CollectiveVoice

The National Alliance of Drug and Alcohol Treatment and Recovery Charities

Written evidence submitted by Collective Voice to the Justice Committee inquiry on Tackling drugs in prisons

About Collective Voice

Collective Voice is the alliance of charities that provide drug and alcohol treatment and recovery services. We work to ensure that the knowledge and expertise of this field contributes to the development of policy and practice.

We are submitting to this inquiry because our members provide treatment for people with issues related to substance use both in prisons and the community. We believe this work offers insights on how the system can work more effectively and efficiently to reduce substance use, risk and harm.

This submission does not include responses to questions 4, 5, 6 or 7, as we believe these will be covered effectively by responses from other organisations, including our own members.

Scale and impact

1. What is the current scale of drug use in prisons in England and Wales?

- What are the primary factors driving the demand for drugs in prisons?
- To what extent are new psychoactive substances and synthetic cannabinoids a growing challenge compared to traditional drugs?

Drug use in prisons is widespread. Inspections find that it is common for up to half of prisoners to be using drugs, with a considerable proportion of these only developing a problem after arriving in jail.[1]

While substance use is more likely where drugs are readily available, this does not explain the particularly high rates of use and problems in prison. Alcohol and other drugs are readily available in the community, and yet many individuals are not developing problems until they enter prison. The problem is not simply the availability of drugs in prison, but the setting itself.

Substance use can be a form of escapism, and in prison it would appear that people use substances to address boredom and fear. There is a lack of structured, purposeful activity in prison, which can be a protective factor against problematic use of drugs. Moreover, short stays in prison and limited capacity of wider support services can exacerbate the factors that drive people to use substances.

New psychoactive substances pose specific challenges for established methods that aim to control supply and demand. These formulations can make it harder to stop supply into prisons, as they allow for highly concentrated and unusual packages – for example imbuing paper with the substance. If they do get in, it is harder to detect the presence of newer substances, as testing must also develop in response to identify the substance and where someone has used it.

[1] See https://hmiprisons.justiceinspectorates.gov.uk/news/chief-inspectors-blog-drugs-and-disorder-worrying-times-for-prisons/

The lack of knowledge of these substances and their effects – both amongst people using them and professionals who might respond – means there are potentially greater risks compared to more established drugs. Attempts to keep up with these developments can create a vicious cycle, as restrictions and attempts to control supply could push people towards ever evolving substances, with increased risk.

2. What impact does the presence of drugs have on the mental and physical wellbeing of prisoners, particularly vulnerable prisoners or those not previously involved in illicit activity?

Using substances can exacerbate mental health issues, and it can be a challenge to maintain recovery from substance use issues where drugs are readily available. The use of drugs in prison is also linked to debt and exploitation by organised criminal groups, increasing people's vulnerability.

Substances delivered to or manufactured in prison are particularly unpredictable, and we understand that the most vulnerable prisoners are coerced to 'test' these substances by using them for the first time. This places them at risk of serious health harm.

3. What is the impact of drugs on the safety of the prison environment for prisoners and staff?

Drugs can lead to two key types of risk to prisoners and staff, through their use and their supply.

An individual cannot be certain of exactly the substance they are using or the dose, the likely effects and possible risks. This is even harder to judge for new substances, not well known to either people using them or support staff. Individuals may become less predictable and reasonable when intoxicated, or through addiction, posing risks both for staff and other prisoners. There are also some risks to staff from second-hand exposure to drugs.

The criminality and violence associated with the supply of drugs is intensified in prison, and can pose risks to both prisoners and staff through exploitation and threat. In such an atmosphere, it can be difficult to deliver a safe environment for positive rehabilitative activity of any kind.

Tackling demand

8. How effective are existing measures, such as substance-free wings, in tackling the demand for drugs in prisons?

Support for serious substance use issues is most effective when it is intensive, with suitable resources and space. Well-run drug recovery wings (DRWs) and incentivised substance free living (ISFL) units can provide this.

However, these initiatives require appropriate resourcing and buy-in from senior management and

staff to create the right setting, culture and referral pathways, which is not always present. In some cases we understand that these units are used as a location of last resort for prisoners who do not have substance use issues.

There are also challenges with coordinating funding and support in these units. While the facilities have been developed with specific funding and oversight by HM Prison and Probation Service (HMPPS), there has been no corresponding investment in the treatment and recovery services, which are commissioned by NHS England (NHSE) within wider healthcare contracts. Some areas also report that national models of service design can lack both consistency (with different prisons having different levels of resource and buy-in) and flexibility, restricting innovation.

Even where they are effective, ISFLs and DRWs may be limited in their impact on substance use across a whole prison. Most obviously, they can support only a limited number of people. They are also designed for a particular model of problematic substance use, treatment and recovery. People who do not have a pre-existing substance use issue, but see their problems as a reaction to the prison environment, are less likely to seek out or accept help from treatment and recovery services. While assertive outreach work with these individuals has proved effective in some locations, this takes considerable additional resource, which is not always available.

Reducing overall demand for drugs in prison requires directly tackling the underlying causes of much substance use: boredom and fear. If prisons were safer, with good access to mental health support and ample opportunities for structured, engaging, purposeful activity, substance use would decline, along with reoffending.

9. What impact does drug testing have on reducing demand in prisons, and to what extent is HMPPS's current approach to drug testing effective?

Initiatives such as drug testing are most effective when they result in swift and certain consequences,[2] but there are two current challenges in applying this in prison.

First, testing is not applied comprehensively or consistently such that people using drugs in prison expect to be tested. This is partly because use of drugs is now so widespread that it would be impractical to test everyone who might be using. And where someone does test positive, they should be referred into treatment – but there is no national protocol to promote this.

Second, today's drugs market features rapidly changing substances, with testing protocols and technology playing catch up. For drug testing to be comprehensive, it must become ever more complicated, but as noted above this can push people towards newer, riskier drugs.

Testing should be part of a broader approach to screening people's support needs. Given that many people develop substance use issues after arriving in prison, screening should not be a one-off activity

[2] See, for example, https://journals.sagepub.com/doi/full/10.1177/0141076816682366

on entry, particularly as they may not have the trust in staff to disclose substance use at this initial stage. People should instead have their needs assessed and proactively monitored as they go through their time in prison.

10. What role should prison governors and staff play in identifying and addressing drug misuse?

The involvement of governors and prison staff in the design and development of specialist substance use treatment and recovery support is limited by the current funding and commissioning arrangements.

At present, these services are included as one element of general healthcare contracts arranged and monitored through NHSE. This distances provision from the prison and its staff and overlooks key outcomes that treatment should be delivering. Treatment can be effective in reducing reoffending and shrinking the market for drugs in prisons, both of which are key outcomes for prison governors. But neither of these elements are included as key performance indicators for prison-based treatment services, as they are not healthcare outcomes.[3]

Crucially, addressing substance use issues should entail addressing the personal, social and economic factors that can shape these issues – but equally, if we get them right, can promote recovery. If we are to address the harm from substance use effectively, we therefore need to take a wider view of people's lives and environment, and ensure prison staff and governors prioritise space and resources for meaningful activity.

But by placing the responsibility for specialist services within wider healthcare, there is a risk that prison staff and leadership see substance use issues more generally as the domain of healthcare, and are not aware of the wider contribution they can make to supportive environment that identifies and addresses these issues.

There are nevertheless positive examples of prison staff addressing substance use directly. For example, in HMP Erlestoke, officers are trained as facilitators of SMART groups – a form of mutual aid to support people looking to change their substance using behaviour.[4]

Support for prisoners

11. To what extent is drug treatment and healthcare in prisons effective?

- To what extent are there sufficient resources and trained professionals to support prisoners with their recovery?
- How effective are screening tools in identifying individuals with drug-related issues at the point

[3] See https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2024-to-2025/nhs-public-health-functions-agreement-2024-to-2025#key-performance-indicators

[4] See https://smartrecovery.org.uk/

of entry?
- How effective are current practices for the continuity of drug treatment services post-release?

Dame Carol Black has conducted a review of prison-based substance use treatment, and has already outlined her recommendations to the Government. Although the sector has not seen the report or recommendations, we actively supported and participated in the review and would urge the Government to act on what it already knows and work with the sector to improve support.

Treatment in the community demonstrates what the sector can achieve when there is investment and strategic leadership of this agenda. As part of the previous government's drugs strategy, there was significant investment in substance use treatment and clearly stated ambitions to increase the number of people accessing treatment in the community and improve the proportion of people with a substance use need identified in prison who go on to access support in the community on release ('continuity of care').[5] Both elements had headline metrics in the drugs strategy National Outcomes Framework.[6]

This results are clear. More people are in treatment in the community than at any point since 2009-10, and progress is being made at an impressive rate, with 2023-24 seeing the largest rise in adults in treatment since 2008-09.[7] Similarly, the continuity of care rate has improved dramatically from 33% in 2019 to over 54% today.[8]

The contrast with prison settings, where there has been no equivalent strategic focus, performance management or investment, is instructive. While there has been a steady increase in the number of people accessing support in prison in the last three years, numbers remain well below pre-COVID figures. The prison data series starts in 2015-16, and the 2023-24 figures were down 17% from that high starting point.[9] In the community, the comparison is an 8% increase.

We have noted elsewhere in this submission that current models and resources in prison are insufficient to engage the full range of people who might benefit from support, notably those who use non-opiate or new synthetic drugs. Again, this directly contrasts with community settings. It is people using alcohol or drugs *other than* opiates who have seen the biggest increases in engagement in treatment in the community, demonstrating that where there is investment and focus, services can

[5] Initial funding was available prior to the 2021 publication of the drugs strategy (e.g. https://www.gov.uk/government/news/148-million-to-cut-drugs-crime) and then the drugs strategy saw additional funding (e.g. https://www.gov.uk/government/publications/extra-funding-for-drug-and-alcohol-treatment-2023-to-2025) and the National Outcomes Framework

[6] See : https://www.gov.uk/government/publications/drugs-strategy-national-outcomes-framework

[7] See https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report

[8] See https://www.ndtms.net/Monthly/ContinuityOfCare

[9] See https://www.gov.uk/government/statistics/substance-misuse-treatment-in-secure-settings-2023-to-2024

provide an attractive offer for a wide range of people who need support.[10]

12. What improvements can be made to the commissioning and delivery of drug treatment services to ensure better outcomes?

The current structures and processes of substance use commissioning do not give this specialist service the necessary resource or strategic focus required to deliver its full potential impact.

In 2021, Dame Carol wrote that provision for substance use treatment and recovery in the community 'urgently needs repair'.[11] The same description could perhaps be applied to the prison setting today.

The Government already has the diagnosis of the problem from Dame Carol's corresponding internal report on prisons, and we also have the evidence of what has worked to turn a similar situation around in the community.

We therefore recommend that there should be new, dedicated investment for substance use treatment in prison, and a clear strategic focus on this issue from all relevant departments and agencies.

The current arrangement of sub-contracting substance use treatment and recovery services as just one element of a general healthcare contract narrowly positions substance use treatment as a healthcare service under the remit of the NHS, which is at odds with both the type of work being done and the outcomes it delivers.

Substance use issues are shaped by wider factors including prior trauma, mental health, and social and economic issues such as employment and housing, and effective treatment must therefore take a similarly broad approach, using psychosocial interventions and linking to broader work and meaningful activity. This is particularly important in prison, where mental health issues are much more common than amongst the general population.[12]

Treatment and recovery services also deliver outcomes that stretch beyond health, reducing reoffending and reducing the illicit market for drugs in prisons.

The risk in the current arrangement is that healthcare commissioners and providers, with many other areas of concern, may not give substance use issues the specific attention and resource they need,

[10] See https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report#trendsover-time
[11] See https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery
[12] See https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/96306.htm

and they are unlikely to prioritise the wider outcomes that could be delivered.[13] Conversely, prison staff and senior management – for whom those outcomes are potentially invaluable – are not directly involved in service design and contract management, so are less involved in driving these key outcomes and making essential links to wider supportive work.

These arrangements can also limit the influence and effectiveness of wider investment across the system. For example dedicated drugs strategy roles within HMPPS do not have a formal role in commissioning substance use services , where they could potentially add value.[14]

Partnership structures in the community – including links into prison – have been central to driving improvements in outcomes, mirroring joined-up leadership within central Government.[15] Comparable structures and processes involving all the relevant partners are not in place locally to oversee and drive improvement in prison treatment.

We recommend that substance use treatment in prison is directly commissioned as a dedicated service, and overseen by a partnership of stakeholders with a specific focus on wellbeing and social functioning including reducing reoffending.

Such partnerships could also improve efficiency of relevant wider work. For example, there are currently at least four separate services and systems in operation to help improve continuity of care, from NHSE's RECONNECT, the Probation Notification and Actioning Project (PNAP)Treatment, community treatment providers conducting in-reach to prisons, and probation commissioning rehabilitative services for substance use, often separate from local authority commissioned services.

We recommend that the Office of Health Improvement and Disparities, HMPPS, and NHSE coordinate activity to support people who leave prison with a substance use treatment need.

13 Overall, what progress has been made to date on implementation of the Government's 10-year 'From Harm to Hope' drug strategy in relation to tackling drugs in prisons?

The Conservative Government described *From Harm to Hope* as the 'formal, substantive response to the Independent Reviews of Drugs led by Dame Carol Black and accepts all of her key recommendations', but those reviews did not include treatment in prisons.[16]

Dame Carol recommended specific changes in funding and governance for community-based

[13] Reducing reoffending and affecting overall substance use in prisons are not key performance indicators as part of NHS healthcare in prisons contracts: https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2024-to-2025/nhs-public-health-functions-agreement-2024-to-2025#key-performance-indicators

[14] See https://www.gov.uk/government/publications/process-evaluation-of-hmpps-roles-supporting-the-drug-strategy

[15] See https://publications.parliament.uk/pa/cm5804/cmselect/cmpubacc/72/report.html

[16] Taken from https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

treatment, and the injection of new funding and a revitalised approach to governance and oversight of this agenda has delivered results in the community.

By contrast, the commitments made in *From Harm to Hope* in relation to prison-based treatment were more limited, and as a result there has been less progress. Just two of the Government's commitments in the strategy referred to prison: restricting supply and continuity of care.[17] Neither of these focus on delivering substance use treatment in prison, and where there has been progress on continuity of care this has been driven to a considerable extent by investment and oversight on the other side of the prison gates, in the community treatment and recovery system.

If we are to deliver real change in prison-based treatment, we need to look beyond *From Harm to Hope*, which was fundamentally limited in scope. Dame Carol's more recent internal review of prison drug treatment could be the basis for a cross-government approach to improving support in prison for people who use alcohol and other drugs. We look forward to working with the Government and the full range of stakeholders to ensure that people can access the support they need.

[17] Worded as: 'restricting the supply of drugs into prisons – technology and skills to improve security and detection' and 'keeping prisoners engaged in treatment after release – improved engagement of people before they leave prison and better continuity of care into the community'.