Collective Voice

JUSTICE SELECT COMMITTEE INQUIRY INTO THE PRISON POPULATION 2022

WRITTEN EVIDENCE SUBMITTED BY COLLECTIVE VOICE, APRIL 2018

ABOUT COLLECTIVE VOICE

Collective Voice is a group of seven voluntary sector organisations who have come together to ensure that the voices of the drug and alcohol treatment sector and those who use our services are represented effectively. The member organisations are: Blenheim, Change, grow, live, Changing Lives, Cranstoun, DISC, Phoenix Futures and Turning Point.

EXECUTIVE SUMMARY

- Drugs and alcohol are two of the six main drivers of crime recognised in the Home Office's Modern Crime Prevention Strategy.
- 45% of acquisitive crime is committed by heroin or crack cocaine users.
- Drug treatment is the single most effective means to reduce drug-related crime.
- Successive governments invested in treatment to create a comprehensive system able to engage and retain offenders at every stage of the criminal justice system.
- The Home Office estimates that this accounts for 30% of the dramatic reduction in acquisitive crime this century.
- Since 2013, investment in drug and alcohol treatment has reduced by 25% in cash terms.
- Drug treatment was championed by the Home Office, the police, and the probation service. It is not a natural priority for the NHS. In large measure, disinvestment is a consequence of drugs and drug-related crime no longer being a priority for ministers or police leaders as it was seen as "problem solved".
- The "world class" system responsible for reducing crime, improving rates of recovery, controlling the spread of blood borne viruses, and reducing drug-related deaths is being dismantled, jeopardising each of these societal benefits.
- The extreme resource constraints in prison and the crisis in probation created by the failure of Transforming Rehabilitation have severely compromised the criminal justice system's capacity to support drug misusing offenders.
- Projecting forward to 2022, unless action is taken the system will continue to fragment, causing increasing numbers of vulnerable individuals to cycle between community- and prison-based systems, neither of which can meet their needs. Whilst in prison they will be an expensive problem; whilst in the community they will be a threat to community safety.

INTRODUCTION

1. This submission focuses on the current challenges presented to HMPPS and the wider criminal justice system by the misuse of drugs and alcohol with particular emphasis on the role of treatment. The overall picture is troubling, and projecting forward to 2022, it is difficult to see much opportunity for optimism whilst the structural and resource issues that make the current environment so challenging persist.

CONTEXT

2. The Home Office Modern Crime Prevention Strategy (MCPS)[1] identified drugs and alcohol as two of the six major drivers of crime in our society. The use of illegal drugs is estimated to cost

[1] Home Office (2016) *Modern Crime Prevention Strategy*, available online [accessed 20/4/18]

society £10.7bn a year of which drug-related crime constitutes £6bn. There is a particularly strong association between heroin and crack cocaine use and acquisitive crime. The Home Office estimates that 45% of acquisitive crime, other than fraud, is committed by regular heroin/crack users and that at least half of the very steep rise in acquisitive crime in the 1980/90s is attributable to the heroin epidemic of those decades. 30% of the fall in such offences in the first decade of this century is attributed to the decline in the numbers of heroin/crack users and the rapid expansion of treatment availability post-2001.

3. Home Office policy articulated by the MCPS and the 2017 Drug Strategy[2] emphasises the strong evidence identifying access to drug treatment as the most potent response available to government to reduce offences such as burglary and shoplifting. Unfortunately despite this, investment in drug treatment, both in the community and in prison, has reduced by around 25% in cash terms since 2012/13, placing the crime reduction benefits of treatment at risk.[3]

DELIVERY LANDSCAPE PRE-2013

4. Between 2001 and 2008, investment in drug treatment increased approximately threefold from £250m to £750m a year, largely driven by the policy imperative to reduce drug-related crime. Despite significant pressures on public expenditure, successive governments sustained this level of investment until 2013.

5. This created a treatment system regarded as world-class, which had at its heart a comprehensive process of identification and ready access to treatment across the criminal justice system. The Drug Intervention Programme (DIP) established testing on arrest, and deployed drug workers in custody suites, courts, and to facilitate access to treatment on discharge from prison. Integrated Offender Management and Prolific and Priority Offender schemes integrated police probation and drug treatment staff together to provide packages of care and surveillance in the community for the most challenging offenders. Drug Rehabilitation Requirements provided courts with access to treatment-based community sentences accompanied by judicial oversight. The Integrated Drug Treatment System (IDTS) provided evidence-based pathways in prison, offering maintenance- and abstinence-focused treatment. Treatment in prison and in the community was commissioned as a whole system, facilitating continuity of care on release. Crucial to all of the above, local police commanders and local chief officers of probation were influential members, together with the NHS and local authority, of the partnerships which commissioned treatment services and were accountable to government for the public money invested.

CURRENT DELIVERY LANDSCAPE

6. The success of drug treatment policy between 2001 and 2013 was summed up by David Cameron in 2012: “We have a policy which actually is working in Britain. Drug use is coming down, the emphasis on treatment is right, and we need to continue with that to make sure we can really make a difference.”[4] This had contributed to falling drug use overall, a dramatic decline in the use of heroin and crack amongst young people, significant reductions in drug-related crime, improvements in the quality and availability of treatment, fewer drug-related deaths, and an increase in rates of recovery.

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[2] HM Government (2017) *2017 Drug Strategy*, available online [accessed 20/4/18]

[3] Collective Voice analysis of local authority and prison spend on drug and alcohol treatment

[4] Quoted in The Guardian, 10 December 2012, available online [accessed 20/4/18]

7. However, as is acknowledged in the 2017 Drug Strategy, treatment on its own is only one of the services necessary to enable individuals to recover and leave addiction behind. Particularly for offenders, drug dependence is typically accompanied by a raft of other challenges: fragile mental health, declining physical health, long-term unemployment, compromised educational attainment, homelessness, social isolation etc. Furthermore, these wider issues are as likely to predate the onset of dependence as they are to be a consequence of drug use. Despite the success in expanding clinical drug treatment from 2001, much less has been achieved in integrating services to enable much-needed access to mental health treatment, employment, and stable housing. To address this and integrate wider services with clinical treatment, it was decided, as part of the implementation of the Health and Social Care Act (HSCA) in 2013, to place responsibility for commissioning drug and alcohol treatment with local authorities as part of their new public health responsibilities.

8. Paradoxically, the very success of drug treatment has resulted in ministers, the criminal justice agencies, the media, and the public no longer seeing drugs as a priority. In this environment, it is not possible to justify the dedicated funding, specialist commissioning, and performance management structures that oversaw drug treatment up to 2013. These have been replaced with a system in which drug and alcohol treatment is the sole responsibility of the local authority, funded via the public health grant and overseen by Public Health England.

9. The HSCA established Health and Wellbeing Boards (HWBs) to foster the local partnerships required to make the new system work. Despite strong pressure from the Home Office, the criminal justice system was largely excluded from HWBs, which have been (understandably) preoccupied with managing the grave challenges social care presents to both the NHS and local authorities. Substance misuse has therefore not been a focus for HWBs, resulting in the local partnership vital for delivering multi-faceted cross-cutting issues of which drug and alcohol treatment is a classic example disappearing.

10. Home Office advocacy of continued partnership has been undermined on the ground by declining police interest, the emerging role of PCCs, and the impact of Transforming Rehabilitation on the probation service. Facing severe financial constraints, Chief Constables and PCCs have shifted their attention and their resources away from the relationship between heroin and acquisitive crime, which is seen as part of the diminishing "traditional crime" agenda, towards the growing terrorism threat and long-neglected issues such as domestic abuse, sexual violence, child sexual exploitation and modern slavery. The probation service, which had been very influential in local partnerships, has retreated from external engagement to focus on implementing Transforming Rehabilitation. As argued by the Chief Inspector of Probation in her evidence to this committee in April, this has been to the long-term detriment of the probation service's ability to shape the local delivery landscape to make it responsive to legitimate needs of the criminal justice system and the courts.

11. The absence of criminal justice service advocacy has had profound consequences. Drug and alcohol treatment is not a natural priority for the NHS or public health. Despite the significant crime and wider social harms associated with drug and alcohol use, the incidence of ill-health and early death associated with dependence is a fraction of that associated with traditional NHS priorities: heart disease and cancer, or the emerging challenges of the ageing population. Similarly, local Directors of Public Health are entirely legitimately much more interested in

tobacco, obesity, air quality, and the health risks of non-dependent alcohol use than they are the relatively limited health consequences of dependent drug and alcohol use. Add to this the severe financial pressures felt by local authorities and it is hardly surprising that drug and alcohol treatment has experienced significant cash reductions in budgets, averaging 25% across the country which has resulted in the available resource diminishing by around 30% in real terms since April 2013.[5]

COMMUNITY TREATMENT

12. The scale of disinvestment has placed significant challenges on treatment providers. During 2016-17, 279,793 individuals were in contact with treatment services in the community,[6] broken down as follows:

Opiates (and any other substance)	146,536
Non-opiates only	24,561
Non-opiate and alcohol	28,242
Alcohol only	80,454

13. The number of people accessing alcohol treatment is in decline, despite the system not engaging about five out of every six people who would benefit from specialist treatment.[7] Waiting times for treatment remain at historically low levels, five days compared to 9 weeks prior to 2001, but 40% of opiate users remain outside the system[8] and to protect access, commissioners are increasingly restricting their ask of providers to a bare bones service prioritising maintenance prescribing of methadone and deprioritising services focused on housing, employment, families etc. This is the exact opposite of the Home Office's aspiration for treatment set out in the Drug Strategy which recognises that for individuals to recover, they need a wide range of social support as well as access to clinical treatment. However, the reality in many places is that there is an increasing gap between policy aspiration and its affordability.

ARREST

14. The point of arrest is an ideal opportunity to engage drug/alcohol misusing offenders in treatment. These were the first services to see significant reductions in resources post-2013, leaving a patchwork of differential provision across the country, implicitly acknowledged in the 2017 Drug Strategy. Testing on arrest has been scaled back; the number of dedicated drug treatment staff working in custody suites has been drastically cut in many places and entirely withdrawn in others. This is being compounded by centralisation of custody suites placing them out of reach of local treatment providers, particularly in rural areas. Where adequate resources

[5] Collective Voice analysis of local authority and prison spend on drug and alcohol treatment
[6] Public Health England/Department for Health (2017) *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2016 to 31 March 2017*, available online [accessed 20/4/18]
[7] Calculated using NDTMS data from 2014/15 (Public Health England/Department for Health (2015) *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015*, available online [accessed 20/4/18]) and estimates of alcohol dependence in England (Pryce et al (2017) *Estimates of alcohol dependence in England based on APMS 2014*, available online [accessed 20/4/18])
[8] Calculated using NDTMS data from 2014/15 (Public Health England/Department for Health (2015) *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015*, available online [accessed 20/4/18]) and opiate and crack cocaine use prevalence data (Liverpool John Moores University (2017) *Estimates of opiate and crack cocaine use prevalence: 2014 to 2015*, available online [accessed 20/4/18])

have been retained, the absence of effective partnership arrangements can reduce efficiency by duplicating effort and a lack of coordination.

15. A few areas have retained strong local partnerships which continue to invest. In Essex, the county council, PCC, and, local NHS have integrated services in custody suites for substance misuse with those for mental health and learning disability, providing an enhanced and more cost-effective service. This demonstrates the continued significance of local partnerships and the opportunity which is being lost by not integrating Liaison and Diversion schemes nationally with the remnants of existing drug and alcohol services.

COURT

16. A similar pattern is apparent at the point of sentence. Dedicated drug and alcohol staff at courts have almost disappeared. Probation disengagement from partnerships has resulted in poor liaison between probation and treatment providers. CRCs have been resistant to engagement with magistrates. NPS staff preparing pre-sentence reports appear reluctant to refer to treatment, not helped by courts' growing reliance on verbal reports. DRRs and ARRs are increasingly not enforced. Before 2013, there was a very close working relationship between the courts, the probation service, and treatment providers. This is at risk of breaking down to be replaced by estrangement, distrust, and blame.

PRISON REGIME

17. The overwhelming message from drug and alcohol treatment providers delivering services in prison is that the most important barrier to the effective delivery is the cumulative degrading of the prison environment over the past decade. Echoing the Chief Inspector of Prisons' remarks to this committee in April, treatment providers experience the absence of a safe and decent regime as seriously compromising their efforts, and report that this is compounded by staff shortages which result in resources that should be available to support drug and alcohol treatment being transferred to other more pressing matters within the prison. Ultimately, safety and order must be prioritised over rehabilitation and recovery. An understaffed prison will never be able to provide an environment conducive to effective delivery of drug and alcohol treatment.

18. Delivering drug and alcohol services in prison is a constant struggle with the constraints of the regime. Staff shortages limit the time prisoners have out of cell which demands choices be made about access to services, with healthcare, education, and work all competing with drug and alcohol services for scarce prisoner time. This is doubly frustrating for staff as they are acutely aware that if individuals are to embark on a drug-free and crime-free life on release, they will need to address their offending, mental health, employment, housing, and family links alongside their drug and alcohol use on a daily basis. Rationing access to services for this vulnerable and risky group in society is an obvious false economy.

INTEGRATED DRUG TREATMENT SYSTEM IN PRISONS

19. As much drug and alcohol treatment in prison is subsumed within large generic healthcare contracts, neither MOJ nor NHS England are able to accurately report the level of spend. The best available information suggests that current spend for the secure estate is about £80m,[9] a reduction of about £38m (32%) from the £118m allocated in 2012/13, reflecting the level of

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[9] Prisons: Drugs: Written question – 8130 to Department of Health, 4 September 2017, available online [accessed 20/4/18]

reduction experienced in the community. As in community services, reduced budgets have driven both efficiencies and reductions in provision. Direct clinical services, particularly substitute prescribing and alcohol detox, have been prioritised at the expense of access to mental health support and the wider range of services that make sustaining recovery on release more likely. As resource constraints bite, caseloads grow and the time available for the highly skilled and time-consuming engagement between drug worker and drug user reduces. Successful work with drug users demands practitioners establishing a relationship seeking to use this to capitalise on glimmers of motivation to support the individual to make changes in their life, or begin the process to move off methadone and try an abstinence-based route to recovery. In this environment, services increasingly fall back on overseeing substitute prescribing, which offers the best value public health and crime reduction return available with limited investment.

THROUGH THE GATE

20. Most drug misusing offenders are serving short sentences, often weeks rather than months. This population therefore had the most to gain from the original promises made on behalf of Transforming Rehabilitation in general and Through the Gate in particular. Unfortunately drug and alcohol treatment providers' experience almost exactly mirrors that of the two chief inspectors who gave evidence to this committee in April:
    - Chief Inspector of Probation: "Regrettably, none of the government's stated aspirations for Transforming Rehabilitation have been met in any meaningful way."[10]
    - Chief Inspector of Prisons: "If Through the Gate was removed tomorrow the impact on prisons would be negligible."[11]

21. The impact of this on the drug misusing population goes far beyond lost opportunities for rehabilitation. Currently only one in three of those discharged from prison in need of continuing drug treatment actually establishes contact with a treatment service on release.[12] Public Health England's strategy to reduce drug-related deaths identifies discharge from prison as the point of maximum risk of overdose and maintaining contact with treatment services as the key intervention to stem the rise in drug-related deaths.[13] The failure of Through the Gate is therefore not only a lost opportunity to promote recovery from drugs and desistance from offending; it is also contributing directly to the current record levels of drug-related deaths.

22. A higher proportion of the female prison population have a history of drug misuse. The absence of effective through-care arrangements impacts particularly on women, who are usually located at considerable distance from home, challenging a creaking prison system to establish effective working relationships with a large number of local treatment providers.

23. It is worth noting that Through the Gate services existed prior to 2013 as part of the DIP arrangements and the expectation that this would in future be provided by CRCs was one of the factors behind commissioners' decisions to withdraw these dedicated services.

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[10] HM Inspectorate of Probation for England and Wales (2017) *2017 Annual Report*, available online [accessed 20/4/18]
[11] Chief Inspector of Prisons' evidence to Justice Select Committee, 17 April 2018
[12] Public Health England (2018) *Public Health Outcomes Framework – at a glance*, available online [accessed 20/4/18]
[13] Public Health England (2016) *Understanding and preventing drug-related deaths*, available online [accessed 20/4/18]

IMPACT OF LICENCE CONDITIONS

24. The failure of Through the Gate is compounded by the consequences of the imposition of licence conditions without support, particularly on the chaotic population who experience substance misuse, mental health, and homelessness. Alongside the traditional demands of the churn of short-term sentenced prisoners and remands, staff are now having to deal with a significant number of licence recalls, typically in the prison for 14 days. Notions such as sentence planning and preparation for release are redundant in these circumstances. HMP Durham has responded by establishing a team of "Revolving Door" workers to deal with this population. In reality, few services are available to meet the needs of this extremely marginalised group either in prison or the community.

SPICE

25. Spice constitutes a major challenge across the prison estate, although use is significantly lower in women's prisons. Issues concerning acute health risks to users, violence to staff and other prisoners, and bullying and intimidation associated with dealing etc. have been well documented.[14] Although spice use in prison is common, and not confined to those with a history of drug dependence, the very visible spill-over into the community is concentrated among the subset of prisoners who experience multiple disadvantage. Although prison will be a gateway to drug use and potentially dependence for some, in the main the individuals whose spice use continues on release will be those with pre-existing heroin and/or alcohol dependence allied to a history of mental ill-health and homelessness. Long-term solutions therefore lie in reducing the vulnerability of this population and working to prevent the next generation at risk of repeating this pattern, rather than focusing on one particular drug. This is recognised in the 2017 Drug Strategy, but against the background of dramatic increases in homelessness and underfunded mental health and drug and alcohol services in the community, compounded by the inability of the prison system to respond to the identified needs of short-term prisoners, it is difficult to see how this cycle will be interrupted.

CONCLUSION

26. Prison is the place where society warehouses its problems. It should not surprise us that the cumulative impact of austerity on those with the least capacity to cope presents an escalating challenge. Meanwhile, the government is increasingly becoming concerned about the resurgence in violence associated with drug markets, increases in the use of crack cocaine, and slight but troubling increases in traditional acquisitive crime.[15] As the Home Office attributes 30% of the reduction in acquisitive crime this century to the ready availability of drug treatment, it is difficult not to see an association between disinvestment from treatment and the recent increases in acquisitive and violent crime. The response the government advocates in its 2017 Drug Strategy – an integrated, resourced, and seamless service accountable to local agencies working in partnership – mirrors what existed as recently as 2013; what is lacking is the political will to act.

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[14] HM Inspectorate of Prisons (2015) *Changing patterns of substance misuse in adult prisons and service responses*, available online [accessed 20/4/18]

[15] HM Government (2018) *Serious Violence Strategy*, available online [accessed 20/4/18]