ACMD

Advisory Council on the Misuse of Drugs

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Dear Sir/Madam,

Call for Evidence - Custody-Community Transitions

I am writing to you to request your assistance in relation to the Advisory Council on the Misuse of Drugs' (ACMD) Custody-Community Transitions Working Group.

The Custody-Community Transitions (CCT) Working Group has been established following concerns over the increasing harms related to drug use among offenders. Levels of drug use are high amongst offenders, and people entering and leaving custodial settings are known to be particularly vulnerable to harms, including death by overdose.

The group will focus on identifying the harms associated with transitions between custody and the community. The inquiry will identify existing recommendations in this area and ask to what extent these have been implemented. The CCT final report will specify the barriers and opportunities for more effective implementation and will assess if there is a need for new or adapted recommendations.

The Working Group will consider issues that are relevant to transitions by adults (aged 18 or over). It will include a specific focus on the needs of women and of people of black and minority ethnic origin.

The ACMD set up the CCT Working Group in 2017 under the Chairmanship of Alex Stevens, Professor in Criminal Justice at the University of Kent.

The ACMD is holding the CCT Evidence Gathering Public Meeting on **08 June 2018**; where the Working Group members will consider both oral and written evidence from key stakeholders (venue: **Park Plaza Country Hall)**.

The ACMD would like to invite you to submit both oral and written evidence as part of this Inquiry. Please confirm whether you will be willing to deliver a presentation at the Evidence Gathering Inquiry on 08 June 2018 or if you intend to submit written evidence to the working group.

We would request that oral presentations are submitted by **01 June 2018** and written evidence is submitted by **20 June 2018**. Please forward your evidence to Matthew Gavin at Gavin.Matthew1@homeoffice.gsi.gov.uk

Please note if the ACMD receives a large response to its call for evidence, then a further meeting may be scheduled at a later date to take additional oral evidence.

We would appreciate if you could kindly address the questions listed below within your oral and/or written evidence.

Although your expertise might be better suited to tackling only a subset of the following questions; it would be very helpful if you were to address as many questions as you can, especially in your written evidence. Your oral presentation may need to be more focused to fit into the time available for each presentation (up to 20 minutes).

Q1. What are the most important harms and benefits associated with transitions between custody and community by people who use drugs?

We are specifically interested in evidence on:

a) Recent developments in drug-related harms in police custody.

While not necessarily a *recent* development in drug-related harms in police custody, we are very concerned about ongoing drug-related deaths in police custody and lack of preventative action in this area.

The law clearly states that if a police officer has “reasonable grounds for believing that a person” in their custody “may have swallowed a Class A drug”, that in response a senior officer “may authorise that an x-ray is taken of the person or an ultrasound scan is carried out on the person (or both)” by medical professionals and with consent.[1] However, it necessitates that a person suspected of swallowing controlled drugs is brought into the care of medical professionals. It is therefore entirely inappropriate for police officers to physically attempt to retrieve suspected drug packages themselves. In 2011, the Independent Police Complaints Commission (now the Independent Office for Police Conduct or IOPC) reported on one case where brutal “techniques” used to retrieve a package included "pinching his nose, kicking him in the face, using a baton on his throat like a rolling pin and then using the baton to try and force his teeth apart".[2] This is sadly still and ongoing issue, as the IOPC reported this year on a case where “where a person is fleeing the police or apparently swallows drugs to evade arrest” which was described as follows: “Police are informed that a man is apparently selling drugs and they approach the suspect. On sight of the officers, the man is seen to swallow a package and immediately

begins to choke. Officers attempt to retrieve the package and provide first aid, however the man dies on arrival at hospital".[3] Several deaths have also been recently reported in the media where the individual was under police restraint after allegedly swallowing drug packages. In some of these cases, not only are these people victims of police brutality but they are demonized and blamed on the basis they are suspected drug dealers, this is in the absence of evidence or any finding that they were in fact supplying drugs. Following the outcome of an investigation into Rashan Charles' death, Weyman Bennett, co-convenor at Stand Up To Racism, commented:

> *"We now know that the initial statements put out at the time of Rashan's death were misleading or outright lies. Justification for his death looks increasingly at the hands of those people that forcibly restrained him. The attempt to smear Rashan as somebody involved in drugs was an attempt to assassinate his character. We hold the police wholly responsible for these false statements that were put out, and we demand justice for Rashan."*[4]

The Home Office recently reported that, in England and Wales between 2004/05 and 2014/15, "drugs and/or alcohol" featured as a cause in 49% of the deaths in police custody and that the most common reason for detention in these cases was for a "drink and/or drug offence" (19%). The report rightly identified that "screening processes for arrestees on their reception into custody are important for identifying risks for police detainees".[5] Yet, it is not clear what specific action is being taken to prevent further avoidable drug-related deaths in police custody. We would therefore recommend the following specific actions:

(i) Police officers must assess whether someone in their custody is at risk of drug-related harm or death due to drugs ingested and should receive training in this area, such as overdose awareness training, to support the assessment;

(ii) If an individual in police custody is assessed as being at potential risk of drug-related harm or death due to drugs ingested, this should trigger an immediate and urgent medical examination by a medical professional. Under no circumstances, should police attempt to forcibly remove suspected drug packages themselves;

(iii) Police officers should receive training on naloxone administration and should carry naloxone in order to prevent opioid-related overdose deaths in custody.

b) Recent developments in harms related to the use of novel psychoactive substances (NPS) in custodial setting.

Despite a significant body of evidence suggesting that random mandatory drug testing (rMDT) is costly, an ineffective deterrent and can exacerbate drug-related health harms for people in custodial settings[6], rMDT continues to be adopted in UK custodial settings. These points were recently as stated by Joe Simpson, assistant general secretary of the Prison Officers Association:

> *"What has the MDT done? I think it's taken prisoners from soft drugs to hard drugs, that's what it's done because, when I joined, the drug of choice was marijuana, that was it. Now it's all cocaine, heroin, New Psychoactive Substances. Why? Because it stays in the system less so they've got a better chance of beating the MDT because when they are found to be positive, we punish them."*[7]

The EMCDDA has warned that the recent introduction of rMDT for *some* synthetic cannabinoids in the UK is likely to be ineffective at deterring drug use and exacerbate drug-related health harms due to drug substitution, such as with synthetic opioids.[8] Detection of these drugs also has the potential to create harms associated with the

criminalisation of possession of a psychoactive substance in a custodial setting[9] (please refer to Question 1(g) for more information on this point).

c) Recent developments in harms and benefits related to the transition of people who use heroin between the community and custody (on entry to custody and on release).

There is clearly a very high risk of premature mortality for people who use heroin (and indeed people who use opioids more broadly) when they are released from prison, compared to the general population.[10] To reduce the risk of such premature mortality, national naloxone programmes have been implemented in Wales, Northern Ireland, and Scotland; part of these programmes provide (as well as monitor and report on) take-home naloxone (THN) to people released from custody.[11] Yet, it is entirely unclear whether THN is being provided to people released from custody in prisons in England. Release is aware that NHS England conducted an audit of THN provision to people released from custody in England and is currently in the process of appealing a denied freedom of information request for this information. Last month, a government response to Grahame Morris MP on the issue stated:

> *"Information on how many prisoners are provided with naloxone when released from prison in England is not currently available. This data is due to be published in 2019. […] There is no national programme that mandates the supply of Naloxone for at-risk prisoners on their release, and the Government does not have any plans to bring forward legislation to make this a mandatory requirement for prisons. The commissioning of substance misuse treatment for prisoners is the responsibility of health and justice commissioning teams in 10 of NHS England's area teams, supported by a central health and justice team. The Government expects commissioners and providers of substance misuse services in prisons and in the community to work together closely in respect to prisoners being released from custody to ensure seamless transfers of care."*[12]

This suggests that THN provision is being pushed onto community providers, which is very concerning considering that last year only 30.3% of adults leaving prison went on to engage with community treatment within 3 weeks of their release[13] and that Release's research found THN provision in the community to be wholly inadequate[14].

In response to a freedom of information request from Release, the National Probation Service also confirmed in August 2017 that "there are no arrangements in place for the National Probation Service in England to supply offenders with THN kits". In the absence of a reason for not providing the life-saving medication to people under their supervision, we would speculate that this could in part be related to requirements to be drug-free while on probation.

In addition to the above, people who are prescribed OST in custody and released without a prescription are at a very high risk of premature mortality. This is known to be a particular issue for people released from custody on a Friday afternoon that are unable to attend an appointment with a community prescriber before the weekend, or in areas where communication between service providers in custody and the community is poor. To prevent premature mortality among this group, we would recommend that people released from custody should be provided with at least a 2 week prescription of OST, either to take-home or to pick-up[15].

d) Development of diversion from custody provisions for people with substance misuse issues.

The current state of UK prisons is unacceptable due to overcrowding and understaffing. Government figures show that UK prisons are well over their recommended capacity levels[16], which is likely a contributing factor to the high levels of self-harm and suicide[17]. Development of diversion for those with drug dependency should therefore be a priority to enable the government to keep the prison population low. Yet, the prison population continues to grow. Adult offenders convicted for indictable offences are now substantially more likely than they were in 2010 to receive some form of custody – 31.8% now versus 23.9% - and the average custodial sentence length increased for these offences over the same period – from 15.2 months to 20.0 months.[18] There is therefore an urgent need to reassess diversion from custody, not only for those convicted of drug offences, but also for all drug dependant offenders.

In addition to the above, there has been a marked increase in suspended sentences over the past 10 years: from 4,000 in 2005 to over 52,000 in 2015[19]. It should not be forgotten that these are in fact custodial sentences; indeed, despite initially being suspended they often mean an actual period in custody is triggered for the offender, where diversion would have been a more appropriate outcome. This problem is becoming so acute that Lord Justice Treacy recently felt obliged to write a letter on behalf of the Sentencing Council to ask Judges, Magistrates and Probation Officers to address this issue, asking for all those involved to be mindful of appropriate sentencing guidelines and emphasising that suspended sentences should not replace Community Orders (COs) in the relevant cases[20]. LJ Treacy's letter states that by the same token, COs have decreased from about 203,000 in 2005 to less than 108,000 in 2015[21], where in fact these would have often been a more appropriate sentence than custody. The decline in COs has apparently been most marked in terms of theft and drugs offences[22]. However, it is important to note that COs are not without their own issues in terms of efficacy and rehabilitation, with about a third of those subject to CO's in 2014 having been caught reoffending within a year of being sentenced and a large majority of the prison population having already received at least one community sentence (76% in 2014)[23]. The system is therefore ripe for an overhaul and needs far more resources than it currently has.

In terms of CO Treatment Requirements for people with drug dependency issues, it is questionable as to whether Drug Rehabilitation Requirements (DRRs) are fit for purpose. The Ministry of Justice's Service Specification for Support Delivery of DRRs states that current government policy "supports a move from a harm reduction approach to one of abstinence"[24]. This approach concerns us, as we believe that harm reduction should always be the overarching aim in terms of drug dependency and that an abstinence based approach *per se* is not necessarily an achievable or desirable goal in terms of each individual case. The 'Strategic Context' of the DRR delivery document also accepts that widespread research has concluded that expenditure on drug treatment "leads to significant savings on the health and social costs associated with drug misuse"[25]. In particular, where completed, DRRs can show a very marked decrease in re-offending rates in comparison to uncompleted/revoked DRRs[26]; the issue is of course enabling these DRRs to be completed as successfully as possible to allow for the best outcomes for both the individual and society. This area needs serious investment and huge cuts in treatment provisions have meant that not only have DRR programmes not had the chance to be further developed for success, but also that the referral rate is at risk in the first place where treatment providers cannot provide a place or the level of care needed. Given the current crisis in funding which seems to be worsening[27], questions therefore need to be asked as to whether cuts in treatment are restricting the availability of DRRs in the first

place and whether this is contributing to the increase in custodial sentences for those with drug dependency issues (please refer to Question 3(d) for more detail on funding cuts).

A number of police forces in the UK have rightly adopted models of policing that seek to divert people into educational and health settings for drug possession offences and other offences. Durham Police force has implemented a diversion scheme for a range of low level offences, this initially included drug possession offences and some acquisitive crimes, but due to the success of the scheme this has been extended to include low level supply offences, where the offender is determined to be a user/ dealer. [28] Durham's scheme, 'Checkpoint', diverts people after arrest on the condition that they undertake a four month programme to address their offending behaviour; as long as they comply, there will be no criminal record. Some initial findings from the pilot period found those who were diverted to Checkpoint had lower re-offending rates compared to those who were subject to out of court disposals, such as cautions. Participants in Checkpoint also reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances; and mental health.[29] Avon and Somerset police have also implemented a street diversion scheme that sees people caught in possession of a controlled drug – regardless of previous convictions – referred to their Drug Education Programme. [30] The experiences of Avon and Somerset and Durham Constabularies have led other police forces and police and crime commissioners to consider implementing similar schemes. West Midlands Police and Crime Commissioner published a report on tackling drugs in their region and recommended that people be diverted away from the criminal justice system for low level drug offences[31].

e) The distribution of such harms and benefits across different groups of people who use drugs as they move in and out of custody (e.g. by area of deprivation, housing status gender, race, age, drug use pattern, remand/sentenced prisoners).

Black and minority ethnic (BME) groups are hugely over-represented in prison, as they make up 26% of the prison population (despite making up 14% of the general population).[32] BME groups are also known to have particular treatment needs related to substance misuse.[33] Yet, specialist services for this BME groups are entirely lacking in both custody and community settings, with substance misuse services moving towards integrated (or 'one-size-fits-all') models of provision.

HM Inspectorate of Prisons has rightly noted that "Women are under-represented in drug treatment services and report less drug use in the community than men, but levels of drug dependence among female prisoners have been found consistently to be higher than among male prisoners".[34] It is also widely accepted that women have particular treatment needs related to substance misuse and experience particular barriers to accessing non-specialist (namely group-based, mixed-gender) substance misuse services.[35] Yet, specialist substance misuse services for women are also entirely lacking in community settings, with a recent report finding that "only around half of all local authority areas in England (n=74, 49.0%) and five unitary authorities in Wales (22.7% of all authorities in Wales) are home to localised support specifically for women", among other identified deficiencies.[36]

With 52 per cent of women reporting use of heroin, cocaine or crack cocaine in the four weeks before being imprisoned[37], it is critical that diversionary schemes are implemented and that drug treatment focuses on providing women specific services. Arguably, the barriers to community drug treatment for women, especially those who are mothers, is compounding the situation whereby women delay accessing treatment services because of the fear of their children being taken into care.

In connection with question (d) above concerning the development of diversion from custody provisions for people with substance misuse issues, we would like to draw attention to particular issues facing women in custody with dependent children. According to a parliamentary debate earlier this month, which recognised "the significant impact that the imprisonment of a parent has on their children", approximately 60% of women in custody have children but there is no data collected on the age of the child or whether they were dependants at the time of the mother being taken into custody. The average length of stay for women in prison recorded as having children is 1.5 years and most are in custody for non-violent offences [such as drugs offences][38]. Given that at least a fifth of women prisoners are lone parents in comparison to 9% of the general population and that only 9% of children whose mothers are imprisoned are cared for by their fathers[39], arguably a high proportion of dependent children are at risk of being taken into care while their mothers are in prison.

Given the huge impact on children that being taken into care can have, including vulnerabilities among this group, this is an area that seriously needs addressing. There should be far greater support in terms of managing the potential harms on dependent children and to this end diversion from custody should be encouraged, especially where women with dependants are concerned. This area urgently needs funding and diversion could allow for this given that imprisoning mothers for non-violent offences not only has a damaging impact for children but also costs the state more than £17 million over a 10-year period, as children of prisoners are three times more likely to have mental health issues.[40]

As such, we are concerned that the particular treatment needs of BME people and women who use drugs are not being met as they move in and out of custody, compared to their white and male counterparts. The particular experience of women in custody with dependent children also merits urgent attention.

In addition to the above, we would like to highlight the particular harms experienced by people who use drugs claiming housing benefits (whether for social housing or private rented accommodation) as they move in and out of custody. Housing benefit can currently be paid for up to 52 weeks for people remanded in custody and up to 13 weeks for people sentenced to custody[41] (which is the equivalent of a 6 month sentence where release occurs at the halfway point). Because the onus is on the individual claiming housing benefit to notify their local council that they are going into custody, many fail to do so during this turbulent time in their lives. As a result, Release frequently works with clients who are face proceedings for benefit overpayments once they are released. Or, where the local authority is aware of their imprisonment and rent is not paid, they incur rent arrears, and potentially lose the property while in custody. Subsequently their ability to apply for housing upon release is negatively affected because there is a risk that they will be considered "intentionally homeless" (one of the conditions of housing under homelessness legislation) by virtue of having gone to prison. A lack of basic needs, such as housing, in these cases will make it extremely difficult for people who use drugs to address any potential substance misuse and/or offending behaviours and thus rehabilitation.[42]

Please refer to Question 2(b) for more information on the particular situation of remand prisoners and OST prescribing.

f) How these harms are likely to develop as the average age of people in prison and of people with heroin problems increases.

The specific harms to women and BME people who are imprisoned is highlighted above. However, there are specific harms related to the prison population as a whole in respect of an ageing cohort of people who are dependent on heroin. The issue of comorbidity and long term health conditions amongst this group has been well documented.[43] As such, such conditions should be addressed by health professionals both in custody and community settings. Although, ultimately imprisoning people for nonviolent offences needs to be urgently addressed because of overcrowding and poor prisons conditions, as highlighted above. The situation in terms of healthcare within the prison estate is worsening due to high levels of 'isolation, lack of purposeful activity, mental health problems use of NPS' all of which is contributing to increased rates of self-harming and attempting suicide.[44] The lack of prison staff is compounding the situation resulting in a restriction to access to health care for prisoners. It is clear that the prison estate simply cannot meet the health needs, especially mental health issues, of those who are imprisoned and that the situation is at crisis point. It is therefore likely that in many cases the specific group of people who have a history of heroin dependency and are ageing are not having their health needs met, despite the State having a duty to provide medical treatment in custody settings.

There are also a number of social issues that this group face on release from prison. This includes significant barriers to accessing the job market as a result of long gaps in employment history due to dependency and imprisonment. With 80 per cent of people who use drugs problematically out of work[45] it is imperative that routes to employment are addressed, this could include tax incentives for employers to recruit people who have a history of dependency and/or offending (please see Question 4(a) in respect of international practices in this area). In addition, as highlighted in Question 1(e) lack of access to housing and housing insecurity are also significant issues for people coming out of prison, with many refused local authority accommodation on the basis that they are 'intentionally homeless'. Issues of family contact are also significant as relationship breakdown is a common experience for many of those who have a history of drug dependency.

Frankly, prison has become largely about punishing individuals and authorities have failed in their duty to help people to rehabilitate their lives. The current conditions in prison mean rehabilitation is impossible. This is why diversion from custody is crucial but it is not enough to simply address someone's drug issues but also to ensure social integration – if we want to improve people's lives then it is imperative that properly funded schemes around employment, education and housing are implemented. At the moment the prison estate is simply an expensive warehousing system, by significantly reducing the prison population through diversion, funding could be utilised to really address some of the fundamental needs of people who have a history of dependence.

g) In what ways the current legislative framework affects these harms and benefits.

Whilst not legislative the impact of the Sentencing Council's 'Drug Offences Definitive Guideline'[46] cannot be underestimated. When this was originally consulted on in 2011 the Sentencing Council stated that their aim was "to ensure that all sentences are proportionate to the offence committed and in relation to other offences"[47] and that "the guideline aims to increase the consistency of sentencing".[48] The applicability of the Guideline has a legislative basis by virtue of Section 125(1) of the Coroners and Justice Act 2009 which provides that for offences committed after 6 April 2010: "Every court – (a)must, in sentencing an offender, follow any sentencing guideline which is relevant to the offender's case, and (b)must, in exercising any other function relating to the sentencing of offenders, follow any sentencing guidelines which are relevant to the exercise of the function, unless the court is satisfied that it would be contrary to the interests of justice to do so."[49] In light of these objectives and the

statutory requirement, sentencing Judges are generally bound to follow the starting point and ranges contained within the Guideline – strict application of this can cause unfairness and result in harm in some situations.

An example of this is the situation related to 'street dealers' which automatically sees an individual deemed as selling directly to users moved from then lowest category of harm – 4 – to category 3, regardless of the amount if drugs involved. Similarly, as soon as there is any element of gain – even where this is not directly financial - a defendant is attributed a significant rather than lesser role. Whilst a defence lawyer would argue that a defendant should be placed in the lesser role, regardless of gain, the Crown Prosecution Service routinely argue for the more serious position. So, the worst case scenario for someone who uses heroin problematically and supplies 2 grams to another user in order to fund their own use will be faced with a starting point of 4 and a half years, within a range of 3.5 – 7 years. There is not even an option for a suspended sentence, combined with a CO, in this scenario because these can only be given for sentence that are up to 2 years in duration. The personal circumstances then only really mitigate down from the starting point towards the lower end of the range. The absurdity of the process is highlighted at this point where a recognised factor reducing seriousness is "supply only of drug to which offender addicted"[50], whereas these very circumstances are what has placed them in such a serious position in relation to sentence.

Someone who is sentenced to immediate custody in this way will then be placed at risk of experiencing all of the other harms associated with prison, and later transition back to the community, discussed throughout this submission. In contrast, local initiatives like Checkpoint in Durham, which is discussed in more detail at 1(d) above – have extended their diversion schemes to include low level dealing between users, in addition to simple possession offences.

The Psychoactive Substances Act 2016 presents its own additional harms in relation to custodial settings. Section 9 of this legislation creates an offence of possession within a custodial institution, which includes prison, and anyone found guilty of this is liable to a maximum sentence of 12 months in prison. This was a significant and worrying departure from the government's original position to not criminalise possession during the Bill's passage, which appeared to respond to media reporting of NPS use in prisons. Indeed, outside of a custodial institution possession of a psychoactive substance is not criminalised, and no explanation has been provided as to why it is deemed necessary to make this distinction. There is no justification to criminalise prisoners more harshly simply because of their already vulnerable position. Whilst there has been some concern expressed around the use of psychoactive substances, particularly synthetic cannabinoids, in prisons the creation of this offence will not deter use in these settings. As evidenced by numerous reports, including the government's own[51], a policy based on punitive user level sanctions has little impact on levels of use. We address the issue of NPS in prisons in more detail in response to 1(b) above.

This approach is completely incongruent to the one taken in relation to prisoners found in possession of drugs which are controlled under the Misuse of Drugs Act (MDA) 1971 (including many SCRAs). There is no specific separate criminal offence of possession of drugs in prison, and whilst it would still be an offence under section 5 of the MDA in practice this would normally be dealt with under the Prison Adjudication System. This discretion is permitted because possession of drugs is not on the list of offences which *must* be referred to police under 'The appropriate handling of crimes in prisons: Protocol between the National Offender Management Service, the Association of Chief Police Officers and the Crown Prosecution Service', and not one which inherently has any of the specified aggravating factors associated with it.[52] The joint protocol further states that "before reporting any incidents to the police, the prison will wish to consider each case to see if it can be dealt with by means of the Prison Adjudication System which can in some instances provide a relatively quick and cost effective means of dealing with minor crime in prisons."[53]

The ability to provide for effective diversion from custody to community disposals for those who are drug dependant is affected by the way that drug treatment and harm reduction services are funded, commissioned and delivered. Since local authorities became responsible for funding and commissioning these services under the Health and Social Care Act 2012, they have also faced an estimated 37.3% reduction in central government funding between 2010/11 and 2015/16[54]. "Drug misuse treatment" faced more reductions in funding than any other public health area in 2016/17 with a 14% reduction in funding between 2015/16 and 2016/17 and with further cuts planned up to 2020-21.[55] Localism has further created a 'postcode lottery' whereby service provision is inconsistent across the country. These reductions in funding are a "false economy"[56]; it is estimated that "for every £1 million taken out of the treatment system there could be an increase of approximately 9,860 drug-related crimes per year at an estimated cost to society of over £1.8 million".[57] More importantly, this negatively impacts on service users due to under-resourced and over-burdened services that are struggling to provide "support for people with complex needs".[58] There has also been a tendency to frequently re-commission these services over this period, often to the detriment of service users. This is supported by the ACMD's recent finding that frequent re-procurement of services was "costly, disruptive and mitigates drug treatment recovery outcomes".[59] Any effort to reduce the number of people being sent to prison for drug-related offences, and treat this as a public health issue, will require a halt to this programme of disinvestment and a renewed financial commitment to drug services.

For those returning to the community following a period in custody, a lack of financial resources and the welfare benefits system can create further barriers to a smooth transition. The travel warrant and discharge grant provided on release from prison are insufficient to meet someone's needs until they are able to secure social security benefits or paid employment. Applying for benefits in advance of release can be problematic, and is particularly difficult for people who use drugs and are too unwell to work, as they will be required to provide evidence of their medical condition and undergo an assessment in relation to their capability to work. Whilst Job Seekers Allowance is paid relatively quickly upon applying, many areas are now rolling out Universal Credit as the primary benefit, and this system has been fraught with payment delays. There is at least a 5 week wait from the date of application – 1 week 'waiting time' plus 1 month assessment – and the benefit is then paid monthly in arrears. This is simply impractical for someone who has been released from prison with virtually nothing, and increases the risk of reoffending in the early stages post-release.

Q2. What are the most important existing recommendations in this area, and to what extent have they been implemented?

We are particularly interested in:

a) Existing recommendations in relation to prison security as it affects drugs and NPS, and the extent of their implementation.

The current prison minister, Rory Stewart, has recommended increased body-scanners, dogs and fixing windows to reduce drug use in prisons, with rMDT rates as a measure of success.[60] Considering the cost and unreliability of sniffer dogs[61] and rMDT (please refer to Questions 1(b) and 4(b) for more detail on unreliability and negative effects) to detect drugs, we would advise against this approach and would instead emphasise the need for adequate healthcare provision for people who use drugs in custody (please refer to Question 2(b) for more detail on healthcare provision).

b) Existing recommendations in relation to the provision of healthcare in custodial settings to people who use drugs.

In our experience, there are large gaps in many areas of healthcare provision to people who use drugs, both when entering and during spells in custodial settings. Of particular concern is where, despite a recognition that co-occurring substance use and mental health problems are deeply embedded in custodial populations, very little has been implemented in almost a decade since the recommendations of the Bradley Report[62] to ensure that the needs of this group with 'particularly complex co-occurring needs'[63] are met. Another area of concern is the somewhat confusing and non-uniform approach to prescribing pain medication, either as an adjunct or replacement to, existing OST medication. This especially applies to gabapentin and pregabalin, where an audit of prescribing in prisons found 23 (of 94) sites used gabapentin (16) or pregabalin (7) as first line opioid therapy (contrary to recent guidance)[64], with other institutions refusing to provide these substances under any conditions. This inconsistency means prisoners may be inappropriately titrated from existing medications, and therefore are potentially receiving inadequate doses.

There is currently a lack of clear guidance on the appropriate management of opioid maintenance within secure settings, which appears to stem from a policy disparity between the most recent nationally accredited clinical guidelines on managing drug dependence (the 'Orange' guide) and those specifically issued earlier by the Department of Health (DoH) on prison based opioid maintenance. The latter document introduced the (seemingly arbitrary in terms of evidence base) figure of 26 weeks as a sentence length above which 'it should be explained that at an appropriate time there will be an expectation that the prisoner works towards reducing their dose of OST medication, and that abstinence remains the ultimate goal'[65]. By contrast, the latest Orange guide (2017) states 'It is difficult to justify on the basis of clinical evidence, a required withdrawal of OST from a prisoner based on a particular duration of imprisonment (not least in circumstances that their prescribing clinician and team consider that continuing OST is judged to be the treatment they still need).[66] Although these more recent guidelines would seem to supersede the earlier DoH ones, the 26 week figure has nonetheless proved resilient and we have encountered it being cited in justification for non-consensually reducing dose levels of prisoners on OST in the past 12 months.

In addition, the lack of needle syringe programmes in UK prisons leaves people who inject drugs in custody extremely vulnerable to HIV and viral hepatitis infections and other health harms[67]. While *John Shelley v United Kingdom* was not upheld, it is important to note that the main reason for this was because the appellant lacked legal standing. The decision not

to provide NSPs in UK prisons is still not justifiable[68] because the reasons for limiting the principle of equivalence[69] are not evidence based[70].

c) Existing recommendations in relation to the provision of healthcare for those serving community sentences who use drugs

In the context of severe budgetary restrictions resulting in "efficiency savings" and recovery-oriented performance management[71], we feel that the most important existing recommendations in relation to the provision of healthcare for this group are those recently proposed by the ACMD[72].

Release's legal team reports that some of our clients, who would potentially benefit from DRRs as part of a CO, do not often have the most appropriate requirements imposed because of external rather than individual clinical reasons. The most common example we encounter is clients who would benefit from residential treatment, but due to limited funding and/or places in residential treatment, community treatment is imposed instead. Or, more worryingly, a custodial sentence.

d) How recent developments in the management and commissioning of drug, alcohol and mental healthcare services in custody and in the community have affected the provision of healthcare services to people who have drug problems, and the extent to which existing recommendations are met.

Please refer to Question 5.

e) Whether there is scope for learning from different models of service delivery between countries of the UK.

Release and 21 MPs (from the Labour Party, SNP, Green Party, and DUP)[73] have called for a national naloxone programme to be implemented in England as a matter of urgency, after our research found THN provision to be wholly inadequate.[74] National naloxone programmes currently exist in Scotland, Northern Ireland and Wales; this facilitates recording/monitoring and ensures a level of consistency between local authority areas and accountability.[75]

f) Recent developments in information sharing between custody and community transition

A recent report published by the Ministry of Justice and PHE[76] indicated that if people using substances problematically get into treatment their offending reduces. However, this report also highlights that there is still poor pick-up of released prisoners who need further treatment by community-based treatment agencies, with only 30% being retained in treatment post-release.[77] This indicates that there are still significant barriers to information sharing and the smooth transition of those with substance use issues being returned to community settings, which will inevitably lead to greater rates of recidivism and significantly poorer health outcomes for the majority of people in this category. These issues are additionally often poorly jointly understood by those working in either mental health or substance misuse services, meaning an increased danger of people 'falling through the cracks' when being transferred between custody and community settings. A proper investment in specialist dual-diagnosis teams would be seen as a step forward in tackling this issue.

Q3. What are main barriers and opportunities to improve community-custody transitions for people who use drugs?

We are specifically interested in:

a) What mechanisms of support, accountability and management would facilitate the implementation of recommendations in this field?

One of the major issues related to transitioning from custody to community is the difficulties in accessing drug treatment in the community (as discussed above). It appears that there are no effective referral routes that ensure access, especially where someone is receiving OST in prison. It is therefore imperative that there is greater accountability between NHS England and local PHE bodies to ensure that those being released have ongoing access to their medication and that services are working together to ensure a seamless transition. More broadly, we would recommend that funding for drug treatment be shifted into NHS Commissioning practices, as recommended by the ACMD[78]. This may lead to greater accountability for patients and would also reduce the current risk around public health funding, which is not only susceptible to continued cuts but at risk of politicization locally. This is of particular concern moving forward when the ring fence for public health funding is removed in 2020, leading to financing for these areas having to be raised through local taxes.

In relation to the issues related to securing welfare benefits upon release from prison, as discussed at 1(g) above, there is a significant need for a joined up approach between MoJ and DWP to ensure that benefits can be paid swiftly. Where possible this should be through an advanced and expedited application process – establishing and using a care of address where necessary - that allows resources to be available upon release. Where this is not possible, short term advances should be applied for and be paid as a matter of course.

Similarly, the problems identified at 1(e) above, regarding lack of secure housing can be addressed by instituting a collaborative approach with local authorities to process housing applications in advance of someone being release from prison. Resettlement officer positions within prison should be funded as a priority to prevent problems transitioning at the point of release.

On a practical level, making sure that someone is not released on a Friday afternoon with no opportunity or recourse to access advice and assistance, and secure accommodation and income would greatly assist.

As mentioned above (in Questions 1c and 2e), a national naloxone programme in England would ensure greater accountability and management of THN provision to people released from custody to prevent premature mortality among people who use opioids following prison release.

b) How working relationships between national and local bodies can best support improved practice?

   See above 3 a)

c) How the current legislative frameworks and harms from experience of custody may act as a barrier.

   Please see 1 g)

d) How can the likely returns on investment that accrues to communities and criminal justice agencies through crime reduction be provided through the budgets that support the provision of health and other services that produce these benefits?

Crime reduction benefits have historically been the primary justification for providing health and other services for people who use drugs in the UK, despite the likely over-estimation of drug-related crime[79]. Instead, we would propose that people who use drugs are entitled to such services under the right to the highest attainable standard of health.

As the ACMD has reported, there have been substantial funding cuts to drug treatment and harm reduction services.[80] Some of the detrimental effects of reduced funding on service users include: "over-reliance on volunteers" at the expense of qualified clinical staff[81], higher caseloads, and "replacing one-to-one contact with group work"[82]. The UK government therefore is in violation of its core obligation of non-retrogression to progressively realise the right to the highest attainable standard of health[83], which cannot be justified on the grounds of resource scarcity[84], given its "misallocation of public resources" [85]. Instead of funding these cost-effective services, the UK government spent an estimated £1.6 billion in 2014/15 alone on drug law enforcement, despite being unable to demonstrate any impact on the availability of drugs and identifying many unintended harmful consequences of enforcement (e.g. "health harms from varying purity of drugs", drug market violence).[86] Law enforcement efforts were overwhelmingly targeted at possession offences, as 83% of all drug offences recorded by the police in 2016/17 were for drug possession and just under 76% of total drug offences recorded were for the possession of cannabis.[87] By decriminalising the possession of controlled drugs for personal use, resources could be diverted from the criminal justice system into health and other services for people who use drugs, thus ensuring a greater return on investment for communities and criminal justice agencies.[88]

Q4. Could you share any practices, including international approaches, that:

a) Appear to reduce harms (or maximise benefits) related to community-custody transitions?

As highlighted at Q1 (f) there are a number of social harms created by long term or repeated periods in prison.

Portugal implemented an employability scheme for people who have a history of problematic drug use called 'Life Employment' (Programa Vida Emprego, 'PVE'). The PVE scheme is available for a range of people including those engaged in drug treatment in a prison setting. Those participating in the scheme receive continued support from PVE coordinators, these coordinators also seek out potential employers and businesses who are willing to employ those on the scheme. There are financial incentives for employers including reimbursement of expenses linked to training apprentices in the scheme, and an 'employment support' contribution where PVE provides 80 per cent of salary costs for two years to employers hiring those who have had a history of dependency. Another element of the scheme is to provide a grant to employers for salary and social security costs totalling 12 times the national minimum wage. Employers qualifying for this scheme must commit to social integration and employment practices and evidence the outcomes of those employed, they must also commit to running the scheme for four years. In addition, the PVE will provide loans to people who have a history of dependency to set up their own businesses.[89] These kind of programmes can achieve the social integration which is so absent from the UK system.

In addition 'housing first' schemes should be made available to those leaving prison.

b) Appear to increase harms related to community-custody transitions?

One of our main concerns here is with the application of rMDT for recently detained prisoners; this is largely centred around the lack of robust testing methods, improper use of equipment, and inaccurate interpretation of results. This is exemplified in the approach to cannabis testing, where Prison Service Order 3601 stipulates that a positive reading in urine at +30 days from induction to custody can result in a charge being laid of intentional

administering of a controlled drug. Whilst allowance is made in the guidance for mitigating circumstances to be considered, in practice there is rarely adequate provision made for the detainee to explore these options, despite there being a considerable body of academic research to challenge the accuracy of using this time window as an irrefutable cut-off point for detection of last exposure. This also applies to an extent to other substances, such as certain opiates that have unusual half-lives, such as buprenorphine. The most common outcome of failing an rMDT is an extension to the detainee's sentence, which is not only potentially unjust but adds an additional financial burden to the state and contributes to overcrowding.

Q5. Could you share any examples of commissioning or managing services in ways that address the community-custody transition in ways that fulfil existing recommendations?

a) What are the commissioning or service delivery gaps around provision of drug testing and drug treatment?

Competitive tendering across virtually all spheres of drug treatment provision has created disparities in available services in different areas, and custody settings have not escaped this. There is unfortunately little incentive for community-based services to proactively engage with recently released offenders, due to two main factors: (1) the recommended post-release drug testing requirements are particularly onerous, in some cases unrealistically so; for cocaine/crack, for example, the recommended frequency of testing is 'minimum twice a week' for at least a 6-week period following the initial test, and potentially to the full 12 months for those on licence[90]. Whilst the cost of this may be met by National Probation Service and Community Rehabilitation Companies' central funds, this level of scrutiny is unlikely to encourage, and highly likely to deter, the individual from seeking assistance from the local community provider, who may well have their own testing protocols to satisfy additionally. There is often no standardised process for agreeing the minimisation of excessive testing requirements between custody and community based providers. (2) The often co-occurring physical and mental health issues, breakdown of social bonds leading to lack of housing stability and difficulty in accessing employment, educational and other welfare services experienced by former (particularly longer term or repeat) prisoners mean that they are a particularly vulnerable client group who require extra levels of attention and investment to achieve positive outcomes. Increasingly tightened budgets mean there is a lack of inducement to actively engage this population group beyond minimal statutory requirements.

The CCT Working Group's membership is listed in the Annex. Further details about the ACMD can be found at; https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs

I would like to thank you for your assistance in this matter and look forward to hearing from you.

Yours sincerely

Dr Owen Bowden-Jones
ACMD Chair

Professor Alex Stevens
Working Group Chair

Annex – ACMD Custody Community Transitions Working Group Membership

Membership from the ACMD

Professor Alex Stevens
Annette Dale-Pererra

Co-opted Members

Mark Gillyon-Powell
Lesley Graham
Charlie Lloyd
Majella Pearce
Mark Johnson
Simon Hudson

Secretariat

Matthew Gavin (Working Group Secretary)
Linsey Urquhart (ACMD Secretariat)
Zahi Sulaiman (ACMD Secretary)

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