HMPPS drug strategy development consultation – DAJ APPG response

Executive Summary

This document has been produced with the support of front line staff, managers and service users at three national drug and alcohol charities - WDP, We Are With You and Humankind. We welcome the opportunity to input into this strategy and have made a series of suggestions for consideration. If it is useful, we can arrange service visits to prison or community services across a range of venues.

We have a series of core recommendations:

- **Ensure that consistent community diversion schemes and treatment requirements are made widely available as a default sentencing option in pre-sentence reporting** for those with identified alcohol or drug issues nationally. Custody should become a last, rather than a first resort. Invest in drug and alcohol services and the wider system to deliver these locally.
- **There needs to be a significant investment in training and support for staff** in the criminal justice system around substance misuse and mental health issues – this needs to run in parallel to a reduction in the total number of prisoners in the system so that staff have the time available to dedicate to this work.
- **We would welcome a standard core offer of alcohol and drug treatment which is available across all prison establishments** (including male and female establishments and YOI and adult) nationally, with a series of minimum standards relating to wait times, detoxification, stabilisation, treatment and release planning. Minimum funding on a per head basis could be considered for each establishment to ensure parity, as people in prison often experience significant variation in service standards when transfers take place. This could be audited and reported on via relevant inspection regimes and improvements codified and actioned.
- **Transition between prison and the community must be prioritised**

urgently to ensure a significant increase in engagement in community treatment on release and to reduce the risk of drug related death, reduce recidivism and improve health outcomes

- **Naloxone should be funded nationally and made consistently and routinely available** throughout the criminal justice system with an immediate focus on those due for release from custody
- **Drug testing in prisons should be reviewed** in line with our detailed comments and where possible reduced to the minimum necessary.
- **Every prison should have a standard pre-release offer** for people in prison with substance misuse issues which should follow a 'departure lounge' type model
- **Investment in technology is essential** to ensure a minimum standard across the prison estate would ensure data sharing can happen effectively, and would increase communication with people in prison to allow wider access to care and support

1. **To support the "Whole System Approach", we aim to offer a holistic, person centred support package that is trauma informed. What can prisons and probation services do to improve the safety of our service users?**

We welcome a whole system approach and a focus on trauma informed care being central to this new strategy. We need to incorporate planned pathways through multiple services and the development of trauma informed practice across a broad range of services. This will inevitably involve providing training for criminal justice system staff to give them a better understanding of mental health and substance use and an awareness that a large proportion of people they work with will experience mental ill-health issues.

Treatment in prison

- Currently, treatment programmes in prisons look very different across the country and we would advocate a standardised accredited treatment programme across the prison system to ensure consistency of care.
- Safe management of drug and alcohol withdrawal for those going into prison is paramount. We have heard of examples of service users withdrawing severely from alcohol with no support – this lack of support must end.

- Staff need training to understand substances, dependency and possible fatal effects in order to minimise drug related deaths.
- People in prison have reported that often there is the expectation that they must detox upon entry and as a result 'in 24 hours you are broken.' The approach taken to addiction treatment within the community should be taken within prison; for example with options of supervised consumption/reduction regimens or supervised detox.
- Psychological assessments should be completed to ensure mental health needs and/or risks are identified, considered and where possible addressed.
- The Prison population has high-level of blood-borne viruses (BBV). The system needs to ensure there is adequate BBV testing and treatment in prison and on release
- Identification and acknowledgement of people's vulnerabilities and anxieties is essential for any trauma informed approach to care. New prison entrants are often 'scared', particularly if they have not been in prison previously. A national buddy/peer mentor system for those with substance issues would be helpful so that new people in prison have a support mechanism in the prison.

Release from prison

- End the release of people in prison on Fridays (including on the days before bank holidays). Naloxone should also be provided on release (including to those on release on temporary licence and families).
- Accommodation on release needs to be improved by developing better collaborative working with liaison and diversion teams and homeless teams to attempt to deter avoidable short-term breaches.
- Immediate support on release day – we need a model which consistently ensures that there is someone to meet people in prison at the gate and in preparation for release. For example in HMP Exeter there is a 'departure lounge' model in use where people can charge their phone, get clothing, a meal and information on community services.

Facilities and estate policies

- The increased use of technology during the pandemic has shown that there are numerous ways of reaching and supporting people. For prisons that have in-cell phones it has been a great way of continuing support whilst we haven't been able to access prisons and could continue to be

used to provide support and help with pre-release planning, for example: "When I can't see people having my dart worker call helps with my mental health" - Service user from HMP Durham
- There needs to be greater allocation of physical space on the prison estate to carry out therapeutic interventions that all people in prison can access. This must include space for psychosocial interventions and not just clinical interventions.
- Consistency in prison estate policies on drug use and management of incidents - ensuring responses are standardised, trauma informed and health focussed, and not dependent on the individual's prison governor.

Improved communication

- There needs to be improved coordination on release from prison. Where release planning allows, this should involve notifying community services 6 weeks prior, 2 days before and on the day of release allowing services to be better prepared. All community services also need to be provided with all relevant prisoner details regarding plans for post-release, and including information such any potential risks, BBV status, and other relevant information.
- Where there are short-stays/short-notice releases, a program for communication with all key partner agencies in the community should be included in relevant communication at an earlier stage prior to release.

Community/Probation

We would strongly advocate for a reduction in the use of short sentencing and an improvement in community sentencing and out-of-court disposal options. Those on short term sentences are often unable to access treatment. On occasions offenders have had 7 day sentences meaning they have not been seen during this period.

We would also like to see:

- Better pre-sentence/fast delivery report processes for recommending rehabilitation requirements
- Comprehensive health needs assessments as part of community sentencing with screening for drug and alcohol, and for example in the case of older adults, this should include screenings for alcohol-related cognitive impairment by a specialist substance misuse provider.

- Take a multi-agency approach to breach processes - ensuring that alternative solutions to breach are considered or recommendations for adjustments to requirement are taken back to Court - eg personalisation of treatment and funds to do this (for example, to fund residential rehabilitation)
- Improved partnership working between community and probation should include more co-location and place-based provision, which will improve information sharing, partnership development and system working.
- Probation should revisit the criteria for voluntary referrals rather than enforce in licence conditions resulting in inappropriate referrals to treatment services. Better options should be available to people on Community Orders/Licence to engage with substance misuse in a non-time limited/mandated way.

2. **We want drug testing to lead to quality conversations around why people are taking drugs. What do you feel are the benefits of drug testing service users versus the drawbacks? Have you any other suggestions on how else we can use drug testing to restrict supply, reduce demand and build recovery?**

Mandatory drug testing has some advantages in terms of building a picture of what substances are being used within the prison. However, it is a blunt instrument that doesn't necessarily provide any further opportunity to engage with services, and can result in loss of privileges, exacerbation of boredom, less time out of cell, missed appointment / group attendance while in adjudication. As a minimum, we would like to see attendance of the substance misuse treatment provider at adjudication panels to provide the service user an opportunity to engage in a brief intervention session or get an automatic referral into treatment.

There are clear drawbacks of to the mandatory testing approach:

- It is time consuming and resource intensive
- It penalises the user, who is already vulnerable, rather than the dealer
- Prison residents are aware that NPS does not always show up in drug tests which can mean the process does not reduce the amount of using as desired

Voluntary drug testing is often not taken up by people who use our services unless there is a clear benefit to signing up. Voluntary drug testing requires resourcing if it's to be implemented successfully on a large scale.

Our experience is that while it can be an incentive to some, mass voluntary drug testing doesn't work. It's expensive and often those who use it the most have been drug-free for some time and continue to get negative results. Drawbacks include the risk of incentivising gaming of the system, such as creating a marketplace for 'clean' urine.

Service user feedback from a service in Stoke:

- "It's just another way to control us"
- "they just take things off us and then when the TV is gone I just use more because there's nothing else to do"
- "It makes things worse"
- "I don't need a test, I know what I've taken"

Compliance testing to ensure that opiate substitute therapy prescribing continues to be safe is limited in its efficacy as it is a point in time snapshot that provides a short-term answer for a small number of substances and no indication of level of use. Clinical observations and conversations with service users about their presentation and reported withdrawal symptoms are arguably consistently more effective ways of measuring the safety and effectiveness of a current prescription.

Statistics for alcohol and drug treatment in secure settings between 2018 & 2019 show just 11% of the treatment population identify new psychoactive substances as a problem. However, research by The Forward Trust estimates that 60-90% of the prison population have used NPS at some point. Treatment pathways for people who use NPS are not strong enough and there is a need to improve the number of NPS users accessing treatment in secure settings.

Other suggestions

Other suggestions we have include a new approach to drug checking. Rather than testing people, prisons could test the substances seized/found and allow people to disclose confidentiality effects of substances taken (under a scheme). This would also allow prisons to develop better intelligence networks to understand trends in their establishment.

More broadly, we recommend that therapeutic staff who work regularly with people at risk of, or, experiencing multiple disadvantage adopt the techniques of routine enquiry about childhood adversity to better understand both their vulnerabilities and behaviours. There is a challenge in having "quality conversations" whilst in custody. One of the reasons for mistrust is that people in the criminal justice system expect it to be both arbitrary and unfair.

Many women have committed crimes because they are in abusive or adverse situations such as exploitation, or they have a lack of legitimate income to buy basics like food. This was highlighted in the Corston Report (2007), which emphasised that sending women to prison for non-violent crimes, when they pose no threat to society, is ineffective both for the individual's health, wellbeing and recovery, as well as on the cost to society. We need to ensure that services in women's establishments are person-centred and gender-informed. They also need to support women who have committed crimes because of the abusive or adverse situations they have experienced. Ideally though, diversion from custody would be preferential in these cases.

3. **We want to enable our staff to explore the reasons for drug use and provide that safe and non-judgemental for vulnerable people to open up and heal from those traumas. What training modules related to drugs, health and safety should be prioritised for our staff?**

It is important that prison and probation officers, as well as the substance misuse team, have an understanding of the needs of those affected by trauma, mental health and addiction. We would like to see all staff involved within the prison and probation system access the following:

- Drug and Alcohol Awareness as a basic standard for Prison Officer and Probation Officer training (POELT standard training). Training to include potential reasons for drug use to aid empathy, what treatment is/user experience etc.
- Mental health first aid or awareness
- Naloxone and overdose awareness training
- Trauma Informed Care and Adverse Childhood Experiences
- Presentations from people with lived experience of prison and substance misuse

Additionally, the following could also be offered to staff across the system:

- Safer Injecting and Safer Use
- Motivational Interviewing
- CBT skills
- Harm Reduction and Relapse Prevention
- Counselling skills
- An understanding of PTSD
- Non-judgemental behaviour

There also needs to be a broader focus on culture change around drugs and alcohol in the criminal justice system to ensure there is a person-centred approach. This could include:

- Cultural competence - including stigma faced by people who use drugs/alcohol, women, young people, older adults and alcohol, BAME and LGBTQI+ communities
- Understanding health and social care pathways - Training around community substance misuse services, how they work, their processes, what they do and don't offer. Visits to local services as part of inductions could also help foster improved partnership working, referral pathways and processes to aid transition.

Case example

As part of Prison inreach work, a service in Wigan provides public health sessions to people in custody and prison staff, explaining what support is available in the community, dispelling myths that treatment is only for people in active use or requiring medication. At HMP/YOI Hindley a one-off information session was offered by the Wigan community service to 15 people in prison. It resulted in 5 pre-release referrals including 2 for a community rehabilitation programme, 1 for community recovery champion training and 2 NPS users who had not disclosed use during their time in custody. Prior to this the service hadn't received any referrals. Attendee feedback was positive, highlighting a gap in awareness around community options available on release from a substance misuse service, particularly for those abstinent or for substances other than opiates.

4. **We are working to build a better-connected partnership between the courts, prisons, probation, health services, voluntary sector and social**

care etc. How else can HMPPS influence health priorities including substance misuse and mental health?

There are a number of options which we would advocate are given thorough consideration:

- Fund and implement problem solving courts to bring individual solutions for sentencing and offender management. Problem solving courts could also be given powers or personalisation funds to ensure individuals can get the rehabilitation that is needed.
- Co-design of substance misuse and mental health treatment requirements and processes at a local-level and with national evidence to draw from.
- Provide funding as part of pooled treatment budgets specifically for HMPPS pathways for people who use substances/affected by mental health.
- Co-location and joint-solution approaches and multidisciplinary team (MDT) approach.
- There needs to be better connection between system-wide commissioning and solutions. Care navigation roles need to work across a whole system, rather than fulfilling one system element. For example, there could be an expansion of RECONNECT, including more system navigation/partnerships with distinct specialisms (roles within substance misuse that sit between custody and community).
- Courts should consider the difficulty caused when releasing individuals on Fridays particularly those with medication to collect for the weekend. Bridging scripts can help but pharmacies are often closed by the time individuals are able to collect it.
- Advocating for additional funding for community services, in-prison substance misuse services, and ATR/DRR programmes used by probation
- Supporting the WHO Elimination of Hep C project by providing in-custody services, additional funding and resources to test and treat BBVs including Hep C
- Collect and release data around the number of people who have experienced Adverse Childhood Experiences (ACEs) within the prison system; showing the impact of trauma and need for further funding for mental health and addiction
- Out of court disposals and community sentences should be prioritised and the threshold for custodial sentences should be increased, with

provision of clear and enhanced support to act as a catalyst for change (behaviour but also social support – housing, employment, education etc.)., There needs to be clear cell-to-support pathways to support people with critical behaviour change and engagement in core funded treatment and recovery services.

- Specialist substance misuse workers in courts could provide suitability assessments, help with court delays, pre-sentencing and court reports. They could also provide support to those leaving custody from remand prisons.

5. **We know that approx. 34% of our service users engage in treatment after custody within 3 weeks. What more can prison and probation staff do to promote and support recovery?**

There is a huge gap in community to prison transitioning. For those in prison, taking a different approach for those with long and short sentences may be useful. We would strongly advocate:

- Clear accountabilities for delivery elements across service user pathways (linear and non-linear). For example, the increased mortality rate when people leave hospital or prison is clearly evidenced; therefore, accountabilities for providing naloxone and overdose prevention information should be clear and consistently applied.
- Commissioning of community and prison treatment services is key. Timing of contracts is always staggered and as a result people's care becomes affected. Bringing them in-line would improve outcomes for the people who use these services.
- Support for people leaving prison needs to start with effective collaboration between IOM/community substance misuse link worker staff and prison substance misuse staff. This should happen well in advance of someone's release rather than starting at the prison gate. We know that someone is more likely to engage in community services if they've been able to build up a trusted relationship with a worker before leaving custody.
- 3 way meetings prior to release as a minimum standard between the service user, prison and community worker would ensure higher engagement in community treatment. As community providers we have peer schemes and in some cases navigation roles that can support this.

Some of the issues we see regularly include:

- People are regularly released homeless, with no bank account or form of ID to get one.
- Delays and difficulties in passing information (such as alert forms and medication charts) between prison and community services show there should be a standardised pathway developed to ensure continuity of safe and timely prescriptions. Bridging prescriptions should be an assessed standard for any transfers to ensure continuity of care
- People who use our services also cite requiring 'help to re-join the community'. The types of help needed include:
    - 'exit programmes that start prior to release',
    - benefit application support,
    - 'help getting a job',
- help to acquire a 'safe place to go to (and affordable food)' such as 'rehousing' support, 'halfway houses' or 'drug-free hostels.' Those who use our services and our staff have both explained that residents are often either released without housing or are placed in Approved Premises that include both active users and abstinent individuals. This increases the risk of relapse significantly

Restorative justice can help with the transition out of prison and into the community, by creating opportunities for meetings and conversations between prison leavers and affected members of the community. With careful, considerate facilitation, restorative justice can reduce the stress and anxiety surrounding a prison release for everyone concerned. This may also help to reduce the risk of a prison leaver returning to substance use and reoffending as a way of managing feelings of guilt and remorse.

Case example of a prison release scheme

We provide Prison Release Clinics in Leeds. The clinics operate a one-stop shop approach to support. The prison release clinic includes dedicated visits from a Prison Link Worker, which start three months prior to release to ensure there's enough time to put support in place, for example a pick-up from the prison gate on release, prescribing clinics, access to housing etc. Links with relevant service providers, for example local authority housing, is fundamental. These clinics were launched in August 2019 and since then, attendance at first treatment appointments on release from prison has increased by 48%.

Case example in the community

A Women's Diversionary Scheme (WDS) provides an intervention at the point of arrest to adult females who reside within the North Yorkshire force area. The service links some of the most vulnerable women in the community to support that could, for example, help them escape violent and coercive relationships and establish independent lives, reducing the risk of reoffending.

At the end of the last financial year, the WDS had received 64 referrals from North Yorkshire Police and 57 completed successfully. After completing a Quality Deep Dive with North Yorkshire Police's System of 10 cases, we found that in the 10 that successfully completed there were no further offences recorded, five cases had evidence of domestic violence call outs, of the two cases that did not complete – one case had numerous intelligence reports of drug dealing and sex work, and one had no further incidents recorded.

6. **We are looking at the use of Naloxone in Approved Premises. What can we do to reduce overdoses and drug related of those supervised by HMPPS (in custody and in the community?)**

Research by KCL has shown the risk of drug-related deaths is 7.5 times higher in the first fortnight after release than at comparable other times at liberty. However, only 17% of people released from prison last year received Naloxone. This should be prioritised as an area improvement and clarity provided on milestones and the length of time needed to achieve this.

Substance misuse services based in prisons are usually commissioned by NHS England. Substance misuse services in the community are usually commissioned by local authorities, with some input from CCGs. Neither commissioner currently appears to take responsibility for the issuing of Naloxone on release from Prison in a consistent way. This must be clarified.

In order to improve Naloxone provision and reduce drug related deaths, prison and community services should:

- Provide all those with a history of opiate use Naloxone (and training to administer it) whilst accessing the probation service or prior to release from prison
- Providing Naloxone and training to all prison and probation officers

- Community/HMPPS services to train hostels/housing service staff on how to use and provide Naloxone to residents and family members
- Those leaving remand prisons often do not get any support on release. If a substance misuse specialist worker was available in courts they could provide a naloxone kit, housing advice and link them with the local treatment service.

Approved Premises

In terms of reducing overdose and drug related deaths of those living in Approved Premises, we would recommend providing an introductory training to all residents on the risks of using substances. For instance, a recent drugs needs analysis completed at HMP Bedford identified that residents felt that it would help if all residents attended mandatory substance awareness training to reduce the use of NPS. This approach could be taken in Approved Premises.

7. Any other suggestions that you think would be useful for us to consider?

Using criminal justice interventions to deter people from problematic drug use has a limited impact. It can also compound the issues linked to high prison populations. However criminal justice does have a part to play in intervention and behavioural change. The current criminalisation model reinforces disadvantage, which includes difficulties accessing the labour market, strained or broken family relationships, and a lack of positive social networks, etc. These things are all key elements to a person's recovery.

Prioritising diversion from criminalisation, as well as engagement in robust health and socially-oriented provision could make a real difference to a lot of people's ability to abstain from problematic drug use. This can in turn relieve the pressure on police, custody suites, courts, the National Probation Service and prisons.

In addition, we would like to see more consistent and improved funding of ATR/DRR courses as an alternative to custody.

Technology

Our staff highlight the lack of technology in custody as being a core area that needs to be addressed. For example, the use of technology in cell and out on the landings so prison workers could upload casenotes/assessments at the time as opposed to completing everything on paper and then typing it into an electronic

system could free up significant amounts of time. Staffing shortages in prison often affect our ability to do in-reach work. This could be mitigated by allowing the use of video calls to engage people in prison.

Diverse groups

Finally, there are a number of cohorts that often fall through the net within HMPPS:

- 18-24 and 24-30 year olds. These cohorts fall out of the Young Offender category and are often influenced by peers, do not view their substance use as a problem and do not have a family support network when released from prison. These service users often go on to re-offend.
- Bespoke and tailored support and funding for female offenders
- Bespoke support for older adults in the criminal justice system, especially in relation to alcohol use
- Those with poor literacy are also less likely to engage with support in custody due to embarrassment.
- Members of the traveller community can also be difficult to engage due to literacy issues, less likely to admit to a problem and a lack of support network in the community

It is important that any upcoming strategy recognises the needs of these and other diverse groups.

Q8. We very much value your expertise and welcome your comments regarding the current and/or any future HMPPS Drug and Alcohol Strategy

We are pleased to see the plans to develop a Drug and Alcohol Strategy. It is extremely important that the risks associated with alcohol use and withdrawal are appropriately acknowledged and safeguarded against for those on remand or recently starting a prison sentence as well as alcohol's wide ranging impact in offending behaviours across a broad range of offence types. Alcohol needs to be given parity to drugs in understanding behaviour and treatment and rehabilitative options available for those entering or leaving the criminal justice system.