50 years of social action
Blenheim

Failure by Design and Disinvestment: the Critical State of Custody-Community Transitions

Blenheim CDP, a charity registered in England and Wales (293959).

Introduction

This report originally formed the basis of Blenheim's submission in June 2018 to the Advisory Council on the Misuse of Drugs in response to their call for evidence on custody-community transitions.

Blenheim has concerns about two principal issues surrounding our service users being released from custody: the high levels of drug-related deaths in the immediate post-custody period, and (often long term) service users dropping out of treatment at a critical time, rendering them both more vulnerable to harm and relapse and undermining positive treatment and recovery work both in the community and in custody.

This paper is focused on these two concerns and is structured in a straightforward manner. We start by presenting a brief overview of the evidence around drug-related deaths and treatment drop-out before examining two key issues which we feel are exacerbating current difficulties – the changes in probation provision and the disinvestment in criminal justice provision within drugs services. Our priority in writing this paper is to highlight a number of recurrent practical barriers to continuity of care and to bring a range of positive practices to the attention of policy makers.

This paper was prepared by Russell Webster on behalf of Blenheim.

About Blenheim

Blenheim is a charity that helps people struggling with alcohol and substance misuse across London by providing accessible support and help to end their dependency. We have a number of recovery services running across Bexley, Enfield, Hammersmith and Fulham, Haringey, Hillingdon, Islington, Kensington and Chelsea, Lambeth, Lewisham, Redbridge, Tower Hamlets, and Westminster. Each of these services provides free, friendly, and non-judgmental support, offering unique and tailored services to the individuals and their communities. For over 50 years Blenheim has been pioneering services and social action. As a charity, we are committed to innovating and campaigning for best practice and positive change in the alcohol and substance misuse field.

The Evidence

Drug-related deaths

There is a growing international evidence base about the high risk of overdose and death of opiate using prisoners, in particular in the period immediately post-release. A recent large scale Norwegian study[1] examined the deaths of all prisoners in the first six months of their release over a fifteen year period (1 Jan 2000 to 31 December 2014); the sample comprised 92,663 prisoners released a total of 153,604 times and the study found that overdose was the most common reason for death at every time period within the first six months post-release.

During the first week post-release, overdose deaths accounted for 85% of all deaths, with accidents accounting for 6% and suicide for 3%. Overdose deaths peaked during the first days post-release, and thereafter declined gradually during the first month post-release. During the second week post-release, the total number of deaths approximately halved (versus first week), with overdose deaths accounting for 68% of all deaths. During weeks 3–4 and months 2–6, overdose death accounted for 62% and 46% of all deaths, respectively.

Table 2: All-cause and cause-specific mortality rates during different time-periods following release (n=91090); crude mortality rates (CMR) per 1000 person-years and 95% confidence interval (CI).

	First week		*Second week*		*Weeks 3-4*		*Months 2-6*		*Total 106 months*	
	n	*CMR (95% CI)*	*n*	*CMR (95% CI)*	*n*	*CMR (95% CI)*	*n*	*CMR (95% CI)*	*n*	*CMR (95% CI)*
Overdose deaths	123	42.9 (35.5 - 50.3)	52	18.2 (13.4 - 23.1)	50	8.8 (6.4 - 11.2)	268	4.5 (3.9 - 5.1)	493	7.0 (6.3 - 7.6)
Accidents	9	3.1 (1.1 - 5.1)	7	2.5 (0.7 - 4.2)	4	0.7 (0.0 - 1.4)	82	1.4 (1.1 - 1.7)	102	1.4 (1.1 - 1.7)
Suicide	4	1.4 (0.1 - 2.7)	5	1.8 (0.3 - 3.3)	11	1.9 (0.8 - 3.1)	54	0.9 (0.6 - 1.2)	74	1.0 (0.8 - 1.3)
Cancer/ cardiovascular	3	1.0 (-0.1 - 2.2)	6	2.1 (0.5 - 3.7)	7	1.2 (0.3 - 2.1)	61	1.0 (0.7 - 1.3)	77	1.1 (0.8 - 1.3)
Other	6	2.1 (0.5 - 3.7)	7	2.5 (0.7 - 4.2)	9	1.6 (0.6 - 2.6)	114	1.9 (1.5 - 2.3)	136	1.9 (1.6 - 2.3)
All causes	145	50.5 (42.5 - 58.6)	77	27.0 (21.1 - 32.9)	81	14.3 (11.3 - 17.4)	579	9.7 (8.9 - 10.6)	882	12.5 (11.6 - 13.3)

[1] Anne Bukten, Marianne Riksheim Stavseth, Svetlana Skurtveit, Aage Tverdal, John Strang & Thomas Clausen (2017) High risk of overdose death following release from prison: variations in mortality during a 15 year observation period. Addiction Volume112, Issue 8 August 2017 Pages 1432-1439.

The authors suggest that the high proportion of overdoses in the immediate period following incarceration might reflect prison settings where released inmates typically have a history of heroin or opioid use, and may also be particularly high in settings where polydrug injection is a common mode of administration. For several years, Norway, like the UK, has been ranked as one of the European countries with the highest rates of overdose mortality, often explained by high rates of injecting drug use and an ageing polydrug-using population.

Recent UK research[2] also found that the first week following prison release was the period of highest risk of mortality with drug-related deaths the main cause.

We do not have an accurate figure of the number of drug-related deaths of recently released prisoners in England and Wales, although the latest ONS Statistical Bulletin[3] revealed there were 3,744 drug poisoning deaths involving both legal and illegal drugs in England and Wales registered in 2016; this is 70 higher than 2015 (an increase of 2%) and the highest number since comparable statistics began in 1993.

Treatment drop-out post release

There are also robust data available via the National Drug Treatment Monitoring System about the high levels of treatment drop-out on release from custody. The latest figures[4] show that just 30.3% of adults who engage with substance misuse treatment in custody engaged in community-based structured treatment within 21 days of release:

> **“Public Health Outcomes Framework indicator 2.16 – adults with a substance misuse treatment need who successfully engage in community-based treatment within 3 weeks, following release from prison, 2017-17”**

[2] Phillips, H. Gelsthorpe, L. & Padfield, N. (2017) Non-custodial deaths: Missing, ignored or unimportant. Criminology and Criminal Justice https://doi.org/10.1177/1748895817745939

[3] Office for National Statistics (2017) Statistical Bulletin: Deaths related to drug poisoning in England and Wales: 2016 registrations

[4] Office for National Statistics and National Drug Evidence Centre (2018) Secure setting statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2016 to 31 March 2017

Area	n	%	95% Lower CI	95% Upper CI
North East	926	40.7	38.7	42.7
North West	1539	30.7	29.4	32.0
Yorkshire & The Humber	1036	32.1	30.5	33.7
East Midlands	722	29.6	27.9	31.5
West Midlands	1256	31.5	30.1	33.0
East of England	808	32.8	31.0	34.7
London	1075	21.0	19.9	22.1
South East	870	28.9	27.3	30.6
South West	773	35.5	33.5	37.5
England	**9005**	**30.3**	**29.8**	**30.8**

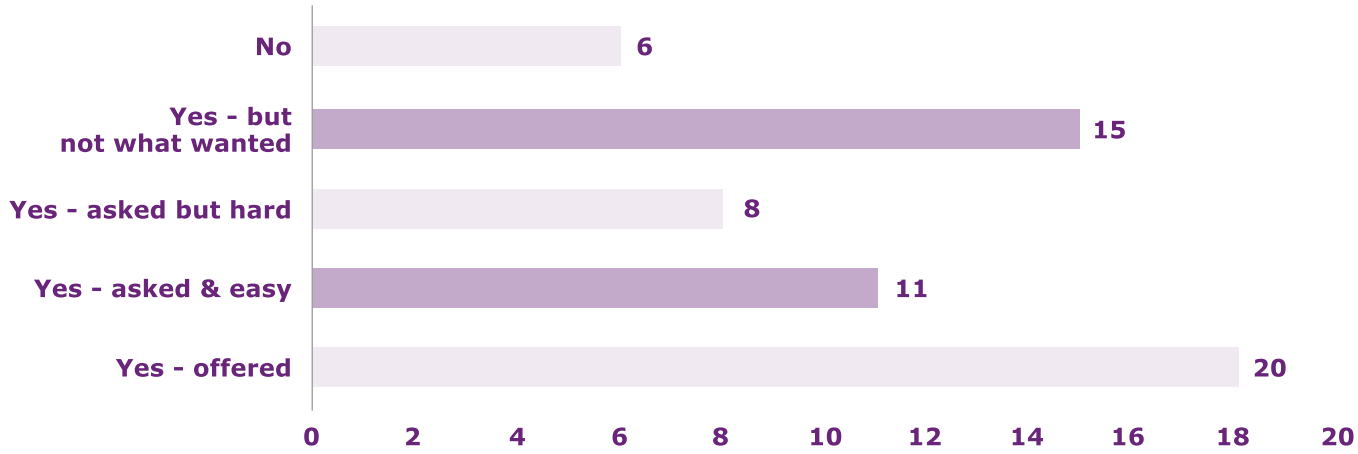
A 2017 study by Webster[5] gathered the views of 111 individuals who had sought Opioid Substitution Treatment in custody in England and Wales within the last two years. Interestingly, the study found a wide range of experiences of OST in custody with a significant minority finding it easier to access OST in custody than in the community. **The main findings were:**

- The quality of OST varies considerably between establishments.
- There was little consistency of approach with different prisons adopting different prescribing preferences; some favouring methadone, others buprenorphine.
- BAME individuals found it harder to get their prescribing needs met.
- The diversion of prescribed medications is a major concern for many prisons and appears to have substantial impact on prescribing regimes.
- Support for short term opiate using prisoners is lacking even though a large proportion of drug dependent offenders are typically repeatedly sentenced to short prison terms owing to their high volume but low seriousness offending.
- Despite many criticisms, there was an acknowledgement of considerable improvement in prison OST over the last 10-15 years with service users equally split between those who rated their prison drug treatment experience as excellent and good and those who rated it poor or terrible.

[5] The findings of this research and related strategy recommendations are to be found in: Alam,F. et al. (Forthcoming) Optimising opioid substitution therapy in the prison environment. International Journal of Prison Health.

Service users were asked specifically about their experience of continuity of prescribing on release. Eighty six survey respondents answered the question: If you wanted a continuing prescription on release, did you get it? Fifty six of these stated they did want medication on release. The chart below shows how easy it was for them to access this medication. Just over half (29/56 = 52%) were either offered medication on release or asked for it and secured it easily. However, almost two fifths (21/56 = 38%) either received no medication or did not get the type or as much as they wanted.

If you wanted a continuing prescription on release, did you get it? (n = 56)



Several individuals who did receive a continuing prescription commented that they received sufficient substitute medication to last between one and three days before seeing their drug worker in the community. Four respondents reported difficulties in getting seen promptly by their community agency and running out of substitute medication.

The research also included a focus group in the community with nine individuals who had recently accessed OST in custody; four of these interviewees reported difficulties in accessing a continuing prescription on release. One individual was made a follow-up appointment with a drug agency in the wrong town (the city in which the prison was located, as opposed to his home town); two others reported difficulties in getting to appointments in time. They stated that although it was relatively easy to re-schedule an early appointment with a drug worker, it could be several weeks before they were able to see the prescribing physician. In these cases, individuals reported that they had resorted to crime to fund the purchase of heroin.

Exacerbating factors

Changes in probation provision

The changes in probation supervision following the implementation of the government's Transforming Rehabilitation project in 2015 are well known. Blenheim wishes to highlight two particular concerns: the general lack of preparation for release and resettlement work for short-term prisoners (those serving custodial sentences of less than 12 months, many of whom are drug dependent offenders who commit a high volume of low level offences) and the significant reduction in the amount of substance misuse treatment provision commissioned by both the National Probation Service and the 21 Community Rehabilitation Companies.

Our concerns are shared by Her Majesty's Inspectorate of Probation. In HMIP's most recent annual report[6], the Inspectorate noted: "*with few exceptions, we found Through the Gate services extremely poor in both of our inspections*". **Chief Inspector Dame Glenys Stacey goes on to make her point in the most forthright terms:**

> **"It is most unusual for inspection not to drive improvement. CRCs are not paid enough to deliver a full and effective service, however, and are not required by their contracts to provide the intensive help government anticipated. Instead, the minimum requirement is to complete and review resettlement plans for each prisoner, ahead of release. We find that plans are prepared but most are woefully inadequate; most reviews are cursory at best, and very few plans are followed through, to make any real difference."**

[6] HM Inspectorate of Probation (2017) 2017 Annual Report.

Similarly, in a very recent (April 2018) inspection report into probation service supply chains, HMIP concluded:

“ It seems that the third sector is less involved than ever in probation services, despite its best efforts; yet, many under probation supervision need the sector’s specialist help to turn their lives around… It is an exasperating situation. Many are providing more expansive service to individuals than they are paid for. Supply chains are thin, however, and set to get thinner still, as CRCs continue to review and slim down provision. ”

The Inspectorate notes, in somewhat aggrieved terms, that information about CRC supply chains nationally is difficult to acquire:

“ This information was not consistently provided on CRC websites, and was not in the public domain. It was not made readily available to HMI Probation inspectors either: despite requests, neither the MoJ nor HMPPS furnished us with a comprehensive list of Tier 2 providers. ”

The Inspectorate resorted to undertaking its own survey and received responses from 17 of the 21 CRCs. Analysis of the survey found that the value of contracts had reduced substantially since Transforming Rehabilitation with 53% being worth less than £100,000 per year and 34% less than £50,000 per year. 48% contracts were staffed by the equivalent of just two full-time workers. In the eight CRC areas inspected for this report, not a single CRC was commissioning a specialist substance misuse service. Prior to Transforming Rehabilitation, all, or almost all, probation trust areas commissioned expert input from local drug and alcohol treatment services.

The Inspectorate’s concerns are borne out by NDTMS figures[7]. In 2013/14 5% of new presentations to treatment were referred by probation, by 2016/17 this proportion had fallen to 3%. As an organisation, we used to operate a number of dedicated community programmes for offenders subject to drug rehabilitation requirements (DRRs) but most of these have been discontinued by commissioners, mainly owing to funding concerns with the result that DRRs are rarely recommended with the consequent cancellation of more criminal justice specific treatment.

[7] National Drug Evidence Centre. Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS). Parallel reports published in November 2014 and November 2017.

Disinvestment from criminal justice specific services

The disinvestment in substance misuse treatment by the probation service is mirrored by reductions in other parts of the criminal justice system. The Drugs Intervention Programme (DIP), was introduced by the Home Office in 2003 to engage Class A dependent drug offenders in treatment and was funded to the tune of £114,652,800 in 2007/8. The Home Office DIP funding ceased in 2013 with a much reduced level of funding picked up by health and wellbeing boards and community safety partnerships, varying considerably across the country. Again NDTMS figures are telling: the proportion of new treatment presentations referred by arrest referral/DIP reduced from 11% in 2013/14 to 3% in 2016/17. The scale of cuts can be alarming: we took over delivery of a Criminal Justice Intervention Team in Enfield where the number of staff commissioned was reduced from twelve to just two.

Blenheim's experience of this diminishment of DIP is that there can be considerable confusion about which aspects of a local DIP are still running and a lack of clarity about new operational models. In terms of running stripped down DIP teams, we have prioritised the maintenance of key local relationships to ensure an effective service. **Specific examples of our priorities include:**

- Maintaining close arrest referral contacts and engaging local police inspectors to trust the recommendations of experienced local arrest referral workers – more tests are undertaken on inspectors' authority than simply on the basis of an individual being charged with an offence of acquisitive crime, leading to more positive tests and more offers of treatment.

- Maintaining close links with the National Probation Service at court – this allows DIPs to manage budgets by not having a referral worker based full-time in court, safe in the confidence that the NPS will notify us of an individual who needs to be assessed.

- Resisting the temptation to cut prison link roles – without an individual worker with the responsibility to make the custody-community transition work, good work in custody can go to waste.

- Encouraging prison treatment staff to do more than routinely maintain opiate-dependent prisoners on OST and to recognise that for many people, custody can be an opportunity to engage in recovery work.

Similarly, investment in substance misuse treatment in custody has been substantially reduced, mainly as a result of the austerity measures which will see the overall MoJ budget cut by a cumulative 40% in real terms over the fiscal decade ending in 2020. Current projections show the departmental spending limit will be £5.6bn by 2019/20. In real terms, the comparable budget in 2010/11 was £9.3bn[8]. Many providers have found that prisons have not re-tendered substance misuse treatment contracts but integrated these into overall prison health contracts. The lack of dedicated contracts has accelerated the reduction in funding for prison-based drug and alcohol treatment. This impact is again evidenced by NDTMS official statistics: the proportion of new treatment presentations referred by prisons reduced from 9% in 2013/14 to 6% in 2016/17.

Dave had been in and out of prison over the last 10 years and was stuck in a cycle of offending, homelessness and drug use. The Grove's Prison Link Worker started working with Dave early on in his last sentence and they met regularly working on building coping techniques often used in the community, such as; relapse prevention, motivation, life skills and reconnecting with people.

Dave wanted to attend rehab when he was released so the Prison Link Worker sought funding for this and arranged transport to the centre on his release day. Dave completed rehab, is abstinent six months on and has reconnected with some of his family.

[8] Reported in the Law Society Gazette on 20 November 2017 using information provided in a written parliamentary answer: https://www.lawgazette.co.uk/news/moj-reveals-massive-budget-cut-as-new-advice-deserts-open-/5063763.article

Common barriers to continuity of care on prison release

Blenheim's experience is that many of the most common barriers to continuity of care between custody and community are attributable to basic problems and difficulties. **These fall into two main categories:**

1. Reduced funding at every point of the justice and treatment systems.

2. Confusion and miscommunications caused by frequent realignment of services, again often occasioned by the need to operate with reduced funding.

Reduced funding

One of the key critical success factors of the Drugs Intervention Programme was the development of culture of proactivity; practitioners were aware that the criminal justice system has never been as joined up as policymakers would like and therefore operated in full knowledge that workers needed to take positive steps to make the system work and ensure continuity of care between different agencies and facilitate transitions between custody and community. For instance, many DIPs operated detailed case management systems in which awareness of an individual drug using offender's release from prison was triggered 4 to 6 weeks before that date; this enabled workers to track down the individual (who may have been transferred between prisons or had his/her original release date changed) and ensure that a proper release plan was both in place and known to all the key providers. As funding has been reduced, with workers under more workload pressure, this proactive approach has been much more difficult to put in place with the result that a number of everyday difficulties often obstruct integrated case management.
Our staff repeatedly raise such basic issues such as:

- The difficulties in accessing different computerised systems within different agencies, particularly in custodial settings;

- Cuts in staffing resulting in a lack of admin support with frontline practitioners spending disproportionate time on administrative tasks at which they are not particularly skilled;

- Frequent recommissioning, typically with a number of historically separate services being brought together under one contract in order to facilitate cost saving.

Confusion and miscommunications

Communication has always been challenging within the criminal justice system but it has become much more so in recent years owing to the constant restructuring of all the main agencies. **Examples include:**

- Closure of courts and police stations – our staff relate a number of instances where engagement work was taking place effectively at a particular court or police station only for it to be disrupted by a series of closures and relocations;

- The re-purposing of different custodial establishments;

- The confusion inherent in the need to liaise with two separate probation organisations (the National Probation Service and 21 different Community Rehabilitation Companies) in every locality. Long-standing information sharing protocols have to be rewritten and often modified and revised as the new probation system beds in;

- Basic everyday communication being bedevilled by unreliable IT systems, difficulty in accessing Wi-Fi in court and police station settings and the difficulty in getting different case monitoring systems to speak to each other.

Sometimes, these difficulties result in complete system failure with Blenheim staff often receiving the first information about an individual in need of treatment in the community via a fax sent on the day before release. Conversely, carefully developed release plans are often undermined through seemingly minor mistakes – it is relatively common for a released prisoner to be given conflicting appointments with probation and community drug treatment on the day of release. Individuals often prioritise the probation appointment for fear of being recalled to prison and thereby miss their window for engaging with support in the community, suffering the disruption of opioid substitution therapy et cetera. When systems were more fully resourced, it would be commonplace for a drug worker to meet a released prisoner on probation premises, cementing a joined up approach to post-release support.

Other recurrent difficulties reported by our staff are:

- Short term prisoners not entered on the prison computerised system so treatment providers are unaware that they are in need of support and receive no information about their release date.

- Siloed OST provision in prison with those receiving this treatment often not referred for psychosocial support.

- Blenheim treatment services are open late on Fridays to accommodate the disproportionate number of prisoners released on this day (Friday releases also include those who release date falls on the Saturday or Sunday) but it is not possible to contact the prison after office hours to confirm prescription details etc.

- Despite the best efforts of Public Health England, Blenheim workers have found that it is rare for any of our service users to be released from prison having been provided with Naloxone, medication which is literally life-saving in the case of overdose.

The main issue identified by Blenheim staff is the reduction in funding and service provision in the wider social care sector. It is difficult to develop a proper post-release support plan when it is often almost impossible to secure safe accommodation. In our experience, women drug using offenders who are released from prison without appropriate housing are particularly vulnerable to the exploitation of men for sexual profiteering (pimping) or repeat domestic abuse.

Possible solutions

We have catalogued a series of fairly basic, mainstream failings and therefore it is our primary recommendation that criminal justice and treatment services are adequately resourced in order to allow them to operate effectively and to re-prioritise active efforts to cooperate and develop practical and meaningful post-release support plans with the active involvement and engagement of the service user.

There are a number of instances of good practice around the country often led by relatively small third sector services, often despite being underfunded, continuing to work in this way. These organisations are often described as succeeding despite the formal structures of the criminal justice system. **These include:**

- The virtual departure lounge at HMP Ranby which focuses on supporting prisoners to engage with substance misuse, mental and physical health services in the community linked to the services they received in custody.

- North Ayrshire Alcohol and Drug Partnership operate a peer mentor inreach project into HMP Kilmarnock, engaging with service users before release and supporting them through the transition from custody and the early weeks in the community until they are fully engaged with a range of community organisations.

New technology can help bridge the gap between custody and community: a partnership between Socrates Software and Care UK (a large prison healthcare provide) involves Care UK uploading prisoners' medical records so that they can access them on release via a free app to make continuity of care easier in the community; particularly with issues such as mental health and drug treatment where community physicians can continue the same prescribing patterns established by their custodial counterparts. Care UK can also upload community appointments for prisoners organised pre- or post-release and send service users reminders about these via the Socrates 360 app[9].

If policy makers are looking for a structural solution, then the example of the Scottish Prison Service's through care support service is worthy of further exploration. Since April 2015, the Scottish Prison Service (SPS) has been providing a dedicated throughcare support service, with 42 Throughcare Support Officers (TSOs) in 11 prisons. Throughcare involves taking a coordinated approach to the provision of support to people who serve short-term prison sentences (less than four years), from their imprisonment, throughout their sentence, and during their transition back to the community and initial settling-in period.

A 2017 evaluation[10] of this throughcare support service was positive, the research found evidence of better engagement with support agencies, improvements to self-efficacy and desistance and progress on tackling a range of individual issues including substance misuse. **Both treatment services and service users stated that TSO support helped in four principal ways:**

1. Links between TSOs and addictions services in prison helped identify and access support in prison and the community.

2. Liberation day support helped avoid a high risk of drug and alcohol misuse, and the associated health and reoffending risks.

3. Support from TSOs helped keep people focused on recovery and provided a point of contact if there was a risk of relapse.

4. Support from TSOs helped prevent other problems causing relapse.

Conclusion

In conclusion, it is clear that good quality supported transitions between custody and community for people dependent on drugs are now the exception rather than the norm, which they had started to become when the Drugs Intervention Programme was fully resourced. In addition to restoration of funding to all components of the criminal justice and substance misuse treatment sectors, Blenheim urges policy makers to encourage a return to the pro-active case management approach developed under the auspices of the DIP and urgent action by Her Majesty's Prison and Probation Service to ensure that naloxone is distributed to all drug using offenders on release.

[9] https://socrates-software.com/
[10] Reid-Howie Associates Ltd (2017) Evaluation of the SPS throughcare support service.

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