff that housing and drug services were most in demand.

A relatively high proportion of respondents (38% at the four-month stage and 42% at seven months) said that they had needed help or advice in relation to education, training or employment. This contrasts somewhat with the perceptions of staff who suggested that (other than for young offenders) education, training and employment were longer-term aims. However, there are three points worth noting here. First, respondents were not asked to prioritise their needs – education, training or employment may have been a ‘need’ but a less pressing one than health or housing needs. Second, respondents were asked about needs ‘since leaving prison’ (at the four-month stage). They were interviewed around 16 weeks after release so ‘longer term’ needs may have been emerging by that stage. Third, it may be that caseworkers and Transitional Care workers have a different perception of clients’ needs and of what the priorities might be. Previous research on community-based throughcare found, for example, that ex-prisoners more often identified employment and financial issues as being of concern on release from prison than did their supervising social workers (McIvor and Barry, 1998).

From the survey data there were few differences at the four-month stage between those who attended Transitional Care appointments and those who did not. The one significant difference was that those who attended were more likely to say that they had an education, training and employment need – 55% (n=27 out of 49) of those attending compared with 31% of those not. At the seven-month stage, there were no significant differences in the needs reported by those who had attended and those who had not.

Looking at those prisoners where we have data at both the four-month and seven-month stages, attenders were more likely to indicate a need in relation to education, training and employment at the seven-month stage than at the four-month stage. Those who had **not** attended were more likely to have needs in relation to health, drug or alcohol use and benefits or money at the seven-month stage than at the four-month stage.

The Cranstoun monitoring data were also examined in order to identify the needs of those clients who attended Transitional Care. Identified needs related to the six key domains of health (drugs and alcohol), housing, benefits and finance, education and training, employment and social issues. The design of the action plan and log did not allow for any differentiation of needs according to the first, second, third, or fourth appointments. The nature of needs and whether they changed over the course of appointments could not, therefore, be determined. It is possible, however, to report the identified needs of clients who attended at least one Transitional Care appointment following release and the proportion of clients who received notification of an appointment from a community agency within the 12 week post-release period.

In 1136 cases, the ex-prisoner was recorded as having attended at least one appointment post release. In the majority of these cases, information was also available with respect to the needs of prisoners that were identified following release by Transitional Care staff. The relevant data are summarised in Table 15.

**Table 15. General Areas of Need Identified by Transitional Care Workers**

<b>Domain of Need</b>	<b>Number of Cases</b>	<b>Percentage</b>
Health	654	63%
Housing	603	58%
Benefits/finance	346	34%
Education and training	264	26%
Employment	228	22%
Social issues	180	18%

Consistent with the perceptions of Transitional Care staff and ex-prisoners who had been referred to Transitional Care, health and housing needs were most common while needs relating to social issues and employment were least common. There were some significant differences identified in the needs of men and women on their return to the community (Table 16). More specifically, women were more likely than men to have an identified housing need, suggesting that a higher proportion of women were vulnerable in this respect when released from prison (e.g. Scottish Office, 1998; Ministerial Group on Women’s Offending, 2002). Men, on the other hand, were more likely than women to have a need identified in relation to employment, possibly because fewer women were in a position to take up employment as a result of commitments to children and other dependants.

<b>Domain of need</b>	<b>Men</b>	<b>Women</b>
Health	63%	62%
Housing <sup>20</sup>	57%	67%
Benefits/finance	33%	37%
Education and training	26%	21%
Employment <sup>21</sup>	24%	10%
Social issues	18%	24%

The needs of ex-prisoners also differed according to their age (Table 17). Comparing those under 25 years of age with those aged 25 years or older, the former were significantly more likely to be identified as having needs related to education and employment.

<b>Domain of need</b>	<b>Under 25 years</b>	<b>25 years and older</b>
Health	62%	63%
Housing	56%	59%
Benefits/finance	35%	33%
Education and training <sup>22</sup>	33%	22%
Employment <sup>23</sup>	30%	19%
Social issues	17%	19%

The needs on release identified through the qualitative interviews were similar to those identified from the survey, with drugs and housing most prevalent followed by alcohol and benefits/finances. It appeared that clients who attended appointments were likely to do so if they had a pressing housing need and/or need for support in relation to drug use or health issues. However, several respondents commented that what they really wanted was to be put in contact with someone who could help them negotiate the bureaucracy of services they were likely to encounter on release (e.g. benefit applications).

## **Whether needs were met**

### **Health needs**

As previously noted, a total of 654 ex-prisoners who attended at least one Transitional Care appointment were identified from the monitoring data as having a health need. Table 18 shows the number and percentage of prisoners who were assessed as having a range of specific health-related needs and the percentage of cases in which the action identified as being required had been achieved.

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<sup>20</sup>  $p < .05$

<sup>21</sup>  $p < .001$

<sup>22</sup>  $p < .001$

<sup>23</sup>  $p < .001$

<b>Table 18. Health Needs and Whether Met</b>			
<b>Appointments Needed</b>	<b>Action offered and Accepted by Client (n=654)</b>	<b>Action Achieved (no.)</b>	<b>Action Achieved (%)</b>
Drugs Agency	399 (61%)	266	67%
GP Drugs	153 (23%)	83	54%
GP other	115 (18%)	67	58%
Needle exchange	17 (3%)	12	71%
SW rehab assessment	18 (3%)	9	50%
Specialist agency	129 (20%)	66	51%
Alcohol agency	107 (16%)	61	57%
GP register	124 (19%)	81	65%
General information	417 (64%)	284	68%
<b>Total</b>	<b>1479</b>	<b>929</b>	<b>63%</b>

Table 18 indicates that the most commonly required needs among those identified as having health needs were referral to a drug agency, the provision of general information and a GP appointment in relation to their use of drugs. This suggests – consistent with the view expressed by staff - that clients’ health needs at first appointment were very much related to their substance use.

Overall, 63 per cent of health-related needs were reported to having been addressed through an appointment having been made with the relevant community agency during the 12 week post-release period or through general information having been provided. Two-thirds of those who were deemed to require such a service had been referred to a drugs agency. However GP appointments had only been achieved in just over one half of the cases in which they were required.

### **Housing needs**

Housing-related needs were, after health needs, most commonly identified among ex-prisoners. Overall, 58% of clients had a housing need identified at their first Transitional Care appointment. The specific housing needs most often identified included the provision of general information, an appointment with a housing officer and getting onto the local authority housing list (Table 19). Overall, action was reported to have been achieved in respect of two-thirds of housing-related needs identified by Transitional Care staff.

<b>Table 19. Housing Needs and Whether Met</b>			
<b>Appointments Needed</b>	<b>Action Offered and Accepted by Client (n=603)</b>	<b>Action Achieved (no.)</b>	<b>Action Achieved (%)</b>
Housing officer	381 (63%)	263	69%
Social work	18 (3%)	6	33%
Street sleepers	8 (1%)	3	37%
Emergency accommodation	128 (21%)	87	68%
General information	396 (66%)	290	73%
Hostel accommodation	60 (10%)	36	60%
Supported accommodation	63 (10%)	36	60%
Name on LA housing list	189 (31%)	118	62%
<b>Total</b>	<b>1243</b>	<b>839</b>	<b>67%</b>

### Financial needs

Thirty-one per cent of clients who attended at least one Transitional Care appointment had needs related to finances and/or benefits. The provision of general information and/or an appointment with a benefits officer were most often required (Table 20). The relevant action had been taken within 12 weeks in respect of 61% of financial needs.

<b>Table 20. Financial Needs and Whether Met</b>			
<b>Appointments Needed</b>	<b>Action Offered and Accepted by Client (n=346)</b>	<b>Action Achieved (no.)</b>	<b>Action Achieved (%)</b>
Benefits Officer	195 (56%)	128	66%
Debt advisor	9 (3%)	6	30%
Rights officer	14 (4%)	7	50%
Social work	11 (4%)	7	63%
General information	287 (83%)	169	59%
<b>Total</b>	<b>516</b>	<b>317</b>	<b>61%</b>

It should be noted that, following changes to the Transitional Care service, this domain of need is no longer included in the Transitional Care action plan and log. However, the fact that almost one third of those attending an appointment had a need in this area would suggest that it is an area of concern for many ex-prisoners.

### Education needs

Just over one quarter (26%) of ex-prisoners had education or training identified as an area of need. This most often involved the need for general information or referral to a training or education agency (Table 21), with action having been taken in respect of 63% of identified needs. Like finances/benefits, education/training is no longer included as a key Transitional Care domain.



<b>Table 21. Education/Training Needs and Whether Met</b>			
<b>Appointments Needed</b>	<b>Action Offered and Accepted by Client (n=264)</b>	<b>Action achieved (no.)</b>	<b>Action achieved (%)</b>
Education Agency	59 (22%)	38	64%
New Futures	27 (10%)	22	81%
Training agency	93 (35%)	74	80%
General information	245 (93%)	134	55%
<b>Total</b>	<b>424</b>	<b>268</b>	<b>63%</b>

### **Employment needs**

Twenty-two per cent of clients who attended their first appointment had an employment-related need. Relevant actions included the provision of general information or an appointment with an employment agency, with these recorded as having been achieved in 59% of cases (Table 22).

<b>Table 22. Employment Needs and Whether Met</b>			
<b>Appointments Needed</b>	<b>Action Offered and Accepted by Client (n=228)</b>	<b>Action Achieved (no.)</b>	<b>Action Achieved (%)</b>
Employment Agency	115 (50%)	72	63%
General information	242 (106%) <sup>24</sup>	140	58%
<b>Total</b>	<b>357</b>	<b>212</b>	<b>59%</b>

### **Social needs**

The category of 'social issues' relates to the identification of clients' needs in relation to mediation, family work, youth activity, diversionary activities and access to day and family centres. Eighteen per cent of clients who attended Transitional Care had identified needs in this area, these most often taking the form of general information and referral to diversionary activities (Table 23). Overall, specific needs identified within this wider domain were less likely than those in the other key domains to have been met.

<sup>24</sup> The number of ex-prisoners identified as requiring general information about employment was higher than the number identified as having an employment-related need. This could either reflect errors in the completion of monitoring forms or at the data entry stage or it might suggest that some prisoners did not have an employment need per se but would nonetheless have benefited from some employment-related advice.

<b>Appointments Needed</b>	<b>Action Offered and Accepted by Client (n=603)</b>	<b>Action Achieved (no.)</b>	<b>Action Achieved (%)</b>
Mediation service	11 (6%)	7	63%
Family work agency	12 (6%)	2	16%
Youth activity programme	6 (3%)	6	100%
Diversionary activity	27 (15%)	20	75%
Day centre	14 (7%)	7	50%
Family centre	2 (1%)	1	50%
General information	137 (76%)	58	42%
<b>Total</b>	<b>209</b>	<b>101</b>	<b>48%</b>

### Summary of client needs and action achieved

The 'top ten' needs identified from the Transitional Care monitoring data and the extent to which relevant actions had been taken in respect of these needs are summarised in Table 24.

<b>Ranking</b>	<b>Need</b>	<b>Number of Cases</b>	<b>% Actions Achieved</b>
1	Drugs agency	399	67%
2	Housing Officer	381	69%
3	Benefits officer	195	66%
4	Local authority waiting list	189	62%
5	GP drugs appointment	153	54%
6	Specialist agency	129	51%
7	Emergency accommodation	128	68%
8	GP register	124	65%
9=	Employment agency	115	63%
9=	GP other	115	58%
10	Alcohol agency	107	57%

Without doubt, the two most common needs of clients were an appointment with a drug agency followed by an appointment with a housing officer. In the key areas of need, appropriate action was typically reported as having been taken in around three-fifths to two-thirds of cases. The monitoring data largely bears out staff perceptions of clients' needs and data derived from survey and in-depth interviews with prisoners. It is also worth noting, however, that the third most common need – for referral to a benefits officer – was in an area that ceased from April 2004 to be within the remit of the Transitional Care initiative as the service evolved to avoid duplication with other service and to focus on the key issues that Transitional Care might appropriately address.

Further information about the effectiveness of Transitional Care in linking clients with services was provided by the survey data. Table 25 shows the numbers of survey respondents who attended Transitional Care appointments with a particular need and whether that need was met by the Transitional Care worker.

Base: 48 (All those who attended Transitional Care appointments)<sup>25</sup>  
 Source: 4mth data

<b>Table 25. Needs of Those Attending Transitional Care Appointments and Whether Those Needs Were Met by Transitional Care (in order of most common needs)</b>		
<b>Type of Help/Advice</b>	<b>Number of Those Who Saw TC Worker, Who Said They Needed This</b>	<b>Number of Those Who Saw TC Worker, Who Said TC Worker Arranged This</b>
Appt with housing officer	21	13
Appt. with drugs agency/info. on a drop-in centre	19	9
Info. about courses/colleges	19	12
Appt. with GP	17	5
General info. about housing	17	11
General info. about educ., training or employment	15	9
Name on council waiting list	14	9
Emergency or hostel accomm.	14	8
Appt. with alcohol agency/info. on a drop-in centre	12	8
Appt. with job centre, careers service or employment agency	11	3
Appt. with benefits officer	8	4
To register with GP	8	3
Appt. with social work (housing)	6	2
Appt. for rehab assessment	5	5
Appt. with social work (money)	4	3
Help with access to children	2	1
Appt. with social work (family)	1	1

Overall, it appears from the survey data that Transitional Care was reasonably effective in linking clients with services. The small sample means there are few significant differences in the proportions linked with different types of service. However, it does appear that Transitional Care was more effective at arranging appointments with Housing Officers and appointments for rehab assessments, than arranging appointments with GPs or with job centres, careers services and employment agencies.

<sup>25</sup> This data is based on self-reported attendance at Transitional Care appointments, because the questionnaire routing (which determined whether the respondent was asked if their TC worker had arranged the help/advice), was based on whether the respondent had indicated earlier in the interview that they had attended.

## What difference does Transitional Care make?

From the qualitative interviews it appeared that those having contact with Transitional Care reported reduced problems as a result of that contact. However there was also a corresponding reduction in the number of respondents citing reductions in problems since being released who had **not** had contact with Cranstoun in the community.

The more crucial test is whether Transitional Care is linking clients with services **with which they would not otherwise be linked**. If the Transitional Care worker is arranging an appointment that the client would otherwise have arranged themselves (or which their social worker, GP or mother would have arranged for them) then there is potentially no added value in the service.

In order to measure this, we looked separately at each domain in the quantitative interviews, and looked at the proportion of respondents who had any kind of “unmet need” in that domain. An “unmet need” was defined as being a case where the respondent said they had a particular need (e.g. an appointment with a housing officer) but they had not had this need met either by their Transitional Care worker (if they had one) or by anyone else. We then compared the unmet needs of those who had been to Transitional Care appointments with those who had not. There were no significant differences between the two groups, although those who attended Transitional Care were slightly less likely to have one or more unmet needs. The results of this analysis are shown in Table 26.

Bases 49 (all those who attended Transitional Care appointments), 126 (those not attending any Transitional Care appointments)  
Source: 4mth data

<b>Table 26. Respondents with Unmet Needs</b>		
<b>Area of Unmet Need</b>	<b>Number of Those Attending TC With Unmet Need</b>	<b>Number of Those Not Attending TC with Unmet Need</b>
Housing	11 (22%)	38 (30%)
Education, training or employment	10 (20%)	27 (21%)
Benefits or money	2 (4%)	17 (14%)
Health, drug or alcohol use	17 (35%)	40 (32%)
Partner, children other family members	2 (4%)	5 (4%)
Unmet need in any area	24 (49%)	73(58%)

## Uptake of appointments with other services and perceived helpfulness

There is, however, a distinction between referring clients on to other services and ‘effectively linking’ clients with existing services in the 12-week period following release. It is possible, for example, that Transitional Care workers were facilitating links with services but then clients were failing to turn up for appointments or to use those services. It was not possible to determine from the monitoring data whether or not community agencies were actively supporting clients within the 12-week timeframe since this information was not recorded. However, from the qualitative interviews it was apparent that most of those who had contact with Transitional Care following release also had contact with other agencies, including APEX, Turning Point and a drug project. Several of the qualitative respondents who declined to access Transitional Care services on release or who had had *no* contact from Transitional Care suggested that they had been in touch with no agencies since returning to their communities. Others had, however, initiated contact with agencies since being released, including drug services

and social work, Realise, SACRO, APEX, Straight Out and drug and alcohol projects. Some indicated that although they had not attended Transitional Care appointments on release, they had, nevertheless made contact with other agencies with whom Cranstoun had put them in touch while they were in prison. Although there were mixed reactions to the quality of service offered by these various agencies, and a certain amount of ambivalence about their effectiveness in helping reduce problems in respondents' lives, they were generally viewed as worthwhile.

The survey also asked respondents who had indicated that they had received an appointment/link with a service (whether through Transitional Care or elsewhere) whether they had actually attended the appointment or used the service. In the vast majority of cases, the respondent indicated that they *had* attended or used the service.

It is also possible that the links were made, or information was provided, but the client did not find it helpful. For each item (whether appointment, or other link or information) that the respondent said they had received, we asked if they had found it "very helpful", "a bit helpful" or "not helpful". Again, in most cases, the majority of respondents *did* find the appointments or information they have received very helpful.

### **Other outcomes**

The survey data collected at both the four-month and seven-month stages enabled some other outcomes to be examined, namely:

- Health symptoms.
- Drug use.
- Alcohol use.
- Offending.
- Stability/suitability of accommodation.
- Economic activity.

However, before discussing these, it is worth sounding a note of caution. Given the lack of contextual information - which would enable us to look at sub-groups of ex-prisoners with different characteristics - there is a limit to how much analysis can be undertaken and how much should be read into the results. Moreover, the primary aim of Transitional Care is to link clients with services. Ultimately, of course, the assumption is that facilitating better links with services will lead to an improvement in these outcomes - but the evaluation must be focused on the primary aim of facilitating links.

### **Health symptoms**

A version of the MAP instrument was used to measure health outcomes. Respondents in the quantitative study were asked whether they had experienced a particular symptom and, if so, how often they had experienced it in the previous 30 days.

There were no differences at four-months or at seven months, between the mean number of physical symptoms reported by those who had attended Transitional Care appointments and those who had not. Similarly, there were no differences (at either stage) between the two groups overall in terms of the number of symptoms of anxiety or depression reported.

In terms of the difference for each individual between four and seven months, both those who had attended Transitional Care and those who had not, reported more physical symptoms at seven months than they had at four. There was no significant

difference in the mean size of the change between attendees and non-attendees. In other words, attending Transitional Care appointments did not help prevent an increase in the number of physical symptoms reported at seven months. However, it should be noted that the base sizes here are very small (there were only 21 attendees for whom we had both four and seven month data).

Similarly, both attendees and non-attendees reported slightly more symptoms of depression at seven months than they had at four. However the change in the reporting of these symptoms over time was the same for both attenders and non-attenders.

Those who had not attended Transitional Care reported slightly more symptoms of anxiety at seven months than they had at four months. There was no significant difference in the levels of anxiety at each stage reported by those who had attended Transitional Care appointments.

### **Drug use**

Again, a version of the MAP instrument was used to measure drug use. There were no statistically significant differences – at four months alone, seven months alone, or differences over time - between those who had attended Transitional Care appointments and those who had not in terms of whether they had used any drugs in the previous month, the mean number of days they had used each drug in the previous month or in the amount of money they were spending on drugs.

Similarly, at all levels of comparison<sup>26</sup>, those attending Transitional Care appointments were no more likely to be on a methadone script (or a buprenorphine or lofexidine script) than those who did not attend.

There was also no difference in injecting behaviour (at any level of comparison): there were no differences between those who had attended and those who had not in terms of whether or not they had injected in the past month or in the mean number of days they had injected.

When qualitative respondents were asked whether their drug/alcohol use had changed between the period before going into custody and since being released from custody, most believed that their use of substances had reduced or had remained unchanged.

An issue identified by a few respondents was the possibility that liberation grants may well be spent on drugs or alcohol immediately on release, unless alternative, constructive opportunities are made available to ex-prisoners:

“They should have people, [who know] what people need when they get out... when I came out, I didn’t feel part of any circle, know what I mean? I was wanting to leave the old one, the criminal [circle] and I couldn’t fit into anywhere else, ending up just drinking... so I dinnae feel I could walk into a shop buy clothes with a clothing grant. I walked into all the sports shops and just had to walk out because I know everybody was looking at me as if to say ‘aye, he’s into stealing’, know what I mean? That’s the way I think, so I ended up just spending my grant on drink”.

“... you go to prison, they’ll do nothing for you. You come out of prison, you get a lib grant in your hand. Where do you go? You go and buy drugs. I do it, 99% of the people do it and it’s just your routine. A couple of weeks and you’re back in the jail again”.

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<sup>26</sup> i.e. considering the four-month data in isolation, the seven-month data in isolation, or comparing the difference between individuals at four-months and seven-months.

Given that the majority of women in prison report having a history of drug use, the number of women who could be recruited into the sample was disappointingly low. Both women who were interviewed in depth indicated that they needed and asked for help with their heroin addiction in prison but neither heard from Transitional Care on release, even though they expected such contact to occur. Both also suggested that the prison-based caseworkers appeared to place greater emphasis upon housing issues (which they considered less relevant) than upon drugs.

### Alcohol use

An adapted MAP was also used to measure alcohol use. There was no significant difference, at any level of comparison, between those who had attended Transitional Care appointments and those who had not in terms of the mean number of days they had been drinking in the past 30 days.<sup>27</sup> There was also no significant difference between the groups in the mean number of units of alcohol drunk (by those drinking at least once a week).

### Offending

There were no differences between those who had attended and those who had not (at any level of comparison) in relation to whether or not they said they had committed any crimes in the previous month. In total, 41% of respondents at the four-month stage said they had committed a crime/crimes and 49% of respondents at the seven-month stage said had offended in the past month.

Qualitative interview respondents were asked whether they felt their level of offending had reduced since they had been released from prison compared with their offending prior to admission to prison for the sentence under study. Most reported they had not re-offended since leaving prison or that they were offending less (see Table 27).

<b>Table 27. Self-Reported Changes in Offending Behaviour</b>			
<b>Level of Offending</b>	<b>Declined contact</b>	<b>Had contact</b>	<b>Never heard</b>
<b>None</b>	4	2	6
<b>Less</b>	5	3	5
<b>The same</b>	3	-	2
<b>More</b>	1	-	1

In line with recent studies of desistance from offending, respondents suggested that they had become disillusioned or 'burnt out' as a result of their involvement in the criminal justice system to date. This was a major impetus to them reducing or stopping offending. The numbers who attended Transitional Care on release were too small – and the intensity of that contact was too minimal – to be able to suggest that Transitional Care had an impact on this sample's offending behaviour.

Many respondents suggested they were grateful for the advice that they had received from Cranstoun caseworkers in the prison in which they had been held. Whilst one young man suggested that being "banged up for four and a half months basically" had impacted on his reduced offending, he nevertheless felt that Cranstoun's pre-release support had also had a positive impact:

<sup>27</sup> It is particularly important to note here that we are not able to make a distinction at this stage between those with alcohol misuse problems and those using alcohol more appropriately – this makes it more unlikely that we would see a difference in outcome.

"Somebody comes and speaks to you and maybe kinda... put a different point of view in your head... about how drugs work and they even tell you about how your pals have got you in the jail and you think about it. They've obviously been speaking to folk and they know what they're talking about."

Although drug-related advice was not generally considered sufficient to make a difference, longer-term contact and support prior to release was valued and in some cases was thought directly to have reduced the likelihood of drug-related offending. Even so, the challenges posed on release could be significant:

"If you want to stop people re-offending, if you put them back into their own housing scheme where they grew up causing trouble, they are going to do it again, so I don't see the sense in it. If they want to stop me from re-offending, they should move me to a quiet place out of [home town] where I can settle down and go to college".

This suggests that the housing needs of ex-prisoners should be a key priority for housing and other agencies concerned with the re-settlement of prisoners.

### **Accommodation and economic activity**

There were no significant differences, at any level of comparison, between those who had attended Transitional Care appointments and those who had not in relation to the type of accommodation they occupied (e.g. whether house or flat, bed and breakfast, hostel, staying a few days here and there with friends or relatives) or in relation to how long they expected to be in their current accommodation. There were also no differences in relation to ratings of the safety of their belongings.

At the four-month stage, those who had attended Transitional Care appointments were more likely to rate their personal safety in their accommodation as being 'very' or 'fairly' unsafe than those who had not attended (35% of attendees felt unsafe compared with 11% of non-attendees).

There were also no differences between the two groups, at any level of comparison, in relation to economic activity (whether in employment, unfit for work, in education etc.).

### **Christo Inventory scores**

The Christo Inventory is used as a professional audit/evaluation tool, providing an indication of the degree to which a client's substance misuse impacts on their psychological and social well being. It is administered by practitioners, who make an assessment based upon the presentation of the client. In the context of Transitional Care, it was intended to provide a measure of client progress in the period following release from prison.

The Christo Inventory requires client contact for its completion and requires such contact on at least two separate occasions in order that any changes in scores can be measured. Only 331 clients attended three appointments and in only 292 cases were Christo scores available for each appointment. However, comparison of mean scores reveals a gradual reduction in scores from first (2.3) to second (2.0) to third (1.8) appointment<sup>28</sup>. This suggests that clients' social situation and substance misuse behaviour had generally improved over the post-release contact time. However, whether and to what extent these improvements could be attributable to Transitional Care cannot be determined from the available data.

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<sup>28</sup> P<.001



## Perspectives on the effectiveness of Transitional Care

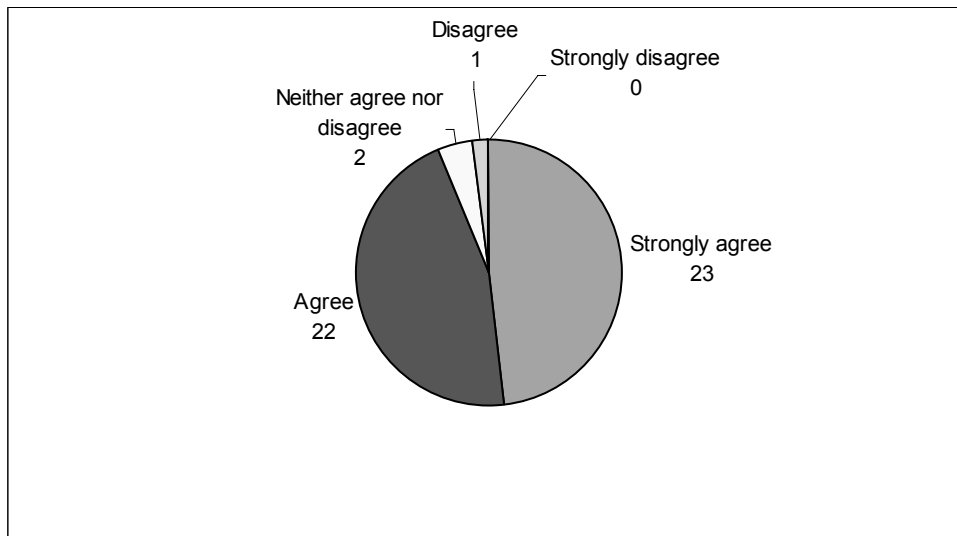
### Ex-prisoners' views about the service received

Those ex-prisoners who did attend Transitional Care appointments were positive about the service they received. Responses to a series of statements about the service are shown in Figures 2-5.<sup>29</sup>

#### Figure 3: Level of Agreement with Statement "The Transitional Care Worker Always Understood the Kind of Help I Wanted"

Base: 48 (All those who saw TC worker post-release)

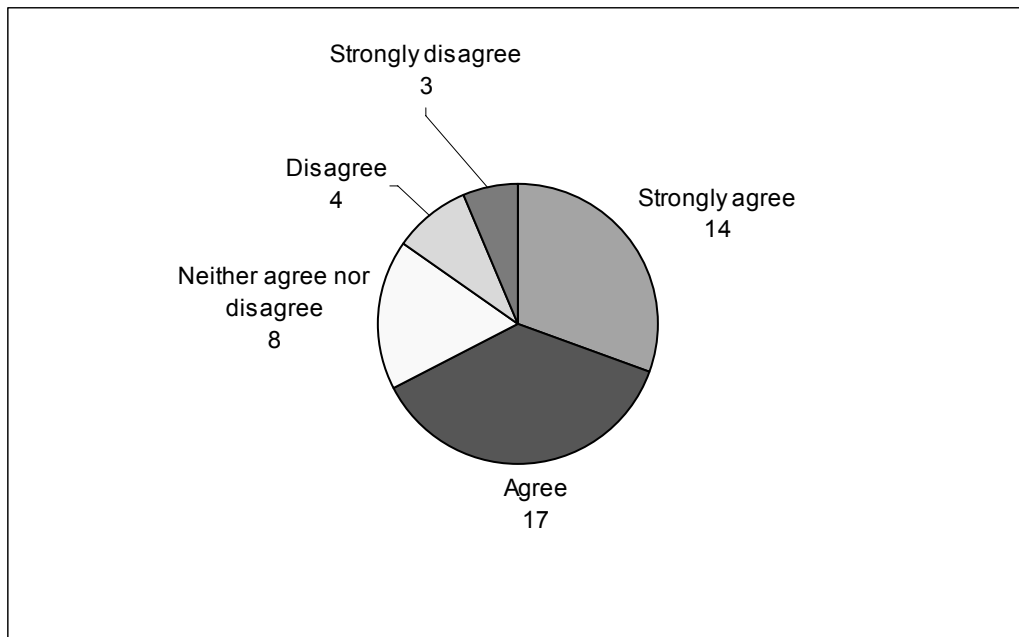
Source: 4mth data



<sup>29</sup> The figures show the number of the 48 respondents who agreed/disagreed.

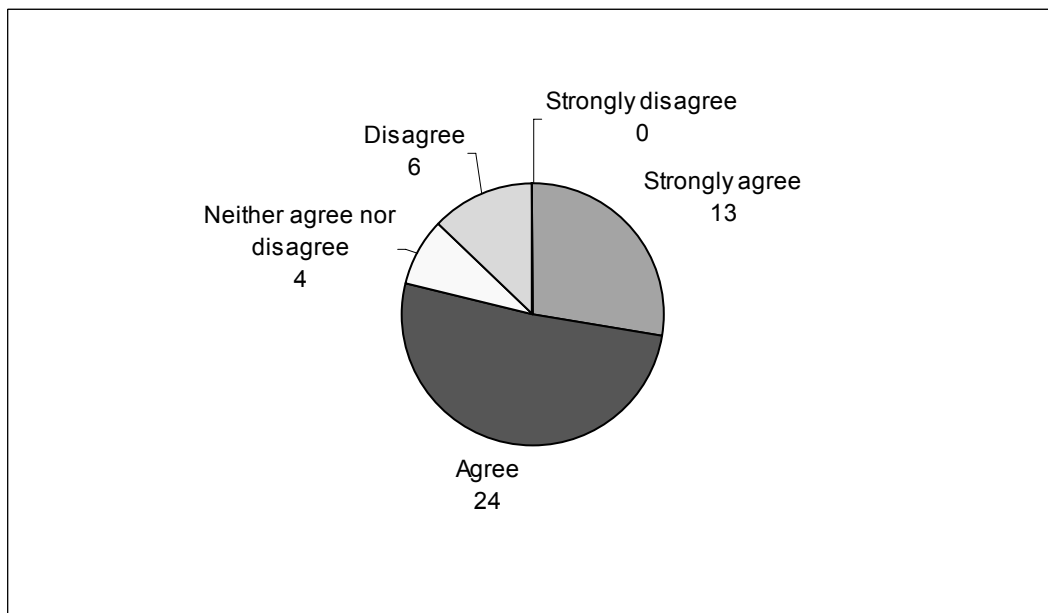
**Figure 4: Level of Agreement with Statement "The Transitional Care worker has helped motivate me to sort out my problems"**

Base: 48 (All those who saw TC worker post-release)  
Source: 4mth data



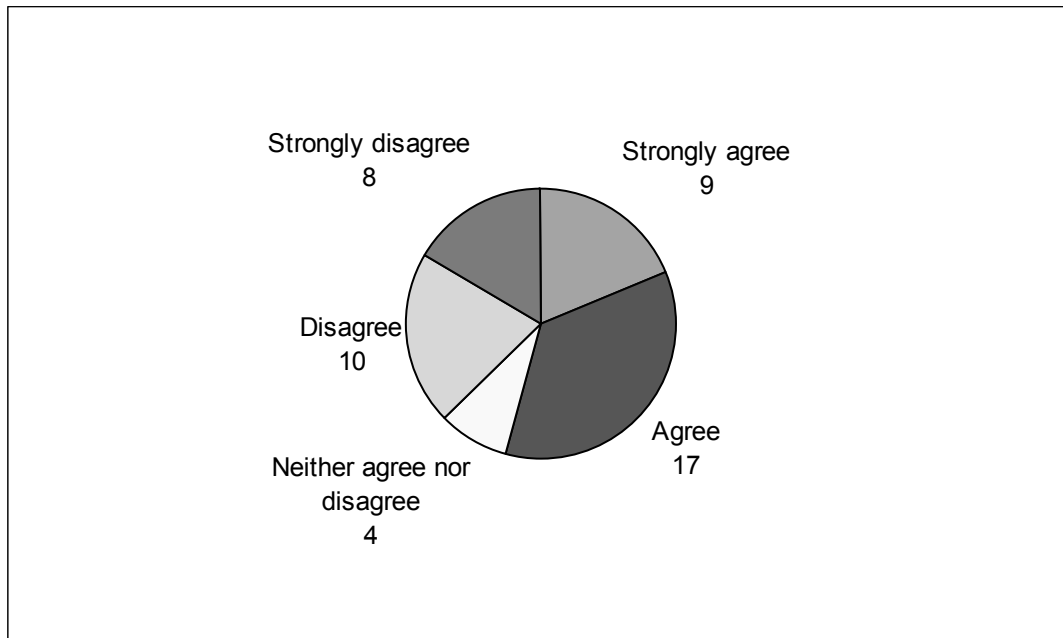
**Figure 5: Level of Agreement with Statement "I have liked all of the Transitional Care meetings I have attended"**

Base: 48 (All those who saw TC worker post-release)  
Source: 4mth data



**Figure 6: Level of agreement with statement "I have not had enough appointments with the Transitional Care worker"**

Base: 48 (All those who saw TC worker post-release)  
Source: 4mth data



Interview respondents mostly described Transitional Care as an advisory and support service, along the following lines:

- To help offenders whilst in prison and to meet them once back in their communities.
- To help with drug problems [only].
- To help with drug and alcohol problems, employment and housing.
- To help people to lead different lives.
- For offenders or ex-prisoners.
- Someone to talk to and to offer help if needed.
- To help you to access necessities or support on release.

The aspect of the service *most* appreciated by those who had direct experience of Transitional Care both within the prison and on release were the workers' friendly and courteous approach, the fact that they made one feel comfortable, and the sound advice they gave on drug and alcohol problems. For those who had contact in the prison but not on release, the main aspect most appreciated was the fact that the worker was someone they could talk to and seek advice from when required. It was also suggested that they could 'back up' individuals who were dealing with other agencies (and one respondent in this respect suggested that they put in a good report for him at court, which resulted in him getting probation rather than a further custodial sentence).

Managers and practitioners suggested that the aspects of Transitional Care that were most effective included the links which could be established for clients between prison and the community, the advocacy role which clients could access and the general 'helping hand' which was made available to individuals following release. There was considerable optimism among professional respondents about the ability of Transitional

Care to reduce drug-related deaths. Respondents were more cautious about the potential to reduce drug use or re-offending, although it was acknowledged that this could be affected in the longer-term. However it was also acknowledged that Transitional Care does provide an opportunity to identify where services are lacking and hence has the potential to move services towards better strategic planning.

Young offenders in particular often appreciated constructive help from agencies in negotiating, not only substance misuse programmes, but also benefits, housing, employment and other related services, often finding the red tape difficult to deal with. One young man highlighted the effectiveness of Transitional Care in by-passing such bureaucratic procedures:

"It was quite good 'cos like usually you need to wait a week or so for an appointment for the Job Centre and stuff like that, eh. So they got us that straight away as soon as I got out."

The aspect of the service *least* appreciated by respondents was that Transitional Care does not necessarily 'deliver' on its promises, a criticism cited by several of the sample. Three respondents also suggested that caseworkers' line of questioning was too intrusive, pressurising or 'fussy' and a fourth respondent thought that they lacked organisational skills.

A number of factors were thought by professional respondents to have prevented the Transitional Care Initiative from being more effective. These included a concerns by some agency managers that insufficient emphasis was being placed upon quality; ex-prisoners' failure to attend appointments and engage with services; and a low proportion of women taking up the service. Concern was also expressed about clients being placed on waiting lists rather than being offered an immediate service and that prison-based caseworkers, by making promises which could not be delivered, were not giving clients realistic expectations of what could be made available on release. Some respondents suggested that the restrictions placed on the amount of client contact were too inflexible, with workers indicating that they would like the opportunity to do more intensive work with clients beyond the limited three-month period. The lack of integrated care in the drugs field was also seen as a problem:

"There are gaps there in the services and the whole idea, I think, is for addiction to have a seamless service and we're not quite there yet. I think we're all working very hard to achieve this in the service but there are definitely gaps where the people can fall through the net and we in fact lose the continuum."

"Commonsense joined-up social policy would assume some sort of link between clinical services within prisons where people have had an enforced detox and when they've been released into the community ...But their immediate need - the one thing that's likely to kill them is going straight into street drug use. So substitute prescribing for people pre-release from prison would probably do a lot more to reduce overdose, address recidivism than any other single factor."

The prison-based caseworkers had also formed views about the effectiveness of Transitional Care. Many felt that if the Transitional Care agency had the ability to be mobile, to meet clients on their terms, to attend appointments with them and to advocate for them, it was more likely that clients would take up the offer of Transitional Care. A few suggested that engagement with the service might be further enhanced if Transitional Care workers could meet clients at the gate when they were released from prison, but they also acknowledged that this would be expensive and not practical in most cases. The caseworkers were of the view that three post-release appointments were unlikely to be sufficient in most cases and that many clients would be in need of

three appointments within the first week of release. They also felt that 12 weeks was probably too short and suggested that Transitional Care agencies were struggling to link clients into existing service provision within the 12-week time frame. Caseworkers perceived housing and drugs services to be in highest demand and, like the Transitional Care workers, thought that, with the exception of young offenders, education, training and employment were for most clients long-term aims.

Turning to a comparison of experiences and views among ex-prisoners who were returning to different areas on release, none of the seven respondents from Fife had contact with Transitional Care on release. In contrast, three of the four Dumfries and Galloway respondents were in touch with the service on release<sup>30</sup>. It appears that the Dumfries and Galloway scheme - by locating the Transitional Care staff within the prison - was better able to offer a constructive, consistent and continuous service to offenders both pre- and post-release. The Cranstoun worker within the prison was spoken of highly by these respondents.

Only two of the 20 respondents from Glasgow had contact with Transitional Care on release, although a further five had been contacted or given an appointment on release but failed to keep it. Most apparently left prison to no official support or throughcare arrangements, even though they all identified multiple problems during the Transitional Care assessment process in prison.

Several respondents were under a possibly misguided impression that Transitional Care staff could and could not do certain things within their remit. Whilst the following misconceptions may be considered one-off, individual viewpoints, they are worth noting because, although only one person may have made each of these remarks, these assumptions may in turn have been received by word of mouth or conveyed to other potential clients by word of mouth:

- Transitional Care cannot work with people whilst they are on probation.
- Transitional Care does not provide services in certain geographical areas.
- Transitional Care only works with homeless people.

Another respondent said that Transitional Care staff had tried to refer him to SACRO on release but that SACRO were unable to help him whilst he was wearing an electronic tag.

Respondents in the qualitative interviews offered suggestions as to how Transitional Care might be improved. Prior to release these included:

- the provision of specific/concrete help and advice during assessment
- greater contact with caseworkers and Transitional Care workers prior to release
- shorter delays between requesting and receiving a prison-based appointment
- increased written publicity about Transitional Care (and possibly a video on induction)
- greater autonomy for Cranstoun caseworkers (including, for example, in relation to facilitating meetings between prisoners and community-based workers)
- the provision of groupwork programmes for young offenders
- improved co-ordination of harm reduction and treatment between Cranstoun and SPS

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<sup>30</sup> The fourth failed to keep an appointment made for him on the day of his release.

the creation of prisons for drug users or for non-drug users, to minimise the likelihood of 'contamination'.

Following release they included:

- provision of fixed appointments as soon as possible following release, to maintain motivation and build on support offered within the prison
- recreational activities for younger offenders
- avoid raising expectations with respect to what can and cannot be offered inside and outside the prison to levels that cannot be achieved. For example, four respondents specifically mentioned – although several others implied – that Transitional Care should 'deliver on promises' and not raise expectations unduly in terms of what they can provide both in and outside the prison: "They say they're gonna help you and they don't. They don't deliver".

### **Cost effectiveness**

Views on cost-effectiveness varied between organisations. The smaller agencies based in the voluntary sector believed that the service was cost-effective. Larger sub-contracted agencies considered that there were probably ways of making the service more cost-effective (i.e. gearing it towards those individuals who wanted it). This was also linked to geographical location. One Cranstoun manager commented that

"I think it's very cost effective in the city, I don't think it's cost-effective at all in the rural areas. I think there are some areas where there are people sitting being paid to deliver a service that they're not".

SPS respondents did not consider the service to be particularly cost-effective:

"In terms of the outputs that are being achieved, I don't think it's resource compatible, for the work that has been put in and what has been achieved".

However, several respondents commented on the importance of making changes in people's lives that could not be measured in monetary terms:

"...if I was to look at it myself, if we can help ten people live a better life and stay alive then it's more than met its cost."

Cranstoun managers were, moreover, clear that changes that were introduced following the review and renewal of the contract in 2003 (for example through increased use of spot purchasing) had made the service more cost effective.

### **Summary**

The Cranstoun monitoring data indicated that health (drug and alcohol) (63%) and housing needs (58%) were most commonly identified by staff among those who attended at least one appointment, followed by benefits/financial needs (34%), education/training (26%) and employment (22%). Women were more likely than men to have identified housing needs while men were more likely to have needs identified in relation to employment. Compared with those aged 25 years or older, younger prisoners were more likely to be identified as having needs related to education and employment. A very similar pattern of needs was obtained from the 4-month ex-prisoner survey data. Seven months after release housing was the most commonly identified need (51% of respondents) followed by education, training or employment (42%).

The effectiveness of the Transitional Care initiative depended on the extent to which it facilitated ex-prisoners' access to community services. Examination of whether or not the required action to meet identified needs (usually making an appointment with a relevant agency) had been achieved within the 12-week post release period suggested that the appropriate action had been taken in between 51% and 69% of cases. However there was no evidence of different levels of unmet need between those who attended Transitional Care appointments and those who did not.

There were no differences in drug use, injecting behaviour, alcohol use and offending among survey respondents who attended Transitional Care and those who did not. There was a significant reduction in mean scores on the Cristo Inventory over successive appointments which would suggest an improvement in psychological and social well-being. However the number of cases was comparatively small and in the absence of an appropriate comparison group it is not possible to attribute changes to Transitional Care.

Ex-prisoners were generally positive about their experience of Transitional Care, valuing the advice they received, the friendly and courteous approach of the workers and, in particular, the assistance they received in negotiating bureaucratic processes to access the services they required. Some, however, were critical of Transitional Care for failing to deliver on its promises, reflecting, it appears, the difficulties reported by staff in accessing services in different parts of the country.





## **Chapter 6: Conclusions**

In this final chapter we summarise the key findings of the research and consider the implications of these findings for the operation of Transitional Care. Although, as indicated in Chapter One, the Transitional Care initiative was discontinued in July 2005, there are lessons to be learned from its experiences of delivering throughcare to prisoners with identified drug problems that can inform the new arrangements that have been put into place from August 2005.

### **Summary of findings**

This chapter of the report summarises the findings from the monitoring data and considers some of the broader issues that appear to have impacted upon the operation of the Transitional Care Initiative. Some of these issues were external to the initiative but nevertheless had implications for its operation while others were intrinsic to it. The fact that we focus here on some of the areas of difficulty should not be seen as a criticism of Transitional Care. The Transitional Care initiative was complex and ambitious and it was therefore inevitable that some aspects proved challenging.

### **Aims of Transitional Care**

All respondents were very clear about the aims and objectives of Transitional Care and defined the concept in terms of identifying prisoners' needs and linking individuals with existing services in the community. Respondents commented that Cranstoun had made significant efforts to ensure that everyone involved in providing Transitional Care was aware of its objectives. It was noted however that 'disparate organisations' with different agency remits in the community (for example, whether they were drug services or provided services in other areas such as employment) were likely to approach these objectives from slightly different perspectives.

Community-based agencies that had been sub-contracted to provide a Transitional Care service clearly shared the objectives of reducing drug-related deaths and linking people into services on release from prison. For practitioners, reducing drug-related harm appeared to be the main reason why agencies were interested in Transitional Care. Sub-contracted agency managers noted that there were various reasons for their involvement with the service though financial incentives predominated. All sub-contracted agency managers believed that their service had something to offer Transitional Care.

### **Organisation and management**

The management structure for Transitional Care was acknowledged to be complex. Relationships and communication between the different agencies was reported to be good but it was suggested that this might be further improved if Cranstoun had more direct management of the service. Some respondents believed that the staffing structure could undermine continuity of service from prison into the community. There was initially perceived to be a lack of co-ordination within and between prison and community services, though the transmission of information between prison caseworkers and Transitional Care workers improved over time.

The training provided for staff involved in the initiative was generally viewed positively and offered an opportunity to contribute to the ongoing development of Transitional Care. However, the arrangements for monitoring were regarded as time-consuming and incapable of reflecting the actual work undertaken with clients. There were also acknowledged to be inconsistencies in the manner in which the forms were completed.

Other agencies were said at times to have been somewhat hostile towards the initiative, which they feared might 'poach' their clients, or, conversely, increase their caseloads. A lack of early consultation with statutory agencies was thought to have resulted in a lack of co-operation, especially from social work departments.

### **Pre-release contact**

In terms of engagement with Transitional Care, it was expected that the worker who would have contact with the client in the community should attend at least one pre-release case conference with the client. One of the aims of this was to increase the likelihood of the client attending appointments post-release. In practice, these meetings did not always happen with around one third of ex-prisoners indicating that they did not see their Transitional Care worker while they were in prison. Interestingly, and contrary to expectations, those who had seen their worker in prison were no more likely to attend after release than those who had not. This suggests that the potential for these meetings to motivate and encourage take-up of Transitional Care by emphasising its potential benefits for prisoners had not been fully exploited.

Monthly reviews were conducted for those deemed to have high complex needs. Otherwise most clients were seen two or three times over the course of their sentence. Remand clients tended to be seen only once for assessment. They were usually given the telephone number of the Transitional Care scheme and sometimes an appointment but the onus was on them to contact Transitional Care. This issue was addressed through the changes that were implemented from April 2004 which included the introduction of 'crisis' Transitional Care for remand prisoners and those serving up to 31 days (see Chapter Three).

More generally, one-to-one work in the prison seemed to be affected by targets and time constraints. Initial targets for the numbers agreeing to be referred to Transitional Care and for attendance at case conferences and pre-release meetings were acknowledged to have been overly ambitious and were subsequently reviewed. Case conferences were seen as crucial though there was a definitional issue with respect to what constitutes a case conference (for example, whether the prisoner was or was not required to participate). Pre release meetings were also seen as good practice but arranging them placed additional demands upon caseworkers. Instead, community-based Transitional Care workers arranged pre-release meetings themselves through the agents visits system.

Having caseworkers integrated into prison addiction teams appeared to ease communication and process issues. Caseworkers could and did co-ordinate the referral process to Transitional Care but it was unclear who had overall responsibility for co-ordination of clients' service provision whilst in prison. This was perceived to result in gaps and duplication in the linking between prison and the community. Some Transitional Care agencies visited 'local' prisons only while others sent a team member to cover. Whilst it was considered preferable to send the actual worker who would be allocated the case rather than another team member, distance, budget and time constrained this.

### **Publicity/Information**

Nine of the 37 respondents who took part in the qualitative interviews could not recall having received any publicity about Cranstoun whilst in prison, although the majority remembered either seeing leaflets or posters or receiving a talk about the service as part of their induction process on admission. This publicity was seen as helpful at the time, but on reflection several respondents suggested that it could be improved. This might include the provision of further information prior to and upon release about the services that Transitional Care could and could not provide.

## **Assessments**

The CAART assessment tool was viewed by staff who used it as a general tool that was not able to address the needs of specific groups of clients such as women and young offenders and that generated too much administration. Doubts were also expressed over whether it was being used systematically to identify and address gaps in service provision: identified needs were said often to be geared to what was available in prison rather than reflecting needs for services (such as counselling) that were not widely available. Caseworker assessment targets were said to encourage an emphasis on quantity rather than quality and there was perceived to be some duplication of the assessment and referral process, partly because of a lack of co-ordination of the work undertaken by external agencies in prison.

The majority of ex-prisoners thought that their assessment was realistic and helpful, not only in identifying their needs, but also in enabling them to talk through problems with somebody who seemed genuinely keen to help. However it was noted by ex-prisoners that it would be useful for assessments to be tailored to individual needs rather than focusing upon pre-defined areas. More alarmingly, it was a common view amongst the qualitative interview respondents that raised expectations with respect to access to services in the community that could not subsequently be fulfilled.

## **Engagement with the service post-release**

Prisoners who were of No Fixed Abode and those deemed vulnerable were considered a priority and generally seen on the day of release (as were other prisoners where it was practical to do so). The mode of response by Transitional Care workers appeared to impact on first appointment attendance (speed, on client terms/territory, ability to provide client needs, home visit, client can go in car). A more proactive, client-centred approach was perceived to result in a better take-up of Transitional Care. Most Transitional Care workers met and occasionally took clients to their first appointment. Where staff endeavoured to meet with clients in 'neutral venues' difficulties were encountered in locating suitable venues. More generally, Transitional Care was perceived to work better if staff were able to advocate and mediate on their clients' behalf, accompany them to appointments with other agencies and generally assist them to negotiate bureaucracy.

Attendance rates were initially low (28%) at Transitional Care meetings and decreased sharply across the potential appointments, though voluntary take-up rates of services by this client group are widely acknowledged to be low. Where reasons for non-attendance were known by staff, a return to custody and/or being arrested accounted for the majority of cases.

Many offenders who were offered Transitional Care had outstanding charges. This, it was suggested by staff, could influence their motivation to engage with services or could result in work undertaken by Transitional Care staff being 'undone' as a result of the client receiving a further remand or prison sentence. There were reports of clients being liberated, engaging with services and making progress and then finding themselves up at court a year later for an 'old' offence. Many staff therefore suggested that if a mechanism could be established for outstanding offences to be 'rolled up' and dealt with all at once, this could improve the motivation of some clients to engage with services.

The amount and quality of pre release work was perceived to impact on attendance for the first post-release appointment. While there was no significant difference between those who had met their worker pre-release and those who had not in terms of whether they attended all their appointments, those who had not met their worker pre-release were more likely to say their reason for not attending was that they had not received an appointment (21 of the 33 individuals who had not met their worker compared with 34 of the 94 who had). Women were as likely as men to attend at least one Transitional Care

appointment but the take-up of Transitional Care was lower among young offenders. Many staff felt that the 'model' of intervention was not the most appropriate for young people with substance misuse problems who were less likely to recognise that they had a problem. However, the form that alternative models might take was not specified.

Attendance rates were also lower among those who were of no fixed abode. This suggests that consideration needs to be given to ways of engaging with these clients as soon as possible after their release from prison.

Formal and informal contact between Transitional Care workers and potential clients was considered important in increasing take-up of the service. It was thought that ex-prisoners would be more likely to attend an appointment with someone they had already met while in prison and through this contact had a clearer notion of what Transitional Care could offer. Some penal establishments were able to allow Case workers and Transitional Care staff greater access to prisoners than others. On release there would appear to be an association between attendance figures and the geographical accessibility of the Transitional Care service.

According to ex-prisoners, the single most common reason for non-attendance was simply not receiving an appointment (regardless of meeting the worker pre-release). This suggests that the process for engaging the client in prison and immediately following release needed to be improved. For those who declined to attend Transitional Care on release, the main reason given was that they felt at the time of release that they no longer needed any help.

In summary, it seems that it was not one factor that determined attendance rates for Transitional Care but, rather, a combination of factors. These included accessibility of Transitional Care within the prison and after release, ex-prisoner lifestyle and attitudes (especially age-related) and outstanding charges and further offending. In addition, the availability of relevant community-based resources into which ex-prisoners might be linked is also likely to have influenced whether or not prisoners were willing to take up the offer of Transitional Care.

### **Prisoners' needs on release**

Overwhelmingly the two most frequently identified needs of clients were support in relation to substance use (appointment with a drug agency) followed by accommodation issues (an appointment with a housing officer). The most frequently mentioned issue at the four-month stage was help in relation to health, drug or alcohol misuse (and, more specifically, "an appointment with a drugs agency or information on a drop in centre" and "an appointment with a GP"). Housing was mentioned by half the respondents at the four-month stage and was the most common need at the seven-month stage. A relatively high proportion of respondents (38% at the four-month stage and 42% at seven months) said that they had needed help or advice in relation to education, training or employment. In relation to needs, there were few differences between those who attended Transitional Care appointments and those who did not.

### **Linking clients into services**

Overall, it appears that Transitional Care is reasonably effective in linking clients with services. However, there was no evidence that it was linking clients with services they would not *otherwise* have made contact with by some other means: there was no significant difference in the level of 'unmet needs' (needs not met by the Transitional Care worker or anyone else) between those who attended and those who did not. Data from both the survey and qualitative interviews, for example, suggest that many of those not making use of Transitional Care on release were, nevertheless, making contact with other agencies and valuing the services they received.

Three appointments were considered to be insufficient to effectively link clients into services. Instead, it was suggested that clients needed more intensive support in first week following release. It was proposed that appointments should be based on need rather than being fixed to three. Most areas were considered to have an adequate range of services, but these did not have the capacity to deal with client demand. Waiting lists for substitute prescribing varied from 6/7 weeks to over one year and clients were reported often to be back in prison before they had been effectively linked into services. Housing services were thought to have improved as a result of recent legislative changes, however there remained a lack of secure, supported temporary accommodation and a lack of housing support workers

### **Health outcomes**

There were no differences in the mean number of physical symptoms, or symptoms of depression, reported by those who had attended Transitional Care appointments and those who had not. However, those who had attended appointments reported more anxiety symptoms at four months (though not at seven) than those who had not, possibly because those who were more anxious on release from prison were more likely to take up the service. There was a reduction in Christo scores over successive appointments among those who attended Transitional Care, suggesting some improvement in psychological and social well-being. However, the number of cases was comparatively small and in the absence of an appropriate comparison group it is not possible to attribute changes to Transitional Care.

### **Drug use**

When qualitative interview respondents were asked whether their drug/alcohol use had changed between the period before going into custody and since being released from custody, a small majority felt that their use of substances had reduced. However, from the survey responses there were no statistically significant differences – at four months alone, seven months alone, or differences over time - between those who had attended Transitional Care appointments and those who had not in terms of whether they were using drugs, the mean number of days they had used each drug in the previous month or in the amount of money they were spending on drugs. Similarly, at all levels of comparison, those attending Transitional Care appointments were no more likely to be on a methadone script (or a buprenorphine or lofexidine script). There was also no difference in injecting behaviour (at any level of comparison): there were no differences between those who had attended and those who had not in terms of whether or not they had injected in the past month or in the mean number of days they had injected.

### **Alcohol use**

There was no significant difference, at any level of comparison, between those who had attended Transitional Care appointments and those who had not in terms of the mean number of days they had been drinking alcohol in the past 30 days. There was also no significant difference between the groups in the mean number of units of alcohol drunk (by those drinking at least once a week).

### **Offending**

There were no differences between those who had attended and those who had not (at any level of comparison) in relation to whether or not they said they had committed any crimes in the previous month. In total, 41% of respondents at the four-month stage said they had committed a crime/crimes since release and 49% of respondents at the seven-month stage said they had offended in the past month.

## **Accommodation and economic activity**

There were no significant differences, at any level of comparison, between those who had attended Transitional Care appointments and those who had not in relation to the type of accommodation they occupied (e.g. whether house or flat, bed and breakfast, hostel, staying a few days here and there with friends or relatives) or how long they expected to be staying in their current accommodation. There were also no differences in relation to ratings of the safety of their belongings.

At the four-month stage, those who had attended Transitional Care appointments were more likely to rate their personal safety in their accommodation as being 'very' or 'fairly' unsafe compared to those who had not attended (35% of attendees felt unsafe compared with 11% of non-attendees). This may be because some of those who attended Transitional Care did so because they regarded their current accommodation as inadequate.

There were no differences between those who attended Transitional Care and those who did not, at any level of comparison, in relation to economic activity (whether in employment, unfit for work, in education etc.).

## **Implications for future practice**

Although there are many caveats attached to the data presented in this report, the following would appear from the data available to represent aspects of practice that were likely to encourage ex-prisoners to engage with Transitional Care:

- Proactive engagement with clients as soon as possible following their release
- Availability of a range of relevant agencies and service providers with sufficient capacity to meet client demand.
- Prioritisation of needs according to their importance for ex-prisoners in the immediate period following release.
- Scope for more intensive engagement with clients as determined by needs.
- Accessibility of staff inside and outside the prison and their willingness to advocate on behalf of and support clients in a variety of ways.
- Mechanisms for effectively linking clients with services as a source of longer-term support.

Similar indicators of good practice and similar difficulties with respect to the provision of services prior to and following release were also identified in Burrow et al.'s (2001) study of drugs throughcare in England and Wales.

## **Conclusion**

The effectiveness of Transitional Care was affected by a number of internal and external factors such as outstanding charges, the complex management and staffing structure and the amount of administration that was required. It was also constrained by the availability and accessibility of services in the community. It appears that Transitional Care was reasonably effective at linking clients with services, although the extent to which it linked them with services they would not have accessed by some other means was unclear and there were no apparent differences in short-term outcomes among those who attended Transitional Care and those who did not. Those who attended appointments were positive about the workers and the service they received. However, the take-up rate of initial appointments was comparatively low, especially among young offenders and those of no fixed abode, suggesting that the process for engaging ex-prisoners needed to be improved and the appropriateness of the model for certain groups of ex-prisoners reviewed.

It was inevitable that an initiative as complex and ambitious as Transitional Care would encounter some challenges. Throughout the period of the evaluation the initiative evolved to take cognisance of emerging issues identified by the research and by the various stakeholders involved in its operation. As understanding of the challenges of providing throughcare services to short-term prisoners with drug problems developed, the need for a new approach was identified. This resulted in the replacement of the Transitional Care initiative with a new national Throughcare Addiction Service. It is hoped that this report, though identifying some of the difficulties faced by the Transitional Care initiative and through identifying areas that were perceived to enhance effective practice, will enable future throughcare services for prisoners involved in substance misuse to be strengthened and improved.





## Appendix 1: Qualitative Case Studies

- **Mike, aged 20**

Mike lived with his mother in Fife before receiving a 5 month prison sentence, of which he served two and a half months in Polmont Young Offenders Institution. He was released in March, 2004, four months prior to interview, and returned to live with his mother.

When in prison, Mike saw a Cranstoun worker four or five times during his two and a half months of imprisonment. He found the assessment process helpful and realistic, having identified his need to address his heroin dependency on release. He also seemed to appreciate the personal contact with someone within the prison:

"I thought it was alright, aye. It helped us a lot... Just like mentally and that, eh. Making me get my head together and that, eh. Making me think about things and that... I thought they were helpful, eh... well, when I was in the jail".

Whilst in prison, the Cranstoun worker referred him to Apex, the service provider for Transitional Care in Fife. He subsequently saw Apex on release regarding employment training, but received no help from them regarding his more immediate drug problem:

"They said they would contact me and get me like to go and see them, just help about drugs and that... They said they'd contact me, eh. [Interviewer: What would you have like them to have done when you got out?] Help with my drug problem, eh... just help with my drugs when I got out the jail and that."

When asked how he would describe Transitional Care to a friend, for example, he said

"they just help you, if you've got problems that you need, like housing, drugs, just like the main issues".

The best thing about them, for Mike, was

"[T]hat they're there, you know, if you need them".

When it was pointed out that they were not there when he needed them, he replied

"Aye, but I could have phoned them up if I wanted to, eh... [but] I didn't think it was necessary".

[This is a controversial point with some of this sample – the extent to which Transitional Care agencies should be proactive in pursuing potential clients on release from prison. Whilst some thought this was necessary given some ex-prisoners' vulnerability and lack of motivation on release, others suggested that there was a limit to what an agency could do without the full commitment of the individual concerned]. Mike added, however, that the worst thing about Transitional Care was

"[S]aying that they'd contact me and they never".

The only time Mike was contacted regarding *Transitional Care* on release was a week prior to interview, when he was approached by a member of the research team (although he thought this person was a member of Cranstoun staff) and asked questions regarding the evaluation.

Mike still has a drug problem, with no support from other agencies, but he said he was reducing his heroin intake through his own determination and with support from his

mother and other family members. He has not committed any further offences since leaving prison and is currently looking for a job although suggests that his criminal record is an obstacle in this respect.

- **Scott, aged 34**

Scott was released from Low Moss Prison in January 2004, 6 months prior to interview, following a three month sentence of which he served 6 weeks. He was living with his parents both before and after his prison sentence. During his assessment with Cranstoun – which was undertaken during one visit only – it was suggested that he did not need their help because he was already seeing an agency regarding his drug problem.

Scott has not had any major problems since returning to the community apart from his drug problem which has been alleviated by his reducing methadone prescription. He has not reoffended since release from prison, but he suggests this is because of being put on a methadone prescription by the agency he was seeing independently of Transitional Care :

“... it’s cos I was offending to feed my drug habit and now I’m on the methadone programme, I don’t need to offend.”

Scott is currently unemployed but looking for work. His parents are very supportive of him. However, he thinks services such as Transitional Care should be more proactive with ex-prisoners, rather than leaving the initiative up to them:

“[They need] to get help from the services that are available when they get out and just no leave it up to themselves, you know... make sure that it’s set up for them coming out... to be there... if they were in my area, I would have maybe mentioned - either when I was in I would have got an appointment for the future when I got out, you know. ”

- **Colin, aged 26**

Colin was released from a local prison in March, five months prior to interview. He had served 7 months of a 14 month sentence. He was living with his girlfriend prior to imprisonment and returned to her house on release. Although he was familiar with Transitional Care, and saw a member of staff regularly whilst in prison

“I seen them about once a week, sometimes twice a week”,

he was unaware of their policy of restricting post-release contact to three months. During these visits in prison, Colin said that Transitional Care workers

“Just asked what I was going to do when I got out and if I wanted, they could help me get, set me up and all that for jobs and things like that.”

The assessment identified his need for support in getting employment, buying clothes and addressing his drug and alcohol problems. He added that on release he expected a similar level of contact:

“Basically they said that they’d come and chat to me every now and again to see how I was getting on. But nobody’s came. Nobody’s came except that woman and she was [doing the research].”

However, he was given help initially by Transitional Care on release, in that they took him to a drug/employment project on the morning he got out of prison. They also referred him to a drugs worker whilst in the prison, but he was not sure where this worker came from:

"I'm trying to think. They work basically for Cranstoun but they weren't Cranstoun, but they worked alongside Cranstoun... I'm not too sure [what they were called]."

He suggested that whilst he could have met with Apex in the prison for employment purposes and with a drugs worker independently of Transitional Care, going through Cranstoun was quicker, since they were based in the prison.

Apart from meeting him on the day of his release, Colin has not seen a Transitional Care worker since:

"Just the day I got out, they done... just the day I got out, that was it. But since then, nothing really. [Interviewer: Did you want to see them again?] Aye, probably, aye... They said they would just meet up for a coffee and things like that... they were supposed to contact me."

Colin said that the employment and drugs agency that he was referred to was not able to help him much, but he had referred himself to another drug rehabilitation project before being imprisoned when he was put on a methadone programme. He was also in touch with Apex on release, who

"pushed things forward a wee bit... just to try and keep it on the straight and narrow and that",

but unable to help him find a job as such. Colin seemed quite confident, however, that his problems had reduced since release in March. His drug use had stabilised because of the methadone and he had not committed any offences since his imprisonment, which he described as 'very unusual!'. Most of his offending had, however, been to feed his drug habit prior to being given a methadone prescription.

When asked to describe Transitional Care, Colin said they were

"quite a good service"

which helps people with housing and drug problems and refers you to a drugs worker if you need one:

"If you need help about life and all that, they'll sit and talk to you about it and that, ken. They're quite good."

However, this was within the prison rather than on release. He had only one suggestion for changing the way Transitional Care operates:

"When people get out, try and keep, try and keep in touch with them instead of just waiting till they reoffend and going back in and then seeing them again... help on release basically."



## Appendix 2: Survey Sample Characteristics

Bases: 175 (4 month data), 222 (7 month data)

<b>Table 1: Demographic characteristics of the Quantitative Sample</b>				
	<b>Number in 4 Month Sample</b>	<b>% 4 Month Sample</b>	<b>Number in 7 Month Sample</b>	<b>% 7 Month Sample</b>
<b>Male</b>	161	92%	199	90%
<b>Female</b>	14	8%	23	10%
<b>16-21 years</b>	40	23%	51	23%
<b>22-25 years</b>	37	21%	41	18%
<b>26-30 years</b>	33	19%	50	22%
<b>31-35 years</b>	29	17%	31	14%
<b>36-40 years</b>	12	7%	17	8%
<b>41-50 years</b>	9	5%	15	7%
<b>51-60 years</b>	3	2%	5	2%
<b>Age not known</b>	12	7%	12	5%
<b>White</b>	105	60%	141	64%
<b>Non-white</b>	10	6%	15	7%
<b>Ethnicity not known<sup>31</sup></b>	60	34%	66	30%

<sup>31</sup> Information on ethnicity is based on the Cranstoun monitoring data, so is therefore unavailable for the 83 cases which could not be matched with the Cranstoun data. The remaining 'unknowns' were where the data was missing from the monitoring data.

Bases: 175 (4 month data), 222 (7 month data)

**Table 2. Local Authority to Which Respondents Were Expected To Return**

	<b>Number in 4 Month Sample</b>	<b>% 4 Month Sample</b>	<b>Number in 7 Month Sample</b>	<b>% 7 Month Sample</b>
<b>Aberdeen City</b>	13	7%	10	4%
<b>Aberdeenshire</b>	1	1%	0	0%
<b>Angus</b>	1	1%	1	1%
<b>Argyll &amp; Bute</b>	2	1%	1	1%
<b>Clackmannanshire</b>	2	1%	3	1%
<b>Dumfries &amp; Galloway</b>	6	3%	10	4%
<b>Dundee City</b>	10	6%	16	7%
<b>East Ayrshire</b>	3	2%	2	1%
<b>East Dumbartonshire</b>	1	1%	1	1%
<b>East Renfrewshire</b>	0	0%	1	1%
<b>City of Edinburgh</b>	7	4%	13	6%
<b>Falkirk</b>	4	2%	5	2%
<b>Fife</b>	6	3%	13	6%
<b>Glasgow City</b>	14	8%	15	7%
<b>Highland</b>	18	10%	17	8%
<b>Inverclyde</b>	4	2%	3	1%
<b>Midlothian</b>	4	2%	2	1%
<b>Moray</b>	1	1%	2	1%
<b>North Ayrshire</b>	4	2%	7	3%
<b>North Lanarkshire</b>	6	3%	12	5%
<b>Renfrewshire</b>	7	4%	7	3%
<b>South Ayrshire</b>	3	2%	4	2%
<b>South Lanarkshire</b>	4	2%	10	5%
<b>Stirling</b>	1	1%	1	1%
<b>West Dumbartonshire</b>	0	0%	2	1%
<b>West Lothian</b>	5	3%	4	2%
<b>Eilean Siar</b>	1	1%	2	1%
<b>LA not known<sup>32</sup></b>	47	27%	58	26%

<sup>32</sup> Information on local authority is based on the Cranstoun monitoring data, so is therefore unavailable for the 83 cases which could not be matched with the Cranstoun data. The remaining 'unknowns' were where the data was missing from the monitoring data.

Bases: 175 (4 month data), 222 (7 month data)

<b>Table 3. Establishment From Which Respondents Were Liberated</b>				
	<b>Number in 4 Month Sample</b>	<b>% 4 Month Sample</b>	<b>Number in 7 Month Sample</b>	<b>% 7 Month Sample</b>
<b>Aberdeen</b>	8	5%	8	4%
<b>Barlinnie</b>	13	7%	17	8%
<b>Cornton Vale</b>	4	2%	10	5%
<b>Dumfries</b>	9	5%	10	5%
<b>Edinburgh</b>	15	9%	16	7%
<b>Glenochil</b>	1	1%	4	2%
<b>Greenock</b>	11	6%	16	7%
<b>Inverness</b>	21	12%	20	9%
<b>Low Moss</b>	14	8%	19	9%
<b>Perth</b>	7	4%	21	10%
<b>Polmont</b>	24	14%	23	10%
<b>Noranside</b>	1	1%	0	0%
<b>Kilmarnock</b>	1	1%	1	1%
<b>Establishment not known<sup>33</sup></b>	46	27%	57	26%

<sup>33</sup> Information on establishment is based on the Cranstoun monitoring data, so is therefore unavailable for the 83 cases which could not be matched with the Cranstoun data. The remaining 'unknowns' were where the data was missing from the monitoring data.





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