



Advisory Council on the Misuse of Drugs

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Rt. Hon. Sajid Javid MP
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12 June 2019

Dear Home Secretary,

Re: ACMD report on Custody-Community Transitions (CCT)

The Advisory Council on the Misuse of Drugs (ACMD) has taken notice of emerging evidence on the increasing drug-related harms in prisons and related to transitions through the criminal justice system. In particular, the increased risk of death, including by overdose, in the weeks immediately following release to the community.

Previous reports by other experts in this field, including the group led by Lord Patel in 2010, had made recommendations to improve continuity of care. However, the extent to which these have been implemented across government is unclear. The ACMD sought to determine the most important existing recommendations and to what extent these had been implemented, and whether there was a need for new or adapted recommendations.

The ACMD invited stakeholders from government departments, service providers, and charities, amongst others, to submit evidence to the inquiry. The ACMD examined the evidence and identified substantial harms associated with transitions by people who have drug-related problems, including:

- High incidence of homelessness. Many prisoners under supervision from the National Probation Service or Community Rehabilitation Companies are discharged to unsettled or unknown accommodation on their first night of release. This increases the risk of relapse and reoffending.
- Adults serving sentences of less than 12 months in England and Wales had a reoffending rate of 64.4% between April and June 2017, with rates likely to be even higher among those with a drug problem.
- Increased risk of death. Death rates among those on post-release supervision, are many times higher than in the general population. The first few weeks immediately following release to the community is the highest risk period.
- Custody as an opportunity to reduce drug problems and offending was often squandered by failure to provide support on release.

There has also been a lack of systematic follow-up on and the fragmentation of responsibility for implementing previous recommendations. Previous reports had highlighted continuity of care as being critical. However, the latest data from PHE suggest that only 32.1% of people assessed as needing treatment when they leave prison enter treatment in the community within 21 days of release.

Equivalence of care between custody and the community has also been stated as important. Current policy outside prisons is to maximise access to naloxone (the medicine that reverses opioid overdose). Despite this, only 12% of prisoners who were previously heroin-dependent left an English prison with naloxone in 2017/18.

The ACMD makes the following **recommendations for systemic improvement** for transitions between custody to community:

1. That the Drug Strategy Board nominates one Minister who will have over-arching responsibility and accountability for the improvement of custody-community transitions for prisoners with complex health needs, including problems with drugs.
2. That this Minister be given the following mandate: To assess and improve performance in delivering officially accepted recommendations on transitions between custody and the community for people with substance misuse, mental health and homelessness problems. The indicators of progress in this area should include the following.
 - a. Reducing the rate of reoffending (within six months and after two years) of people who leave prison and who have an assessed need for drug treatment.
 - b. Reducing the numbers of people who die within four weeks of leaving custody (separated by police and prison custody) and while under the supervision of the probation services. These data should be collated separately for suicides and drug-related deaths, following the definitions that the Office for National Statistics uses for the general population.
 - c. Reducing the proportion of people who leave prison with unsettled or unknown accommodation on the first night of release.
 - d. Increasing the proportion of people who have an assessed need for drug treatment on release who enter treatment in the community within four weeks of release.
 - e. Increasing the proportion of prisoners who are assessed as having a problem with opioids who leave prison with naloxone.
3. That the Minister of Justice (England and Wales), the Cabinet Secretary for Justice (Scotland) and their counterpart in Northern Ireland take further steps to reduce the number of transitions into and out of prisons. This includes reducing the use of short prison sentences of less than 12 months and the number of people who are recalled to prison. This should involve:
 - a. reform sentencing to minimise the use of sentences of less than 12 months, with the aim of eliminating the use in sentencing of periods of less than 3 months in prison; and
 - b. reforms to the system of supervision on licence, so as to reduce the number of people who are recalled to prison.

We also make the following **practical recommendations** to reduce harms:

4. That the prison services of the UK take steps to minimise the release of prisoners with complex needs (including substance misuse) on Friday afternoons.
5. That the Department for Work and Pensions (DWP) should:
 - a. accelerate the introduction of the measures listed in the *Rough Sleeping Strategy* (MHCLG, 2018) to enable prisoners to access employment or Universal Credit immediately on release; and

- b. work in partnership with the courts and the National Probation Service (NPS) to ensure that people who are imprisoned are not overpaid the housing element of Universal Credit.
 - c. Following the completion of the evaluation of the pilots, implement the effective elements identified through evaluation
- 6. That the prison and probation services of the UK should develop and extend services that provide face-to-face, individualised support to prisoners who have drug problems in the run up to release and through the transition to the community.
- 7. That the Drug Strategy Board should make a clear statement that it is the responsibility of the national NHS bodies to ensure that all people who have an assessed problem with opioid use should be given the opportunity to take home naloxone when they leave prison or police custody. The Board should ensure that resources are made available to the national NHS bodies to support this responsibility.
- 8. That relevant agencies (for example, PHE) establish custody-community pathways into identified treatment for prisoners who have an assessed problem with alcohol, cannabis, cocaine, or other non-opioid drugs – as well as for users of opioids. Additionally, that a pathway should be developed that offers sufficient support to enable prisoners leaving abstinence-focused interventions to maintain such change following release.
- 9. That the Home Office should commission research specifically to identify and ameliorate problems and opportunities related to transitions into and out of police custody by people who have problems with drugs. This should include gathering information, across the UK, on:
 - a. the levels of overdose and drug-related deaths in police custody and immediately afterwards; and,
 - b. the coverage and effectiveness of Liaison and Diversion schemes in meeting the needs of arrestees with drug and alcohol misuse problems.

We welcome the opportunity to discuss and present this report to the Drug Strategy Board.

Yours sincerely,



Dr Owen Bowden-Jones
Chair of ACMD



Professor Alex Stevens
ACMD CCT Working Group Chair

Custody-Community Transitions

June 2019

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Summary

This report from the Advisory Council on the Misuse of Drugs (ACMD) provides advice on how to reduce drug-related harms that occur when people move between custody and the community. It seeks to answer three questions.

1. What are the drug-related harms and benefits associated with transitions between custody and the community?
2. What are the most important existing recommendations in this area, and to what extent have they been implemented?
3. Is there a need for new or adapted recommendations?

This report was written by the Custody-Community Transitions working group, chaired by Professor Alex Stevens. It is based on previous reports and evidence gathered by invitation of written submissions and an evidence-gathering day.

The report identifies substantial harms associated with transitions between custody and the community, especially for people who have problems with drugs, including the following.

- Homelessness. In 2017/18, 34.5% of adult prisoners under supervision from the National Probation Service or Community Rehabilitation Companies were discharged to unsettled or unknown accommodation on their first night of release (MoJ, 2018a).
- Reoffending. Adults serving sentences of less than 12 months in England and Wales had a reoffending rate of 64.4% between April and June 2017, with rates likely to be even higher among those with a drug problem.
- Transmission of blood-borne viruses. Prison is a risk environment for the transmission of HIV and Hepatitis C (Dolan *et al.*, 2016), so entry to prison can be a risk for infection, and release may spread that risk to the community. However, the prevalence of HIV infection among prisoners is low by international standards (Golrokhi *et al.*, 2018).
- Increased risk of death, including by overdose. Death rates among prisoners and, especially, those on post-release supervision are many times higher than in the general population. The few weeks immediately after release is a particularly high risk period for drug-related death (Inquest contribution, 2018; also House of Commons Health and Social Care Select Committee, 2018; Phillips *et al.*, 2017; Graham *et al.*, 2015).

For some people, entering the criminal justice system can provide an opportunity to reduce drug misuse and enter treatment. However, these benefits are too often squandered by the failure to provide continuity of care between custody and the community (Lloyd *et al.*, 2017).

This report identified a number of important previous reports and recommendations that have been made on this issue (see Appendix 2), including:

- Bradley (2009) *The Bradley Report: Lord Bradley's Review of people with mental health problems or learning disabilities in the criminal justice system* (the Bradley review); and,
- Patel (2010) *The Patel Report: Reducing Drug-Related Crime and Rehabilitating Offenders: Recovery and Rehabilitation for drug users in prison and on release: recommendations for action*.

These reports have not been systematically followed up, so it is difficult to know the extent to which they have been implemented. There are, however, concerning indicators of failure to implement previous recommendations, including the following.

- On continuity of care: Patel (2010) identified this as the key element in reducing drug-related problems for people leaving prison. However, the latest data from Public Health England (PHE) suggest that only 32.1% of people who are assessed as needing treatment when they leave prison enter treatment in the community within 21 days (PHE, 2018a).
- On equivalence of care: Bradley (2009) endorsed the principle of equivalence of healthcare between custody and community. Current policy outside prisons is to maximise access to naloxone (the medicine that reverses opioid overdose). However, only 12% of prisoners who were previously heroin-dependent left an English prison with naloxone in 2017/18 (PHE, 2019). In Scotland, 664 take-home naloxone (THN) kits were issued in 2017/18, to approximately 35% of the prisoners who tested positive for opioids at reception (ISD, 2018a).
- On reoffending. The aim of the *Transforming Rehabilitation* White Paper (MoJ, 2013) was to reduce reoffending rates. However, the performance of Community Rehabilitation Companies in providing these services has been widely criticised and they have failed to reduce high rates of reoffending, especially among short-term prisoners. The quality of probation services in England has been diminished (Stacey, 2019). This has particularly worrying implications for people with drug problems, who are in need of additional and specialist support.

In order to facilitate the implementation of existing and future recommendations, this report makes the following recommendations for systemic improvement.

1. That the Drug Strategy Board nominates one Minister who will have over-arching responsibility and accountability for the improvement of custody-community transitions for prisoners with complex health needs, including problems with drugs.
2. That this Minister be given the following mandate: To assess and improve performance in delivering officially accepted recommendations on transitions between custody and the community for people with substance misuse, mental health and homelessness problems.
3. That the Minister of Justice (England and Wales), the Cabinet Secretary for Justice (Scotland) and their counterpart in Northern Ireland take further steps to reduce the number of transitions into and out of prisons, especially as multiple short sentences are associated with increased risk of death. This should involve:
 - a. reform sentencing to minimise the use of sentences of less than 12 months, with the aim of eliminating the use in sentencing of periods of less than 3 months in prison; and
 - b. reforms to the system of supervision on licence, so as to reduce the number of people who are recalled to prison.

This report also makes the following practical recommendations.

4. That the prison services of the UK take steps to minimise the release of prisoners with complex needs (including substance misuse) on Friday afternoons.
5. That the Department for Work and Pensions (DWP) should:

- a. accelerate the introduction of the measures listed in the *Rough Sleeping Strategy* (MHCLG, 2018) to enable prisoners to access employment or Universal Credit immediately on release;
 - b. work in partnership with Her Majesty's Courts and Tribunal Services (HMCTS) and the National Probation Service (NPS) to ensure that people who are imprisoned are not overpaid the housing element of Universal Credit; and,
 - c. Following the completion of the evaluation of the pilots, implement the effective elements identified through evaluation.
6. That the prison and probation services of the UK should develop and extend services that provide face-to-face, individualised support to prisoners who have drug problems in the run up to release and through the transition to the community.
7. That the Drug Strategy Board should make a clear statement that it is the responsibility of the national NHS bodies to ensure that all people who have an assessed problem with opioid use should be given the opportunity to take home naloxone when they leave prison or police custody. The Board should ensure that resources are made available to the national NHS bodies to support this responsibility.
8. That relevant agencies (for example, PHE) establish custody-community pathways into identified treatment for prisoners who have an assessed problem with alcohol, cannabis, cocaine, or other non-opioid drugs – as well as for users of opioids. Additionally, that a pathway should be developed that offers sufficient support to enable prisoners leaving abstinence-focused interventions to maintain such change following release.
9. That the Home Office should commission research specifically to identify and ameliorate problems and opportunities related to transitions into and out of police custody by people who have problems with drugs. This should include gathering information, across the UK, on:
 - a. the levels of overdose and drug-related deaths in police custody and immediately afterwards; and,
 - b. the coverage and effectiveness of Liaison and Diversion schemes in meeting the needs of arrestees with drug and alcohol misuse problems.

Introduction

There are currently several government cross-departmental commitments related to custody-community transitions. The Drug Strategy (2017) committed to 'looking at how to move to a joint approach to commissioning of health services, including drug and alcohol treatment, in prisons. This aims to give governors more control and accountability over the services and treatments in their prison, and ensure continuity of treatment with services in the community' (HM Government, 2017).

In 2017, the Advisory Council on the Misuse of Drugs (ACMD) established a working group to report on drug-related harms and benefits related to transitions between custody and the community. This followed concerns among members of the Council about increasing harms related to drug misuse as people move through the criminal justice system.

In 2018, Public Health England (PHE) published its guidance for improving continuity of care between prison and the community, which states that continuity of care is a priority for government (PHE, 2018c).

The recently published Prisons Drug Strategy (MoJ, 2019b) outlined its aims to:

- reduce the number of drug-related deaths in custody;
- increase the proportion of those prisoners who complete treatment who do not return within six months, by December 2020; and,
- increase the proportion of prisoners with substance misuse treatment needs who are successfully engaged in community-based treatment within 21 days of release from prison, by December 2020.

The Home Secretary's work programme commission (2017-2019) also requested the ACMD's advice on the following question:

How can the criminal justice and healthcare systems' responses at charging, sentencing, imprisonment and release be made more effective in responding to offenders' drug misuse and its impact on their health and risk of offending?

This report is intended for the Home Secretary and other relevant ministers, including the Minister for Justice and the Minister for Health and Social Care and their counterparts in Scotland and Northern Ireland. It will also be of use to other health and criminal justice agencies. It should be read in conjunction with previous ACMD reports, including the 2016 report on *Reducing opioid-related deaths in the UK* and the upcoming report on *Drug-related harms in homeless populations and how they can be reduced*, which also considers the housing needs of people released from prison.

The three questions that this inquiry set out to answer are listed below.

1. What are the drug-related harms and benefits associated with transitions between custody and the community?
2. What are the most important existing recommendations in this area, and to what extent have they been implemented?
3. Is there a need for new or adapted recommendations?

The focus of the report is on adults only. Custodial settings considered in this report include police stations and prisons in all four countries of the UK.¹

The evidence underpinning this report was collected using the following methods.

- A review of existing recommendations in the field.
- Gathering information on the current state of implementation of these recommendations through:
 - consulting agencies in the field (see Appendix 1);
 - inviting written submissions from these agencies and others, through an open call for evidence;
 - a public evidence-gathering day held in June 2017; and,
 - further discussion with members of the Custody-Community Transitions working group.

The report is structured to follow the three questions that the inquiry set out to answer.

¹ This report has not looked at issues related to immigration detention. There was far less information on police custody than was available on prison custody.

Drug-related harms and benefits associated with custody-community transitions

Crime suspects and detainees, especially those who have problems with drugs, form a diverse and highly complicated group. They have a range of complex needs, often including trauma brought on by adverse childhood experiences, learning disabilities, lack of family support, mental and physical health problems, insecure housing as well as problems with alcohol and other substances (ACMD, 2018). The levels of all these problems are considerably higher among prisoners than in the general population (Revolving Doors, 2013). It has long been accepted that imprisonment is an environment of heightened risk of problems related to drug use, creating a need for specific interventions to reduce drug-related harms (Stevens, Stöver, & Brentari, 2010; Strang, 1993). The overlapping issues of substance misuse, homelessness and mental health among the prison population make it difficult to address one without addressing the others. All have an impact on drug-related harms in the custody-community transitions.

These transitions often create additional risks (Denton, Foster, & Bland, 2017). Both entering and leaving custody can exacerbate drug-related and other problems. Some common risks encountered in custody-community transitions are listed below.

- Create or worsen problems with housing. In 2017/18, 34.5% of adult prisoners under supervision from the National Probation Service (NPS) or Community Rehabilitation Companies (CRCs, excluding London)² were released to unsettled or unknown accommodation on their first night (MoJ, 2018a).³ In Wales, this problem was exacerbated by removing housing priority for released prisoners in 2014.⁴
- Be swiftly followed by reoffending and re-imprisonment. Adults serving sentences of less than 12 months in England and Wales had a proven reoffending rate of 64.4% between April and June 2017 (MoJ, 2019a).
- Increase the risk of acquiring a blood-borne virus (BBV) and of interrupting treatment for HIV or viral hepatitis (SPS, 2012; Rumble *et al.*, 2015; Dolan *et al.*, 2016). Prison systems in the UK have prevented further outbreaks of HIV within prisons and offer opt-out testing for BBVs. Prevalence of HIV infection among prisoners is low by international standards (Golrokhi *et al.*, 2018). However, failure to provide continuity of care for people who have HIV or viral hepatitis as they transition into the community increases risks of disease progression and transmission.
- Lead to an increased risk of death. Death rates among prisoners and, especially, those on post-release supervision are many times higher than in the general population. There were 955 deaths of offenders in the community in England and Wales in 2017/18 (MoJ, 2018b). The few weeks immediately after release is a particularly high-risk period for drug-related death. In 2017, the number of opioid-related deaths within four weeks of prison release was 31 (ISD, 2018b). There is an increased mortality risk associated for people who serve multiple short sentences (Inquest contribution, 2018; also House of Commons Health and Social Care Select Committee, 2018; Phillips *et al.*, 2017; Graham *et al.*, 2015).
- Lead to a rapid return to previous drug-taking behaviours, compromising any benefits of prison treatment (Lloyd *et al.*, 2017).

² Reliable figures were not available for London.

³ The Patel report (Patel, 2010) noted the importance of stable housing. It concluded that there was “a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money, having something meaningful to do, and greater integration and co-ordination with community services”.

⁴ Released prisoners are considered a priority for housing by local authorities in Scotland, but not in England or Wales.

There is a particular problem for people released from custody who use opioids (for example, heroin). Restricted access to heroin while in custody can reduce physical tolerance to these substances. If these people then relapse to drug use on release, they face a heightened risk of dying by overdose. Such relapses and deaths are particularly likely when people are released without access to housing or drug treatment (Farrell & Marsden, 2008; National Treatment Agency, 2012; Marsden *et al.*, 2017).

The range of needs can be especially complex for particular groups of people in the criminal justice system. This includes women, older service users, members of black and ethnic minorities, members of gypsy and traveller communities, and people who have transgender identity. The criminal justice system works with a majority of white, male, heterosexual people of a relatively young age. It is often difficult for this system to adapt to the specific needs of people who are not in this majority (Patel, 2010).

The entry to custody (via arrest or imprisonment) provides an opportunity to take steps that reduce crime and health harms for arrested people, victims and the wider society. Release from custody is a key point for securing these potential benefits. It is often observed that improvements in health and in factors related to reoffending are not maintained on release from custody (*ibid.*).

This signals a broader need to distinguish between the transitions and treatment of individuals on the basis of 'recovery capital' – the social and personal resources needed to enact and sustain change (see, for example, Best & Laudet, 2010; ACMD, 2013). Those with fewer resources and long histories of opioid misuse may benefit particularly from maintained opioid prescriptions and re-engagement with community prescribers following release (ACMD, 2015; Lloyd *et al.*, 2017, pp 16–17). Those with higher levels of recovery capital, and alcohol, cannabis or cocaine dependence (rather than opioid dependence) may be better-placed to engage with abstinence-focused services in prison (ACMD, 2013; Page *et al.*, 2016), though hitherto their subsequent pathway into community support and the nature of community treatment has been less clearly described in policy or research. However, the forthcoming report from the Ex-Prisoners Recovering from Addiction (EPRA) working group, chaired by Lord Patel will outline four 'blueprint' pathways for abstinence-focused through-care, divided by sentence length and gender.⁵

In the last ten years, a new challenge has emerged in the form of synthetic cannabinoid receptor agonists, which are often referred to as 'Spice' (Ralphs, *et al.*, 2017; User Voice, 2016). These have exacerbated problems in prisons around safety, security and health (CJJI, 2017). Prisoners reported that the main reasons for taking synthetic cannabinoids in prison were ease of access, avoidance of drug testing for other substances, and boredom (User Voice, 2016). Action is already being taken by the Ministry of Justice (MoJ) in the '10 prisons project'. However, the Custody-Community Transitions working group learned from Manchester Metropolitan University (MMU) that some interventions have worsened problems related to synthetic cannabinoids. The programme of mandatory drug testing in prisons and the extension of testing on licence may have encouraged prisoners to move to the use of synthetic cannabinoids (which are less often detected in commonly applied drug tests) instead of cannabis, which is usually less harmful (Ralphs *et al.*, 2017). Some synthetic substances were added to the panel of drugs that mandatory drug tests can detect in September 2016. The criminalisation of the possession of recently developed synthetic cannabinoids in custody through the Psychoactive Substances Act 2016 and the subsequent classification of these 'third generation' synthetic cannabinoids under the Misuse of Drugs Act 1971 did not appear to reduce the problems related to these substances in prison (Home Office, 2018).

⁵ Please contact Charlie Lloyd at the University of York for details (charlie.lloyd@york.ac.uk).

Issues around synthetic cannabinoids that are particularly related to custody-community transitions include the following (MMU contribution, 2018).

- The frequent movement of people on short sentences or prison recall from the community into custody facilitates the supply of synthetic cannabinoids in prison.
- It is reported that many people begin or deepen a problem with the misuse of synthetic cannabinoids after entering prison, and may continue these problems on release (see also Lloyd *et al.*, 2017).
- The additional problems caused by the use of synthetic cannabinoids in prison can inhibit effective rehabilitation and resettlement planning. This is because resources are often drawn away from rehabilitation-focused activities to deal with cannabinoid-related emergencies. It is also because the use of synthetic cannabinoids can inhibit individual prisoners' engagement in pre-release planning.

The impact on families of people moving between custody and community can be very damaging. The working group heard from Adfam about the trauma, shame and sense of loss experienced by families whose loved ones enter prison (Condry & Smith, 2018). Particularly for people with drug problems, families very often struggle to find help in dealing with these problems. The imprisonment of a family member can lead to financial difficulties through loss of family income and the cost of visiting prisons, especially for families in less densely populated areas who often have to travel very long distances to visit a prisoner. Families may also feel obliged to house or support ex-prisoners following their release, even when this exposes them to exceptional stress and a real risk of victimisation (Lloyd *et al.*, 2017, pp 207–209).

These difficulties are particularly acute for families where the imprisoned person has parental responsibilities. In the majority of cases, this is a woman. Women's prisons are fewer and further between, exacerbating the difficulty of maintaining family contacts. There is a new government *Female Offender Strategy* (MoJ, 2018c). However, the (2007) recommendations of Baroness Corston's review, which called for "*a distinct, radically different, visibly-led, strategic, proportionate, holistic, woman-centred, integrated approach*" have not been fully implemented (Corston, 2007; also Changing Lives contribution, 2018; Release contribution, 2018).

As many organisations and experts have observed (Collective Voice contribution, 2018; Blenheim contribution, 2018; Release contribution, 2018), the working group was told repeatedly by stakeholders in the field that the reduction of resources spent on prisons since 2010 – while not reducing the prison population – had substantially reduced security and safety in prisons. It had also damaged the ability of prisons to provide effective rehabilitation and resettlement planning (for example, Lloyd *et al.*, 2017, pp 95–96).

This has been compounded by changes to English and Welsh probation services in 2014 that, it was widely predicted, would reduce their effectiveness (for example, Ludlow, 2014). The splitting of provision between the NPS and CRCs has reduced effective partnership working (Collective Voice contribution, 2018). The idea that CRCs would provide 'through the gate' services to help to resettle prisoners on release has not been implemented in practice (for example CJI, 2016; CJI, 2017). The extension of provision of CRC services to prisoners released from sentences shorter than 12 months has increased the number of people on post-sentence supervision (CJI, 2016; House of Commons Justice Select Committee, 2018). However, CRCs have struggled both to provide adequate supervision to their service users (as individual probation officers' caseloads have risen) and to make the financial model work (as CRCs received fewer cases than anticipated) (House of Commons Justice Select Committee, 2018). The number of people who die while under such supervision has increased much faster than the caseload (Inquest contribution, 2018). The number of deaths in

England and Wales was 955 in 2017/18, compared to 560 in 2013/14, an increase of 71%. In the same period, the caseload of offenders supervised in the community increased by 18% (MoJ, 2019c). The operating model for probation services is currently being revised by the MoJ. It should include measures to reduce these deaths, as well as to reduce reoffending.

There is an opportunity to create benefits for service users and society if transitions between custody and community are handled well. A small proportion of people who offend repeatedly commit large proportions of crime. For example, in 2009/10, 49,000 adults were identified as offenders with drug misuse problems. They represented 8.7% of adult offenders but committed 26.8% of proven reoffending by adults (MoJ, 2012, page 18).⁶ Relapse to Class A drug use on release is associated with an increase in the odds of proven reoffending of over 50% (Brunton-Smith & Hopkins, 2013). This prolifically reoffending group tends to experience multiple, short periods of custody. They also experience serious health harms, including highly elevated rates of death on release (Farrell & Marsden, 2008). It is vital that ministers improve the way that agencies within and around the criminal justice system work to reduce the offending and drug use of individuals who are currently enmeshed in such patterns of behaviour, and to support and divert those who may be at risk of becoming serial reoffenders.

Previous recommendations

In developing this work, there are many previous recommendations on which ministers and officials can draw upon (see Appendix 2). The Custody-Community Transitions working group considered two reports to be particularly important. The first was Lord Bradley's (2009) *Review of people with mental health problems or learning disabilities in the criminal justice system* (the Bradley review). The second was Lord Patel's (2010) report on *Reducing Drug-Related Crime and Rehabilitating Offenders* (the Patel report).

The key themes that run through these and other reports (listed in Appendix 2) in the field are as follows.

- That the biggest challenge, and the greatest missed opportunity for reducing reoffending and improving health, is the absence of continuity of care for people who enter and leave custody with complex needs.
- That healthcare provided to people in the criminal justice system should be at least equivalent to that provided in the community.
- Co-morbidity between mental health problems and drug misuse ('dual diagnosis') in prisons is prevalent. There needs to be more clearly defined mechanisms for managing patients with dual diagnosis, formal links between mental health and drug treatment provision, and greater awareness among staff.
- The need for a cohesive, inter-departmental strategy on drug misuse in prison is often raised. Fragmentation between different services and conflict between different organisations' targets was identified as a problem that leads to inconsistency in care and inefficiencies.
- Services should be more integrated. The criminal justice system should coordinate with healthcare providers, mental health services, and community supports to ensure that people are given continuity of care in the vulnerable weeks following release. It is often noted that individuals should be involved in pre-release planning and should be put in contact with support and treatment options in the community quickly after leaving prisons.

⁶ Research from Uruguay suggests that there may be an increase in crime on days when more prisoners are released and that this effect can be reduced by increasing the money given to people on release (Munyo & Rossi, 2015).

- Treatments that help people with drug problems to accrue recovery capital – which includes social relationships, health, skills and aspirations, as well as employment and housing – are identified as valuable to sustained recovery. It is often recommended that local housing and employment organisations are also integrated into the resettlement process.
- The benefits of mutual aid to recovery are often highlighted. Support groups are linked to improved treatment outcomes, and it is suggested that actively guiding people towards these groups improved engagement.
- Ensuring access to services and support is consistent across the country, as adapted to local needs. The difficulty of securing continuity of care for people who are imprisoned far from their homes is frequently mentioned.
- Data collection should be developed, and different organisations should share information where possible to reduce inefficiency, identify areas for improvement and highlight gaps in service provision.
- There should be a national framework for continual improvement of services by setting clear performance outcomes and analysing local needs and evidence of what works.

Implementation of previous recommendations

One of the main findings of this inquiry is that it is very difficult to assess the extent to which previous recommendations in the field have been implemented. This is due, among other causes, to the following.

- *Lack of systematic follow up*

Recommendations and strategies have often been made without a process for generating information that will feed into subsequent improvements. For example, there has been:

- no official report on the implementation of the recommendations of the Patel report;
- no evaluation of the impact of transferring responsibility for prison healthcare to the NHS in England; and,
- no official assessment of the effect of the Health and Social Care Act 2012 on the provision and continuity of drug treatment in the criminal justice system.

There are apparently plans to assess the implementation of the Bradley review, but this has not yet started, and there have been no regular progress reviews.

- *Fragmentation of responsibility for implementing recommendations*

Many of the strategies discussed in this report have their own multi-agency governance boards. However, as the House of Commons Health and Social Care Select Committee (2018) also recently noted, who owns responsibility for making specific improvements is very often unclear. If, as this Committee recommended, the Government is to develop a 'whole system' approach to improving outcomes in and out of the criminal justice system, then clear lines of responsibility and accountability for managing this systemic approach need to be put in place.

In some parts of the system, responsibility for implementing previous recommendations has been placed at levels that are not senior enough to make the necessary changes. For example, the *Rough Sleeping Strategy* (MHCLG, 2018) places responsibility on prison governors to work with the NPS and CRCs to reduce the number of prisoners who are released without settled accommodation. However, neither prison governors nor the NPS or CRCs have the capacity or funds to make more housing available to release prisoners.

- *The absence of systematically collected data*

The Government's drug strategy evaluation (HM Government, 2017) identified substantial gaps in knowledge on the effects of drug policy. The Government decided not to implement previous Advisory Council on the Misuse of Drugs (ACMD) recommendations to enhance research capacity (ACMD, 2016a; 2016b). It is therefore difficult for ministers and officials to know the extent to which previous recommendations and strategies have succeeded in improving processes and outcomes.

Much relevant information is collected. For example, PHE collects data on the proportion of people who are released from prison with an assessed need for drug treatment and who enter treatment in the community within 21 days. This forms part of the *Public Health Outcomes Framework* (PHE, 2018a). However, many other relevant indicators are not collected or collated (see list in recommendation number 2 below). An important example is that there are no nationally reported data on the number of people who die within the first few weeks of release from prison.⁷ This information is reported in Scotland (Graham *et al.*, 2015).

There is a particular lack of collection of information from the perspective of people who go through the transition between custody and the community. Service user involvement in creating and communicating this information would help to improve services.

It should be noted that there have been more systematic efforts to follow up recommendations and strategies in Scotland than in England. An example is the Royal College of Nursing Scotland's 2016 report *Five Years On*, which assessed progress since the NHS took over responsibility for prison healthcare. In 2017, the Scottish Parliament's Health and Sport Committee wrote a report on healthcare in prisons. This was followed by the Scottish Government's establishment of the Health and Justice Collaboration Improvement Board. This plays a broader role across the criminal justice system than the Westminster-based National Prison Health Board. The Scottish drug and alcohol strategy (Scottish Government, 2018b), its justice strategy (Scottish Government, 2012) and its community justice strategy (Scottish Government, 2016) all include relevant plans, and a Quality Outcome and Improvement dashboard is being developed through the Scottish prison health and care programme.⁸

There are, however, important recent developments in England. One is the 2016 *NHS Health and Justice Strategy*, which applies to NHS services across various justice settings. Another is the 2018-2021 *National Partnership Agreement for Prison Healthcare in England*. This agreement brings together the MoJ, Her Majesty's Prison and Probation Service (HMPPS), PHE, the Department of Health and Social Care (DHSC), and NHS England in working towards common objectives. The ACMD supports its aims, especially as they relate to reducing reoffending and enhancing continuity of care for people who have problems with drugs. The 2018 publication of PHE's *Guidance for improving continuity of care between prison and the community* will be important in achieving these aims (PHE, 2018c). This document includes several recommendations for improving continuity of care, in line with the emphasis of the Patel report (Patel, 2010) on this issue.

⁷ The available data show a concurrently high number of deaths among offenders under post-release supervision in England and Wales (MoJ, 2018b), but the number of drug-related deaths that occur among released prisoners in the highest risk period (i.e. the first four weeks) is not publicly reported.

⁸ <https://www.gov.scot/groups/health-and-justice-collaboration-improvement-board/>

Despite the difficulty in assessing implementation, some concerning trends are visible in the data that are available.

- *Continuity of care.* The Patel report stated that the key issue to address was the continuity of care between prison and the community. However, the latest data from PHE (2017/18) suggest that only 32.1% of people who are assessed as needing treatment when they leave prison enter treatment in the community within 21 days (PHE, 2018a).
- *Equivalence of care.* The Bradley review (Bradley, 2009) endorsed the principle of equivalence of health between custody and the community. The current guidelines on clinical management of people with substance misuse problems (DHSC, 2017) states that previously heroin-dependent prisoners should be provided with a supply of THN on release from prison and that commissioners should support the provision of naloxone and overdose training in the community. However, only 12% of prisoners who were previously heroin-dependent left English prison with naloxone in 2017/18 (PHE, 2019), and approximately 35% in Scotland (ISD, 2018a).
- *Reoffending.* The aim of the *Transforming Rehabilitation* White Paper (MoJ, 2013) was to reduce reoffending rates. This was partly to be achieved by providing more support to prisoners released from sentences of less than 12 months, and an expansion of 'through the gate' services. However, the performance of CRCs in providing these services has been widely criticised (Collective Voice contribution, 2018; also House of Commons Justice Select Committee, 2018; (Stacey, 2019). Her Majesty's Inspectorate of Probation recently commented on serious shortcomings in supervision of short-term prisoners on release, with no evidence that expanding post-release supervision to this group reduced their reoffending (HMI Probation, 2019).

Nevertheless, substantial progress has been made in the last 20 years in reducing crime and protecting health in prisons. This includes improved arrangements for assessment and treatment of drug dependence at entry to custody, greater provision of evidence-based treatment for drug dependence (including opioid substitution therapy) in prison, and – more recently – a greater focus on supporting recovery in prisons, including investment in the pilot of drug recovery wings and the Drug Recovery Prison pilot at Her Majesty's Prison (HMP) Holme House (Lloyd *et al.*, 2017).⁹

From the 1990s onwards, connections to drug treatment were created – primarily for opioid users – through arrest referral schemes, the Criminal Justice Interventions Teams and the Drug Interventions Programme (DIP) in England and a rising number of Drug Treatment and Testing Orders in Scotland. The benefits of these initiatives for people with histories of alcohol and non-opioid drug use have not been clearly established. Since central funding for DIP was stopped in 2013, these services have been scaled back. However, NHS Liaison and Diversion schemes now cover 92% of the population of England. These schemes have the potential to provide support around both mental health and substance misuse problems, but the extent to which they are doing so is not yet clear.

In English and Welsh prisons, the provision of screening and treatment was improved through the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) teams and, in England, the Integrated Drug Treatment System (IDTS), which expanded the provision of opioid substitution therapy (OST) in prisons. Although CARAT teams and the IDTS are no longer centrally supported, the legacy of multi-agency working continues. NHS England's service specifications (NHS-E, 2018) explicitly call for a joint, multi-disciplinary approach to the screening, assessment and provision of

⁹ <https://www.gov.uk/government/news/blitz-on-drugs-in-prison-underway>

services for substance misuse, using a range of services that are equivalent to those used in the community.¹⁰ The provision of 'opt-out' testing for blood-borne viruses (BBVs) has increased uptake and the possibility to provide effective treatment in prison (PHE, 2018b).

The bulk of initiatives described thus far were developed primarily to support people who use opioids. As a substantial body of evidence suggests (for example, ACMD, 2013; HM Government, 2017), this group may have different needs and outcomes to people with other drugs of dependence. In this context, it is important to note that custody-community transitions for prisoners leaving abstinence-focused interventions (such as Therapeutic Communities, Forward Trust programmes, and some pilot drug recovery wings) have received very little attention in either policy and/or research. Whilst evidence from the USA suggests that residential aftercare can greatly improve the treatment outcomes of this group (Olson & Rozhon, 2011), further UK research is needed to understand the particular situation of this group who may be at particular risk of relapse following release, and who are currently confronted by a 'cliff-edge of support' on release (Lloyd *et al.*, 2017). This applies to users of drugs other than heroin as well as to people who have become abstinent from heroin in prison and wish to remain so on release.

Despite considerable progress, many organisations have reported severe problems in prisons in recent years. These problems are experienced particularly acutely by people who have problems with drugs. Within the remit of this report, significant problems still occur at transitions between custody and community, as noted above.

New recommendations

The ACMD recognises that a large number of recommendations have been made in this field and that there are various government commitments on taking action on custody-community transitions. This report has therefore focused its recommendations on systemic and practical issues, which will improve the implementation of existing and future recommendations. Existing recommendations can be seen in the reports listed in Appendix 2. Additional recommendations are bound to be made in future by similar agencies. There needs to be a process in place for implementing and reviewing such recommendations.

As the Drug Strategy Board was established to oversee the delivery of the Drug Strategy (HM Government, 2017) and drive action across Government and its partners, the ACMD has targeted several recommendations to the Board so that there is clear ownership and accountability for the commitments.

Systemic recommendations

- 1. That the Drug Strategy Board nominates one Minister who will have over-arching responsibility and accountability for the improvement of custody-community transitions for prisoners with complex health needs, including problems with drugs.**

¹⁰ The Custody-Community Transitions working group did receive evidence on ongoing problems with these specifications, including a lack of clarity about which agency is responsible for providing and paying for naloxone for released prisoners. A potential disparity between advice on how decisions are taken on the length of time that patients should receive opioid substitution therapy was also reported between two Department of Health reports (DH, 2011 and DHSC, 2017).

The rationale for this recommendation is that there are many recommendations that relate to custody-community transitions that had previously been accepted as necessary but have still not been implemented. For example, continuity of care from custody to release is still far below the level required to support effective rehabilitation and desistance from problematic drug use and offending. The proportion of people leaving prison with no stable accommodation is still too high. The proportion of people who have problems with opioids who leave prison with naloxone is far below what is needed to protect against death by overdose. Responsibility for implementing such recommendations is currently shared among a wide range of bodies below ministerial level, and progress requires cross-departmental action. The previous Prisons Minister took personal responsibility for reducing violence in ten prisons. It is the ACMD's view that lead ministerial responsibility is required to ensure that previously recommended improvements are delivered to improve custody-community transitions.

2. That this Minister be given the following mandate: To assess and improve performance in delivering officially accepted recommendations on transitions between custody and community for people with substance misuse, mental health and homelessness problems. The indicators of progress in this area should include the following.

- a. Reducing the rate of reoffending (within six months and after two years) of people who leave prison and who have an assessed need for drug treatment.
- b. Reducing the numbers of people who die within four weeks of leaving custody (separated by police and prison custody) and while under the supervision of the probation services. These data should be collated separately for suicides and drug-related deaths, following the definitions that the Office for National Statistics uses for the general population.
- c. Reducing the proportion of people who leave prison with unsettled or unknown accommodation on the first night of release.
- d. Increasing the proportion of people who have an assessed need for drug treatment on release who enter treatment in the community within four weeks of release.
- e. Increasing the proportion of prisoners who are assessed as having a problem with opioids who leave prison with naloxone.

The indicators listed here relate to the key aims of the criminal justice and health systems: to reduce reoffending and to protect public health. Previous recommendations – particularly on assuring continuity of care and addressing the complex needs of people with substance use problems – will have the effect of reducing reoffending and damage to health, of which a key indicator is the level of mortality among released prisoners. The data on deaths after prison and police custody are already collected in Scotland as part of the Quality Improvement & Outcome Framework (Police Care Network, 2015). The evidence submitted to the ACMD supports the importance of providing stable accommodation and continuity of treatment on release. The evidence also supports the effectiveness of providing take-home naloxone in reducing deaths. Reflection on these indicators should be included in the evaluation of the current drug strategy.

3. That the Minister of Justice (England and Wales), the Cabinet Secretary for Justice (Scotland) and their counterpart in Northern Ireland take further steps to reduce the number of transitions into and out of prisons, especially as multiple short sentences are associated with increased risk of death. This should involve:

- a. **reform sentencing to minimise the use of sentences of less than 12 months, with the aim of eliminating the use in sentencing of periods of less than 3 months in prison; and,**
- b. **reforms to the system of supervision on licence, so as to reduce the number of people who are recalled to prison.**

The evidence submitted to the ACMD shows that transitions between custody and community are inherently risky. People with drug problems are particularly likely to experience such transitions, as they are frequently given short prison sentences for repeated acquisitive offences and are often recalled to prison from probation supervision in the community due to breaches of conditions. These transitions damage continuity of care, and so increase the potential for reoffending and relapse to problematic drug use. Short prison sentences are less effective than community penalties in reducing reoffending. The improved effect of court orders compared to short prison sentences increases for people with multiple previous offences (Hillier & Mews, 2018). Multiple short sentences are also linked to higher mortality (Graham *et al.*, 2015). Community penalties are also substantially cheaper than prison sentences (Justice Select Committee, 2018). Therefore, this report recommends that these two further steps (reforming sentencing and supervision on licence) are taken to reduce the use of short periods in prison, which account for a large proportion of the transitions between custody and community (both through short sentences and recalls on licence). These offenders can be dealt with more effectively in the community, and this should be a main aim of the planned reforms to probation.

The Secretary of State for Justice has stated that there is too much use of short sentences (Gauke, 2018). However, existing measures to reduce the use of these sentences in England (including Liaison and Diversion schemes and community sentence treatment requirements [CSTRs]) have not substantially reduced the numbers of short sentences that are given.¹¹ The number of drug rehabilitation requirements commenced under a community order or suspended sentence order in England and Wales fell from 13,617 in 2011 to 8,719 in 2017 (MoJ contribution, 2018).

CSTRs are more effective than short prison sentences in cutting reoffending (MoJ contribution; also PHE, 2017; MoJ, 2018d). However, changes to court and probation services, and ongoing cuts to funding for drug treatment services through the public health grant are limiting sentencers' use of such requirements (CJJI, 2018). In some cases, courts would like to make such orders but cannot due to a lack of available treatment options (Stacey, 2019). There is also a risk that increased use of CSTRs (and of Scottish Drug Treatment and Testing Orders) can lead to 'net-widening'; bringing more people into more intense supervision from the criminal justice system by applying more demanding sentences to people who would not otherwise have gone to prison (Malloch & McIvor, 2013). The CSTR protocol pilots that were jointly run by the MoJ, DHSC, NHS England and PHE provide valuable lessons on how to improve the use of CSTRs.

Under the Criminal Justice and Licensing (Scotland) Act 2010, the Scottish Government introduced a presumption against custodial sentences of less than three months. This has had some effect in reducing the shortest sentences, but 3,495 people received a sentence of less than 3 months in Scotland in 2016/17 (Scottish Government, 2018a). The Scottish Government is now considering strengthening this presumption and extending it to reduce the use of sentences under 12 months.

¹¹ Contribution received from the Prison Reform Trust, see: [Bromley Briefings Summer 2018, Prison Reform Trust](#)

When prisoners are released under licence to the supervision of the NPS or CRCs, they can be recalled to prison for breaching conditions of their licence. In the year 2017/18, there were 22,183 licence recalls to prisons in England and Wales. This is an increase of 27% since 2013/14. These recalls increase the number of transitions between custody and community. As noted above, these transitions increase the risk of health problems and often break continuity of care. They also create an opportunity to smuggle substances, including synthetic cannabinoids, into prison. A 2018 thematic inspection on enforcement and recall by Her Majesty's Inspectorate of Probation (HMI Probation, 2018) found that:

- post-custodial supervision by CRCs was poor;
- CRCs were 'stretched beyond their capacity'; and,
- enforcement had the effect of compounding rather than lessening the sense of a revolving door between prison and the community.

The HMI Probation recommended that the Government "*should ensure that probation services are sufficiently resourced to supervise individuals with complex needs [including people with substance misuse problems] effectively*" and that Her Majesty's Prison and Probation Service (HMPPS) "*should set expectations that CRCs and the NPS develop partnership-based approaches with key local stakeholders to manage those released from prison on licence*" (*ibid.*). The ACMD supports these recommendations. HMI Probation has also recently recommended that the Ministry of Justice '*review the suitability of the sanctions available for breaches of post-sentence supervision (PSS) and consider alternatives that enhance the purpose of rehabilitation*' (HMI Probation, 2019).

In England and Wales particularly, a more radical approach is needed to succeed in reducing the use of short sentences, as was recognised by the former Prisons Minister.¹² This report therefore recommends that the Justice Secretary aligns policy in England and Wales with the Scottish Government's intention to substantially reduce the use of custodial sentences of less than 12 months. This will require legislative change, reforms to sentencing guidance, and robust steps to improve the confidence of the courts in the quality and safety of supervision on community sentences. The process and effects of such changes should be subject to robust, independent evaluation.

Practical recommendations

In support of the systemic recommendations made above, and by others in the field, this report makes the following practical recommendations.

4. That the prison services of the UK take steps to minimise the release of prisoners with complex needs (including substance misuse) on Friday afternoons.

Between January and June 2018, 11,080 people were released on a Friday from prisons in England and Wales.¹³ As prisoners with release dates on Saturdays, Sundays or a bank holiday Monday are released on Fridays, more than a third of prisoners are released on Fridays. In the working group's evidence gathering were several reports that release on a Friday – especially when that release is late in the day – makes it difficult to access stable housing, drug treatment, and connections with

¹² <https://www.independent.co.uk/news/uk/home-news/prison-jail-sentences-less-six-months-minister-a8724311.html>

¹³ <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-11-13/190798/>

probations services and job centres. People often have to attend several appointments on their first day of release. If these appointments are missed on a Friday, then the person may be left for the weekend with no housing, no money and no drug treatment. These are circumstances in which relapse to drug use and offending are highly likely to occur. These issues have also been highlighted by the National Association for the Care and Resettlement of Offenders charity (NACRO, 2018).

5. That the Department for Work and Pensions (DWP) should:

- a. accelerate the introduction of the measures listed in the 2018 *Rough Sleeping Strategy* (MHCLG, 2018) to enable prisoners to access employment or Universal Credit immediately on release;**

The *Rough Sleeping Strategy* committed the DWP to the following measures:

- increasing the level of prisoner engagement with Prison Work Coaches;
- supporting prisoners to begin the Universal Credit claim in prison;
- continuing work to support prisoners to open bank accounts in prison; and,
- supporting prisoners to verify their identity for Universal Credit purposes.

- b. work in partnership with Her Majesty's Courts and Tribunal Services (HMCTS) and the NPS to ensure that people who are imprisoned are not overpaid the housing element of Universal Credit; and,**
- c. Following the completion of the evaluation of the pilots, implement the effective elements identified through evaluation.**

Several contributors to the working group's evidence gathering commented on the difficulties faced in accessing accommodation and money to live on after release from prison. This is particularly problematic for people who have drug problems, as was also identified in Lord Patel's report (Patel, 2010). Some also commented on the difficulties faced by people who have their Universal Credit payments reduced due to overpayments that occur when the housing element is paid while the claimant is in prison.

The DWP informed the working group that similar measures had been piloted at Her Majesty's Prisons (HMPs) Wayland, Norwich and Belmarsh. This report recommends that – following the currently ongoing evaluation of these pilots – the effective elements of this approach be rolled out quickly to other prisons.

6. That the prison and probation services of the UK should develop and extend services that provide face-to-face, individualised support to prisoners who have drug problems in the run up to release and through the transition to the community.

The ACMD asked respondents to its call for evidence to identify elements of good practice in reducing harms related to custody-community transitions. The features listed in this recommendation are the common elements of the examples of good practice reported by these respondents. They fit with the wider body of evidence that suggests that the most effective services offer holistic support and create good rapport between professionals and people who wish to desist from crime and problematic substance use (Sapouna, Bisset, & Conlong, 2011). They also align with recent guidance (PHE, 2018c) to increase the use of 'in-reach' services to improve the continuity of care between custody and the community. These services should include connecting people with mutual aid groups that can support them on release. They should also include the establishment of stronger links with substance misuse specialist supported housing programmes, where these exist.

- 7. That the Drug Strategy Board should make a clear statement that it is the responsibility of the national NHS bodies to ensure that all people who have an assessed problem with opioid use should be given the opportunity to take home naloxone when they leave prison or police custody. The Board should ensure that resources are made available to the national NHS bodies to support this responsibility.**

In 2011, Scotland launched a centrally funded National Naloxone Programme, designed to increase the provision of naloxone to prisoners who needed it before their release across the Scottish prison estate (Horsburgh & McAuley, 2017). An evaluation showed a 60% reduction in the proportion of opioid-related deaths that occurred within 4 weeks of prison-release (from 10% to 4%) (Bird *et al.*, 2017). Naloxone provision to prisoners on release from prisons in Wales is also nationally funded.

The English N-ALIVE randomised trial showed that it was also feasible to provide naloxone in English prisons. Released prisoners more often use naloxone to reverse overdoses that are experienced by others, rather than themselves (Parmar *et al.*, 2017). This suggests a potential diffusion of benefit from providing naloxone pre-release in preventing overdose deaths in the community.

The Scottish experience has provided a number of useful operational lessons for maximising the potential of naloxone to save lives on release from prison. This includes, for example, ensuring that a naloxone kit is placed in a prisoner's valuables before their release date so that the person does not have to wait for a kit to be delivered to them on that day (Horsburgh, 2018). The bulkiness of the kit has been a barrier to people carrying it for when they might need to use it, but different formulations and more compact intra-nasal kits that have recently become available offer the potential to increase the life-saving use of naloxone (Bird & McAuley, 2019).

- 8. That relevant agencies (for example, PHE) establish custody-community pathways into identified treatment for prisoners who have an assessed problem with alcohol, cannabis, cocaine, or other non-opioid drugs – as well as for users of opioids. Additionally, that a pathway should be developed that offers sufficient support to enable prisoners leaving abstinence-focused interventions to maintain such change following release.**

The experience of the drug recovery wing pilots suggests that existing services in England do not provide sufficient responses to the needs of people who have problems with substances other than opioids. It also suggests that the benefits of abstinence-focused interventions in prisons are often lost when people are released (Lloyd *et al.*, 2017). **Therefore, the ACMD recommends that post-release pathways for people with non-opioid problems and for people who have achieved abstinence in prison be strengthened.** This could include reference to the *Drug, Alcohol and Tobacco Health Services in Scottish Prisons: Guidance for Quality Health Service Delivery* (NHS Scotland, 2016) and the police care network's guideline for substance misuse in police custody (Police Care Network, 2015).

- 9. That the Home Office should commission research specifically to identify and ameliorate problems and opportunities related to transitions into and out of police custody by people who have problems with drugs. This should include gathering information, across the UK, on:**
 - a. the levels of overdose and drug-related deaths in police custody and immediately afterwards; and,**
 - b. the coverage and effectiveness of Liaison and Diversion schemes in meeting the needs of arrestees with drug and alcohol misuse problems.**

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Appendices

Appendix 1 – Stakeholder engagement and Quality of Evidence

The Custody-Community Transitions working group wrote to stakeholders requesting written or oral submissions. Written evidence was received from the following:

- Adfam
- the Association of Police and Crime Commissioners (APCC)
- Blenheim
- Changing Lives
- Clinks
- Collective Voice
- the Care Quality Commission (CQC)
- Essex County Council
- Forward
- HM Inspectorate of Prisons (HMIP)
- HM Inspectorate of Probation (HMI Probation)
- Humankind
- Indivior
- INQUEST
- Manchester Metropolitan University
- Ministry of Justice (MoJ) and HM Prison and Probation Service (HMPPS)
- Newcastle University
- NHS England
- Phoenix Futures
- Police and Crime Commissioner (PCC) North Wales
- Positive Prison, Positive Futures
- Release
- West Yorkshire Police

Oral Evidence was received from the following at the evidence gathering day:

- Vivienne Evans – Adfam
- John Jolly – Blenheim
- Paul Hayes – Collective Voice

- Hattie Moyes – Forward Trust
- Rob Ralphs – Manchester Metropolitan University
- Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPPS)
- Kate Davies – NHS England
- Karen Biggs – Phoenix Futures
- Nino Maddalena and Alicia Cooper – Public Health England (PHE)

This report also draws on evidence from peer reviewed literature, independent report, and policy evaluations. The majority of evidence used was from the UK but some international examples are referred to. Evidence gathered was considered in line the ACMD's SOP for quality of evidence.

Appendix 2 – Previous recommendations reviewed by the inquiry

Bradley, Lord K. J. C. B. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system* (p 226). London: Department of Health.

Corston, J. (2007) *The Corston Report: a report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system.*

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Appendix 3 – List of abbreviations used in this report

ACMD	Advisory Council on the Misuse of Drugs
BBV	Blood borne virus
CARAT	Counselling, Assessment, Referral, Advice and Throughcare
CCT	Custody-community transition
CJJI	Criminal Justice Joint Inspectorates
CRCs	Community Rehabilitation Companies
CSTR	Community sentence treatment requirements
DH	Department of Health
DHSC	Department of Health and Social Care
DIP	Drug Interventions Programme
DSB	Drug Strategy Board
DWP	Department for Work and Pensions
EPRA	Ex-Prisoners Recovering from Addiction
HMCTS	Her Majesty's Courts and Tribunals Service

HMIP	Her Majesty's Inspectorate of Prisons
HMI Probation	Her Majesty's Inspectorate of Probation
HMPPS	Her Majesty's Prison and Probation Service
IDTS	Integrated Drug Treatment System
ISD	Information Services Division (Scotland)
L+D	Liaison and Diversion
MHCLG	Ministry of Housing, Communities and Local Government
MMU	Manchester Metropolitan University
MoJ	Ministry of Justice
NACRO	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NPS	National Probation Service
OST	Opioid substitution therapy
PHE	Public Health England
PSS	Post-sentence supervision
THN	Take-Home Naloxone

Appendix 4 – Working Group Membership

Professor Alex Stevens – Chair of ACMD's Custody-community transitions working group, ACMD member.

Annette Dale-Perera – ACMD Member (Until Jan 2019)

Rosalie Weetman – ACMD Member (From Oct 2018)

Charlie Lloyd – University of York

Lesley Graham – Information Services Division Scotland

Mark Gillyon-Powell – NHS-England

Alpa Parmar – MoJ

Mark Johnson – User Voice

The working group also received input from various government stakeholders, including teams in PHE, HMIP, MoJ, HMPPS, and NHS-E.

Appendix 5 – ACMD Membership

Dr Kostas Agath	Consultant Psychiatrist (addictions), CGL Southwark
Dr Owen Bowden-Jones	Chair of ACMD, Consultant psychiatrist, Central North West London NHS Foundation Trust
Dr Anne Campbell	Lecturer in social work and Co-Director of the drug and alcohol research network at Queens University Belfast
Mr Mohammed Fessal	Chief Pharmacist, CGL
Dr Emily Finch	Clinical Director of the Addictions Clinical Academic Group and a consultant psychiatrist for South London and Maudsley NHS Trust.
Mr Lawrence Gibbons	Head of Drug Threat – NCA Intelligence Directorate – Commodities

Dr Hillary Hamnett	Senior Lecturer in Forensic Science, University of Lincoln
Professor Graeme Henderson	Professor of Pharmacology at the University of Bristol
Dr Carole Hunter	Lead pharmacist at the alcohol and drug recovery services at NHS Greater Glasgow and Clyde
Professor Roger Knaggs	Associate professor in clinical pharmacy practice at the University of Nottingham
Professor Tim Millar	Professor of Substance Use and Addiction Research Strategy Lead at the University of Manchester
Mr Rob Phipps	Former Head of Health Development Policy Branch, Department of Health, Social Services and Public Safety, Northern Ireland
Mr Harry Shapiro	Director - DrugWise
Professor Alex Stevens	Professor of Criminal Justice, University of Kent
Dr Richard Stevenson	Emergency Medicine Consultant, Glasgow Royal Infirmary
Dr Paul Stokes	Senior Clinical Lecturer in mood disorders, King's College, London
Dr Ann Sullivan	Consultant physician in HIV and Sexual health.
Professor Matthew Sutton	Chair in Health Economics at the University of Manchester and Professorial Research
Professor David Taylor	Professor of Psychopharmacology, King's College, London
Professor Simon Thomas	Consultant physician and clinical pharmacologist, Newcastle hospitals NHS Foundation Trust
Dr Derek Tracy	Consultant Psychiatrist and Clinical Director, Oxleas NHS Foundation Trust
Miss Rosalie Weetman	Senior Commissioning Manager of Substance Misuse