Collective Voice

ACMD CALL FOR EVIDENCE: CUSTODY-COMMUNITY TRANSITIONS

WRITTEN EVIDENCE SUBMITTED BY COLLECTIVE VOICE, JUNE 2018

About Collective Voice

1. Collective Voice is a group of eight voluntary sector organisations who have come together to ensure that the interests of the drug and alcohol treatment sector and those who use our services are represented effectively.

2. This submission is informed by focus groups, held in April 2018, with treatment providers working in all parts of the criminal justice system and with service users who have been in custody. We focus here on drug treatment, but much the same could be said about alcohol treatment.

The Government' aspiration

3. The Government's 2017 Drug Strategy[1] aspires to create an integrated, resourced and seamless service accountable to local agencies working in partnership. It has at its heart a comprehensive process of identification and ready access to treatment across the criminal justice system. Liaison and Diversion schemes supported by testing on arrest are designed to provide opportunities to deploy drug workers in custody suites and courts. "Through the Gate" services are expected to facilitate access to treatment on discharge from prison. Integrated Offender Management schemes coordinate the activities of police, probation and drug treatment staff to provide packages of care and surveillance in the community for the most challenging offenders. Drug Rehabilitation Requirements provide courts with access to treatment-based community sentences accompanied by judicial oversight. The Integrated Drug Treatment System (IDTS) delivers evidence-based pathways in prison, offering maintenance- and abstinence-focused treatment. Treatment in prison and in the community is envisioned as a whole system, facilitating continuity of care on release, with the partnerships between the NHS commissioned prison system, the local authority commissioned community system and the criminal justice agencies all required to facilitate this, fostered and maintained by Health and Wellbeing Boards.

The chaotic and fractured reality

4. The very clear message from service users and practitioners is that this vision of an integrated, resourced, seamless service contrasts starkly with their chaotic, underfunded and fractured real world experience. The harsh reality is that the staffing crisis in prison makes delivering drug treatment in custody extremely challenging, limiting both the range and the impact of interventions. The "Through the Gate" arrangements, despite being seen as the justification for the Transforming Rehabilitation reforms of the probation service, have collapsed. The capacity of the community treatment system to respond to the legitimate aspiration of service users to achieve recovery has been severely compromised by resource constraints. The services operating at the interface between criminal justice and drug treatment such as Liaison and

[1] HM Government (2017). *2017 Drug Strategy*. Available online, accessed 20 April 2018.

Diversion and Drug Rehabilitation Requirements are severely depleted and are a pale shadow of the robust services that existed a decade ago.

5. At the heart of this failure is a fragmented system which lacks direction and accountability. The system has been set up to be locally driven. However, in an era of austerity, services provided to unpopular marginalised groups such as drug users will always struggle to be adequately resourced by hard pressed local authorities, prison governors and the NHS. If the government is to have any chance of achieving its aspirations in drug policy, the leadership and accountability role envisaged for the Home Secretary within the 2017 strategy needs to be grasped urgently.

Funding and the erosion of treatment and recovery capacity

6. Home Office policy articulated by the Modern Crime Prevention Strategy[2] and the 2017 Drug Strategy emphasises the strong evidence identifying access to drug treatment as the most potent response available to government to reduce offences such as burglary and theft. Moreover, the Government is increasingly concerned about the resurgence in violence associated with drug markets, increases in the use of crack cocaine, as well as persistent increases in traditional acquisitive crime.[3] 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 need to properly fund drug treatment is more evident than ever.

7. Despite this, investment in community drug and alcohol treatment has reduced by around 25% in cash terms or around 30% in real terms since April 2013, placing the crime reduction benefits of treatment at risk. The planned removal of the ring fence on the Public Health Grant makes further reductions probable. Similar reductions have occurred in prison. Drug treatment in prison is subsumed within large, generic healthcare contracts, so that neither the Ministry of Justice nor NHS England can accurately report on expenditure. The best available information suggests that current spend for the secure estate is about £80m[4], a reduction of about £38m (32%) from the £118m allocated in 2012/13.

8. The scale of disinvestment has placed significant challenges on treatment providers. Waiting times for community treatment remain at historically low levels, but 40% of opiate users remain outside the system. The ambition of local authorities and the quality of the services commissioned by them is in decline. To protect access, commissioners are prioritising maintenance prescribing of substitute medication such as methadone, which offers the best value public health and crime reduction return available with limited investment, and at the same time deprioritising services focused on housing, employment, families, etc. Supporting drug users to make changes in their life demands that practitioners establish a relationship in which they can capitalise on shifting degrees of motivation as they emerge. As resource constraints bite, caseloads grow; the number of expensive, skilled, experienced staff reduces;

[2] HM Government (2016). *Modern Crime Prevention Strategy*. Available online, accessed 20 April 2018.
[3] HM Government (2018). *Serious Violence Strategy*. Available online, accessed 20 April 2018.
[4] Prisons: Drugs: Written question – 8130 to Department of Health, 4 September 2017. Available online, accessed 20 April 2018.

and the time available for the highly skilled and time-consuming engagement between drug worker and drug user reduces. Similarly, we are also facing the erosion of the IDTS in prison, with prescribing services being prioritised at the expense of the wider range of services that make a successful transition back to the community and sustaining recovery on release more likely.

9. This resource-driven shift in provision is the exact opposite of the government's vision of a more ambitious, person-centred, recovery-focused treatment offer set out in both the 2010 and 2017 drug strategies. The contraction of services focused on housing, offending, employment and mental health, and the increasingly complex health needs of an ageing service user population has the cumulative effect of rendering the governments aspirations for drug treatment increasingly unachievable across much of the country.

Prison regime & environment

10. Transitions from prison back into the community are not a one-day event. Their success depends on work done with each prisoner throughout their stay in custody, addressing clinical needs alongside building the motivation to change and the resilience to achieve this. In theory, the prison regime provides a wide-open opportunity for supporting prisoners to lead healthier, crime-free lives on leaving prison. But the overwhelming message from treatment providers is that the most important barrier to the effective delivery of services in prisons is not the 30% reduction in resources but the cumulative degrading of the prison environment over the past decade.

11. Our focus groups described delivering drug services in prison as a constant struggle with the constraints of the regime. Echoing the Chief Inspector of Prisons' remarks to the Justice Select Committee in April[5], providers experience the absence of a safe and decent regime as seriously compromising their efforts. They report that this is compounded by prison officer staff shortages, which mean that resources that should be available to support treatment are transferred to more pressing matters. Staff shortages limit the time prisoners have out of cell, requiring healthcare, education, work and drug treatment to compete 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 drug use. Rationing access to services for this vulnerable and risky group in society is an obvious false economy. Added to this, spice constitutes a major challenge across the prison estate. 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.[6]

12. As the Chief Inspector argues, safety and order must be prioritised over rehabilitation and recovery, but an understaffed prison will never be able to provide an environment conducive to

[5] HM Chief Inspector of Prisons' evidence to Justice Select Committee, 17 April 2018. Available online, accessed 19 June 2018.
[6] HM Inspectorate of Prisons (2015). *Changing patterns of substance misuse in adult prisons and service responses.* Available online, accessed 20 April 2018.

the effective delivery of drug treatment[7]. The surest means to justify return on investment of treatment resources is to ensure they are deployed in an environment that maximises rather than curtails their potential.

Fragmentation

13. Until 2013, local police commanders and local chief officers of probation were, together with the NHS and local authority, influential members of the partnerships which commissioned treatment services. They were also accountable to government for the public money invested. Because of the evidence linking treatment access with crime reduction, the criminal justice system (CJS) was a powerful advocate for high levels of investment in treatment within these local partnerships. Since the shift to local authority commissioning and away from partnership with the CJS, this advocacy has been absent from local investment decisions. Drug treatment is not a natural priority for Directors of Public Health or Health and Wellbeing Boards as the impact of dependent drug use on population health is limited and the service user population is politically unpopular. In this context, it is unsurprising that drug treatment has seen levels of disinvestment far higher than other areas of public health.

14. Compounding this, as acquisitive crime fell, in part because of investment in treatment, Chief Constables and Police and Crime Commissioners (PCCs) shifted their attention and resources away from the relationship between heroin and acquisitive crime towards other agendas. The probation service has also retreated from involvement in local partnerships to focus on implementing Transforming Rehabilitation. Consequently, CJS agencies no longer shape the local delivery landscape to make it responsive to legitimate needs of the criminal justice system and the courts.

15. Funding for treatment and related services in any given area, along with the associated decision-making and commissioning, is now scrappily split between several public bodies including local authorities, clinical commissioning groups (CCGs), sustainability and transformation partnerships (STPs), NHS England and PCCs, so that the services it buys are also fragmented across geographies and multiple administrative layers. Treatment providers working in the criminal justice system report how the lack of communication between treatment services, and between treatment and other services, means support is stop-start and lacks coherence. Where it is done well, it is usually as a result of good relations between providers and not 'designed in' by commissioners.

16. This combination of the severe financial pressures felt by local authorities, the absence of criminal justice service advocacy and fragmented planning risks the further decline of the treatment system, the reversing of the successes of recent years and the Drug Strategy stalling before it ever gets started.

[7] HM Chief Inspector of Prisons' evidence to Justice Select Committee, 17 April 2018. Available online, accessed 19 June 2018.

Complex needs

17. 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. These are as likely to predate the onset of dependence as they are to be a consequence of drug use. Although prison will be a gateway to drug use and potentially dependence for some, many prisoners being released are those with pre-existing heroin and/or alcohol dependence combined with these wider problems.

18. Long-term solutions lie in reducing the vulnerability of this population and working to prevent the next generation at risk of repeating this pattern. Drug treatment is only one of the services necessary to enable individuals to recover and leave addiction behind, but operates against the background of dramatic increases in homelessness and underfunded mental health in the community, compounded by the inability of the prison system to respond to the identified needs of short-term prisoners. As is acknowledged in the 2017 Drug Strategy, 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.

Arrest

19. The point of arrest is an ideal opportunity to engage drug offenders in treatment. The existing Drug Intervention Programme services were the first to see significant reductions in resources post-2013, resulting in patchy provision across the country. Liaison and Diversion (L&D), which seeks to provide the same service, is being rolled out nationally. But the reality experienced by service users and practitioners is that testing on arrest has been scaled back and 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 the centralisation of custody suites placing them out of reach of local treatment providers, particularly in rural areas. Where adequate resources have been retained, the absence of effective partnership arrangements can reduce efficiency by duplicating effort and a lack of coordination.

20. A few areas have retained strong local partnerships which continue to invest and commission jointly. In Essex, the county council, PCC, and local NHS have integrated services in custody suites for substance misuse with services for mental health and learning disability, providing an enhanced and more cost-effective service, exactly as envisaged by those who originally conceived L&D. Police officers screen for mental health, substance misuse and learning disability issues and are trained to do this. This demonstrates the continued significance of local partnerships and the opportunity which is being lost by not more consistently integrating Liaison and Diversion schemes with the remnants of existing drug and alcohol services.

Court

21. 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. Community Rehabilitation Companies (CRCs) have become 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. Providers report very low percentages of substance users given Drug Rehabilitation Requirements and these are increasingly not enforced when given. The close working relationship between the courts, the probation service, and treatment provider, established over the previous decade is reported across the country to be breaking down.

Through the Gate

22. Through the Gate services existed before 2013, but the expectation CRCs would pick up this provision emboldened commissioners to withdraw their locally commissioned services. Most drug misusing offenders are serving short sentences, often weeks rather than months. Therefore, this population had the most to gain from the original promises made on behalf of Transforming Rehabilitation in general and Through the Gate in particular. Unfortunately treatment providers' experience mirrors that of the Chief Inspectors for Prisons and Probation who recently informed the Justice Select Committee that "none of the government's stated aspirations for Transforming Rehabilitation have been met"[8] and that the impact of ending Through the Gate tomorrow would be "negligible."[9] The focus groups reported that prisoner contact with CRCs before release is extremely limited, if it happens at all. Moreover, the whole spirit of the original TR proposals has been abandoned as CRCs only work "to the gate" and then pick up the client later in the community. This leaves them alone as they go "through the gate" and hence vulnerable to returning to their old lifestyle.

23. The impact of the failure of Through the Gate on the drug misusing population goes far beyond lost opportunities for rehabilitation and reducing reoffending. 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[10]. 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[11]. This failure contributes directly to the current record levels of drug related deaths reported in previous ACMD reports[12].

[8] HM Inspectorate of Probation for England and Wales (2017). *2017 Annual Report*. Available online, accessed 20 April 2018.
[9] HM Chief Inspector of Prisons' evidence to Justice Select Committee, 17 April 2018. Available online, accessed 19 June 2018.
[10] Public Health England (2018). *Public Health Outcomes Framework – at a glance.* Available online, accessed 20 April 2018.
[11] Public Health England (2016). *Understanding and preventing drug-related deaths*. Available online, accessed 19 June 2018.
[12] ACMD (2016). *Reducing opioid-related deaths in the UK.* Available online, accessed 19 June 2018.

24. The focus groups' experience was that in many areas no-one (CRCs, treatment providers or the local authority) can solve the housing problem, leaving released prisoners at much heightened risk of resuming their previous lifestyle and bypassing homelessness services. Some are later found sleeping rough by outreach teams.

25. The absence of effective through-care arrangements impacts on women in particular as they are often placed far from home. It is challenging, providers say, for prison services to establish effective working relationships with a large number of local treatment providers to whom they must make referrals. Sign-posting women to services and leaving the burden on them to make multiple appointments when they are prioritising relationships with family and children is leading to delays in treatment and higher reoffending rates.

Impact of licence conditions

26. The failure of Through the Gate is compounded by the consequences of imposing licence conditions without support, particularly on people with complex needs, a significant proportion of whom are spice users. Alongside the churn of short-term sentenced prisoners and remands, staff now also have to deal with many more licence recalls, typically in the prison for 14 days. Sentence planning and preparation for release become impossible. HMP Durham has established a team of "Revolving Door" workers, but few services can genuinely meet the needs of this extremely marginalised group.

Conclusion

27. The cumulative impact of austerity on those with the least capacity to cope presents an escalating challenge. Not addressing this risks further increases in drug related deaths, a reawakening of drug related criminality and, in effect, the abandonment of the Government's commitment to recovery. The Drug Strategy vision of an integrated, partnership-led approach overseen by "stronger governance and accountability" remains the right direction of travel. However, over the past year, rather than a cross government "Drug Strategy Board chaired by the Home Secretary to drive action and hold different elements of the system to account"[13], the system has been characterised by continued drift, disinvestment and political disinterest.

28. The role of drug treatment in keeping vulnerable people alive, giving them an opportunity to overcome dependence and protecting the community from crime is as important as ever. Transitions in and out of custody are key points of risk in this process. In Collective Voice's view, long term success will require the Government to finally act on the interventionist agenda it set for itself last year. Further passivity will only entrench the developing crisis.

SUBMISSION: This response was sent to ACMD by email only (Matthew Gavin Gavin.Matthew1@homeoffice.gsi.gov.uk) on 20 June 2018.

[13] HM Government (2017). *2017 Drug Strategy*. Available online, accessed 19 June 2017.