Independent Advisory Panel on Deaths in Custody
Royal College of General Practitioners Secure Environments Group

Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system

January 2022

Contents

Introduction

1. The scale of drug and alcohol misuse in the criminal justice system is significant and both directly and indirectly leads to deaths in custody. It impacts those in custody and the staff who are asked to provide for their care. When individuals are released into the community, support is often not available or accessed. These concerns are occurring against the backdrop of a rising number of drug deaths in England and Wales.

2. This paper presents the findings of joint research carried out by the Independent Advisory Panel on Deaths in Custody[1] (IAPDC) and the Royal College of General Practitioners[2] (RCGP) into these issues.

Policy background

3. In 2021 the IAPDC was asked by Her Majesty's Prison and Probation Service (HMPPS) to contribute to the review of their 2019 drug strategy from the perspective of deaths in custody and meeting obligations to protect lives. The strategy, originally published in 2019, is being revised to address the need for a whole-system approach to tackling drugs and alcohol in the criminal justice system. Due to the impact of drugs, particularly psychoactive substances within prison custody, the former iteration of the strategy focused primarily on the prison estate. The revised strategy will also seek to reduce alcohol and drug-related deaths of prison leavers who are supervised by the reunified Probation Service.

4. The IAPDC welcomes this review and the cross-government approach to drug and alcohol-treatment, particularly in the context of the publication of Dame Carol Black's Independent Review of Drugs[3] in February 2020 which called for a renewed focus on drugs across government. The second part of this review, published in July 2021, called for a whole-systems approach, with government departments working together to provide housing, employment and health support in addition to drug addiction treatment to help prevent deaths.[4]

5. The Prime Minister's Crime and Justice Taskforce (CJTF) was established last year to consider matters relating to the prevention of crime and the effectiveness of the criminal justice system, including using a cross-Government approach to combat drug misuse. The Home Secretary, the Secretary of State for Health and Social Care and the Lord Chancellor are core members of this Taskforce. In January 2021, the Government announced £80 million funding for drug treatment in England in 2021/22 – the biggest increase in 15 years[5]. Most of these funds will be allocated to Local Authorities through universal grants to enhance drug treatment, focusing on drug-related crime and preventing deaths.

6. Government criminal justice interventions concerning substance misuse include the recent roll-out of 'sobriety-tags', which will be worn on an ankle and can measure alcohol intake

[1] Independent Advisory Panel on Deaths in Custody, 'About the IAPDC'. Available at: https://www.iapondeathsincustody.org/about-us-1 [Accessed: 25/03/2021]
[2] Royal College of General Practitioners, 'Secure Environments Group'. Available at: https://www.rcgp.org.uk/clinical-and-research/about/special-interest-groups/secure-environments-group.aspx [Accessed: 25/03/2021]
[3] Home Office. (2020) *Review of Drugs: Phase one report*. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report [Accessed: 25/03/2021]
[4] Home Office. (2021) *Review of Drugs: Phase two report. Available at:* https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery. [Accessed: 23/07/2021]
[5] Home Office. (2021) *Press release: £148 million to cut drugs crime.* Available at: https://www.gov.uk/government/news/148-million-to-cut-drugs-crime [Accessed: 25/03/2021]

through sweat[6], and the introduction of 28 X-Ray scanners which are used to detect contraband entering prisons[7].

7. In December 2021 the Government, responding to Dame Carol Black's review, published a ten-year plan to reduce the supply and demand for drugs and improve treatment and recovery, including within the criminal justice system.[8] The Prisons Strategy White Paper, published the same month, sets out intended plans to address substance misuse in prison.[9]

8. The context of COVID-19 adds extra urgency to this issue. It appears likely that the extensive isolation of prisoners to reduce the spread of the virus, often lasting up to 23 hours a day, will have exacerbated feelings of the hopelessness, boredom and desperation which leads to drug misuse, and presents a clear threat to life.

Methodology and conclusions

9. This report brings together significant expert advice with the specific focus on preventing substance misuse-related deaths. It therefore makes a distinct contribution to the HMPPS review in addition to wider government drug and alcohol policy.

10. The project was led by panel member Professor Jenny Shaw from the University of Manchester, and Dr Jake Hard, chair of the RCGP Secure Environments Group.

11. This paper is split into two main sections:
    - An analysis of current evidence, including a literature review and thematic analysis of findings from criminal justice scrutiny bodies.
    - Findings from an online roundtable event hosted by the IAPDC and RCGP with cross-sector experts on 15 April 2021.

12. This report highlights the need for a whole-systems approach to tackling substance misuse and aiding support and recovery. It also advocates for greater use of harm-reduction initiatives and the use of mechanisms to help ensure recommendations made following a death can be shared with the relevant people. **All work in this area must retain the prevention of avoidable deaths as its key driver.** The IAPDC and the RCGP will progress this work with ministers, officials, and members of the Ministerial Board on Deaths in Custody.

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[6] Ministry of Justice. (2021) *Press release: Sobriety tags launched in England to tackle alcohol-fuelled crime*. Available at: https://www.gov.uk/government/news/sobriety-tags-launched-in-england-to-tackle-alcohol-fuelled-crime [Accessed: 25/03/2021]

[7] Ministry of Justice. (2021) *Press release: X-ray scanners stop over 1,000 illegal items entering prisons.* Available at: https://www.gov.uk/government/news/x-ray-scanners-stop-over-1-000-illegal-items-entering-prisons#:~:text=The%20equipment%20is%20being%20funded,harm%20and%20crime%20behind%20bars [Accessed: 25/03/2021]

[8] HM Government. (2021) *From harm to hope: A 10-year drugs plan to cut crime and save lives*. Available at: https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives.

[9] Ministry of Justice. (2021) *Prisons Strategy White Paper*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038765/prisons-strategy-white-paper.pdf.

Key recommendations

Evidence base

1. The number of substance misuse-related deaths in the criminal justice system is still unclear. The last dataset analysed for deaths in prison is now five years old. The **Office for National Statistics (ONS)** and **HMPPS** should collaborate again on a review to detail the current size of the problem in prisons, with similar work carried out for deaths on community probation. Understanding who is dying and their characteristics should inform the prioritisation of future work to prevent deaths.

Sentencing

2. While funding has been sourced for the rollout of some Court-based Liaison and Diversion services (L&D) and Community Sentence Treatment Requirements (CSTRs), additional resources are still required to ensure greater coverage. Both initiatives help divert individuals with substance misuse problems away from short custodial sentences into treatment and help prevent deaths. However, for these to be effective, community drug and alcohol services need to be adequately resourced by the **Ministry of Justice, NHS England and NHS Wales** and the **Department of Health and Social Care** to ensure full coverage and reduce the waiting times between court sentence and treatment starting. Courts need to be informed about the availability of treatment in the community and provided with updates on treatment outcomes and evaluation.

Treatment

3. Drug and alcohol misuse is often associated with, or caused by, wider social and economic issues. A streamlined approach which encourages services to be collaborative, and ideally co-located, is required to enable services to work in an integrated way in response to multiple social needs (including housing, employment, mental and physical health, and the effects of prior trauma) and not just achieving abstinence. **HMPPS, Ministry of Justice** and the **Department of Health and Social Care** should consider collaborative commissioning of providers, so they become 'catch-all' services rather than providers of a collection of different parts of an individual's recovery.

4. The increased use of the newly available formulation of prolonged-release buprenorphine as an opioid substitution therapy (OST), given as weekly or monthly injection, would help to reduce risk and improve the continuity of treatment to service users as they move between community and prisons. **Substance misuse commissioners and community providers** should work together to ensure continuity in its use.

5. The use of naloxone as a form of harm-reduction for opioid abuse should be expanded, with training provided to prison staff (and members of the public) to raise awareness of overdose response. The use of naloxone would help prevent deaths associated with opioid overdose in the general public and promote a greater awareness of risks relating to drugs. The rollout of staff training in the use of naloxone is already in place in most Approved Premises. **Relevant substance misuse commissioners and community providers** should work together to encourage its use.

6. **NHS England and NHS Wales, HMPPS** and the **Ministry of Justice** should set out a specific approach to substance misuse for women in the criminal justice system and wider community health to account for the large catchment areas of women's prisons and the specific needs and vulnerabilities of women, for example relating to domestic violence and coercion.

Release from prison

7. People are at particular risk of substance misuse-related death when they transition between prison and the community. The introduction of 'bridging liaison' roles, created jointly by **HMPPS** and **NHS England and NHS Wales**, would reduce the risk of professionals working in silos and ensure continuity in treatment plans. Pre-release work should involve greater outreach from prisons to community services. This has a direct positive impact on an individual's compliance post-release and improves staff awareness of support available in the community.

Learning lessons from a death

8. To enable the learning of lessons by services and establishments following a substance-related death, independent recommendations made by **investigators and scrutiny bodies** should be given to specific owners and made with the clear appreciation as to what changes are realistically possible. Greater attention needs to be paid to communication with, and the respectful involvement of, bereaved families. Recommendations and their responses should be centrally stored by agencies so that they can be easily accessed by both operational and policy staff so future deaths can be prevented. This should include jury verdicts as well as matters of concern raised by coroner-written PFDs. The establishment of a national oversight body would serve to ensure timely compliance with recommendations made by coroners and scrutiny bodies.

9. **Investigators of substance misuse-related deaths** should take into account both the clinical and security factors relevant to the incident. Where possible, scrutiny bodies should identify where there had been missed opportunities for diversion. Staff from the relevant agencies should be supported by their organisations during the investigation process.

10. **NHS England and Health Inspectorate Wales** should work in collaboration with investigators to ensure commissioned independent clinical reviewers who assist in investigations into substance misuse-related deaths are qualified and experienced in the subject area. Experienced reviewers should also be involved in investigations into deaths in Approved Premises, where they are currently not utilised.

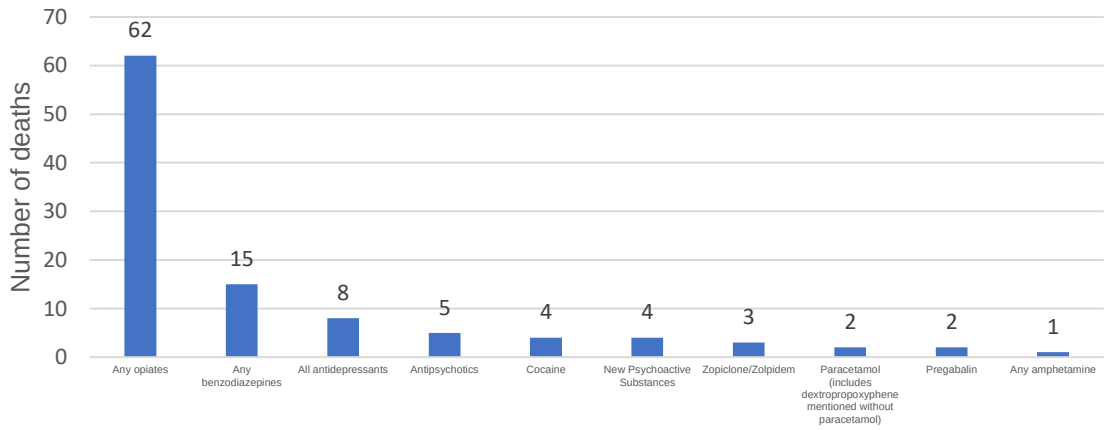
Part one: Background to substance-misuse related deaths in the criminal justice system

Drug and alcohol-related deaths in prison custody

> *"…I'm stuck in hell where it's impossible to be a better man. I'm surrounded by drugs."*[10]

13. There remains a lack of clarity over the precise number of people who are dying from alcohol and drug misuse in the criminal justice system. In 2019, HMPPS worked with the Office for National Statistics (ONS) on a report relating to deaths in prison custody occurring between 2008 and 2016.[11] In total, 1,830 deaths were identified by linking the ONS death registration database with Coroner data and the HMPPS deaths in custody database. Eighty-eight of these were identified as being drug-related, with 12 also being identified as self-inflicted. Eighty-two of the deceased were male. The rate of drug-related prison deaths was relatively similar to male drug-related deaths in the community. Of the 88 prison deaths, opiates were the most common drug type mentioned on death certificates (62 mentions), with methadone, heroin and morphine the most common forms.

Figure 1: Number of drug mentions for drug-related deaths in the prison population, England and Wales, 2008 to 2016



14. The classification of deaths in HMPPS Safety in Custody bulletins does not allow drug-related deaths to be readily identified.[12] Most of these deaths are found in the category of 'other: non-natural' (ONN), but smaller numbers are included in other categories (for example as 'self-inflicted' where there is an inquest conclusion of suicide). Of the 88 drug-related deaths identified in the ONS report, 41 (47%) were classified as ONN by HMPPS, with a further 13 (15%) unclassified awaiting further information (and likely to become ONN once classified). Twenty-four (27%) of the deaths were in the self-inflicted category, and 10 (11%) had been classified as natural causes.

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[10] Independent Advisory Panel on Deaths in Custody (2017) *Keeping safe - preventing suicide and self-harm in custody: Prisoners' views collated by the IAP*. Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ed5178d95645801a7a5e321/1591023614282/Keeping+Safe+-+FINAL+-+Dec+2017.pdf [Accessed: 25/03/2021]

[11] Office for National Statistics (2016) *Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2016*. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsandsuicideinprisoncustodyinenglandandwales/2008to2016 [Accessed: 25/03/2021)

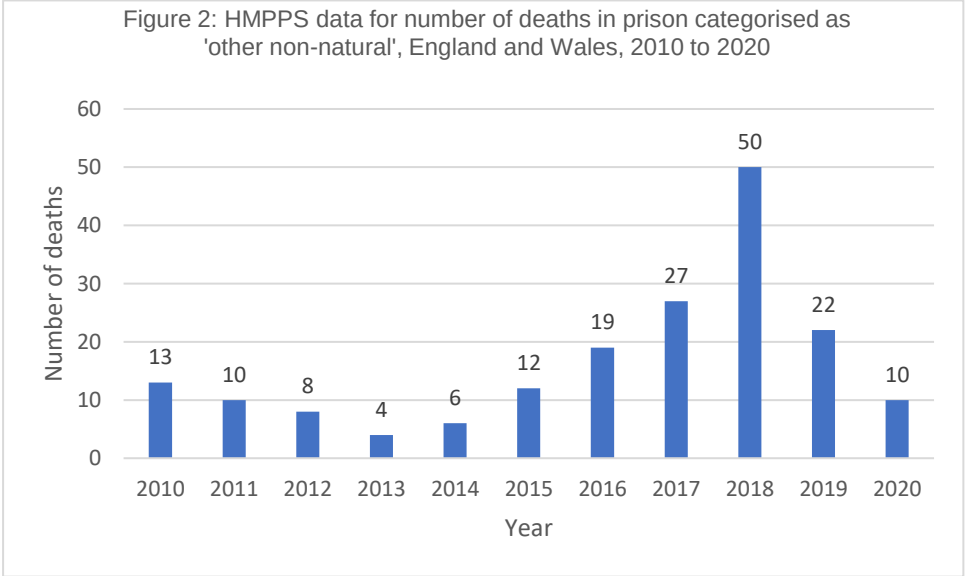
[12] Ministry of Justice and Her Majesty's Prison and Probation Service. (2021) *Safety in Custody quarterly: update to September 2020.* Available at https://www.gov.uk/government/collections/safety-in-custody-statistics [Accessed: 25/03/2021]

15. The ONN category includes a small number of unrelated deaths, such as accidents, but mostly consists of those related to drugs, so offers a useful proxy measure. Historically there were comparatively few deaths in this category until 2010-12, when an increase into double figures can be seen. This was the result of a number of deaths from the toxic effects of combining methadone and other prescription drugs such as pregabalin and gabapentin (often supplemented by other illicit drugs). Major reviews by HMPPS and NHSE resulted in changes to practice around prescribing and supervising the administration of such drugs, and there was a return to lower levels of ONN deaths in 2013-14.

16. A second, more dramatic increase in deaths within this category can then be discerned from 2015 onwards, reaching a peak of 50 in 2018 (and with 11 cases still awaiting classification because of delayed inquests, this is likely to be higher). Many cases since 2015 have been attributed to synthetic cannabinoid toxicity and other effects of the use of psychoactive substances, sometimes alongside prescription or other illicit drugs.

Recommendation: The number of substance misuse-related deaths in the criminal justice system is still unclear. The last dataset analysed for deaths in prison is now five years old. The **Office for National Statistics (ONS)** and **HMPPS** should collaborate again on a review to detail the current size of the problem in prisons, with similar work carried out for deaths on community probation. Understanding who is dying and their characteristics should inform the prioritisation of future work to prevent deaths.

Figure 2: HMPPS data for number of deaths in prison categorised as 'other non-natural', England and Wales, 2010 to 2020



17. Substance misuse is related to self-inflicted deaths. A national census of prisoner suicides between 1999 and 2007 found drug dependence to be significant in explaining suicides with the first week of custody.[13] Such deaths are avoidable. For example, research led by the National Confidential Inquiry into Suicide and Safety demonstrates a dramatic fall in self-

[13] N. Humber, M. Piper, L. Appleby, J. Shaw. (2011) 'Characteristics of and trends in subgroups of prisoner suicides in England and Wales', *Psychological Medicine*. Available at: https://www.cambridge.org/core/journals/psychological-medicine/article/abs/characteristics-of-and-trends-in-subgroups-of-prisoner-suicides-in-england-and-wales/D400EDBD6367B17CE94372D5D12C2BEF/ [Accessed 09/12/2021]

inflicted deaths in prison following the introduction of integrated drug treatment in prison from 2006 onwards.[14]

Drug and alcohol-related deaths on licence following release from prison

18. Until recently, HMPPS Deaths of Offenders in the Community[15] bulletins have used categories that do not allow the identification of deaths related to drugs and alcohol. The 2019-20 bulletin explains that an examination of a sample of cases had revealed that drug-related deaths are for the most part being recorded as 'self-inflicted'. A more detailed classification system was introduced in the 2019-20 publication, and shows 99 post-release deaths (61% of the total of 162 such deaths in the self-inflicted category, and 22% of the total of 458 post-release deaths) described as 'self-inflicted: drug overdose'. The commentary is clear that many of these are not deaths that would fit the definition of self-inflicted in the prison statistics, or be categorised as suicide by ONS. It should be noted that a further 98 post-release deaths were unclassified awaiting further information, and it is likely that this includes further drug-related deaths. Twenty-two (22%) of the 'self-inflicted: drug overdose' deaths occurred within 28 days of release.

19. The 2020-21 publication shows the number of deaths described as 'self-inflicted: drug overdose' increased from 99 the previous year to 146.[16] Of these, 36 occurred within 28 days of release.

20. The more detailed classifications cannot be applied retrospectively, but it is reasonable to assume that a similarly large proportion of deaths classified as 'self-inflicted' in previous years were drug-related. The numbers of 'self-inflicted' (and unclassified) deaths have risen in recent years, in part because the population on post-release supervision increased following the introduction of measures in the Offender Rehabilitation Act in 2015.

21. There is considerable evidence to suggest that people who have recently left prison are at a higher risk of death. One study suggested that male prisoners are 29 times more likely to die in the first week after release when compared to the general population[17], while another suggested the risk of dying in the first two weeks following release was eight times higher for former prisoners who use drugs compared to those who do not[18]. Such deaths could occur following release owing to lower tolerance, a lack of awareness of the strength of drugs recently introduced to the community and an element of 'celebration' of having been released[19].

[14] The National Confidential Inquiry and the Offender Health Research Network at the University of Manchester, National Offender Management Service at the Ministry of Justice and Offender Health at the Department of Health, 'National Study of Self-Inflicted Death by Prisoners 2008-2010. Available at: https://www.research.manchester.ac.uk/portal/files/70238158/report_2013.pdf [Accessed 09/12/2021]

[15] Ministry of Justice. (2020) *Deaths of Offenders in the Community, annual update to March 2020.* Available at https://www.gov.uk/government/statistics/deaths-of-offenders-in-the-community-annual-update-to-march-2020 [Accessed: 25/03/2021]

[16] Ministry of Justice. (2021) *Deaths of Offenders in the Community, annual update to March 2021.* Available at https://www.gov.uk/government/statistics/deaths-of-offenders-in-the-community-2020-to-2021 [Accessed: 13/12/2021]

[17] Farrell, M. and Marsden, J. (2008) 'Acute risk of drug-related death among newly released prisoners in England and Wales', Addiction,103, 2: 251-55.

[18] Merrall, E.LC., Karmininia, A., Binswanger, I.A., Hobbs, M.S., Farrell, M., Marsden, J., Hutchinson, S.J. and Bird, S.M. (2010) 'Meta-analysis of drug-related deaths soon after release from prison', Addiction, 105: 1545-54.

[19] Phillips, J., Gelsthorpe, L., Padfield N., Buckingham, S. (2016) *Non-natural deaths following prison and police custody*, Manchester: Equality and Human Rights Commission.

22. Approved Premises (APs) are used to accommodate some prison leavers who are assessed as presenting a higher risk of harm to the public. A 2017 report[20] by the Prisons and Probation Ombudsman (PPO) outlined that between 2012 and 2017, 29 deaths in APs had been investigated involving individuals whose death was drug-related or who had an identified history of substance misuse. Of these deaths, the majority involved the mixing of two or more substances (most commonly alcohol and opiates) and 11 of the 29 deaths occurred within the first two weeks after release. The review highlighted the need for all substances including psychoactive substances to be tested throughout the resident's stay, to build routine interactions to help prevent missed opportunities for signs of distress, and for the AP manual to provide guidance on drug-related issues for staff.

23. Substance misuse is a relevant factor in deaths within other places of detention across the criminal justice system. The Independent Office for Police Conduct (IOPC) 2020/21 annual report[21] outlined that of the 19 individuals who died in or following police custody, 14 of them had links to drugs or alcohol. This means that they were either in possession of, intoxicated by, or had known issues with drugs or alcohol. A year earlier, the number was 14 out of 18 individuals. Of these deaths, eight (2020/21) and seven (2019/2020) were judged by a toxicology report to have been directly caused by substance misuse.

24. The impact of alcohol misuse among those in the criminal justice system also should not be ignored. This is evidenced by HMI Probation's 2019/2020 annual report[22], which indicated that of those on probation, 42% of individuals identified as having alcohol issues whilst 41% reported drug concerns. Additionally, the link between alcohol abuse and criminality is evidenced by a matching exercise between the Public Health England (PHE) managed National Drug Treatment Monitoring System (NDTMS) and the Public National Computer (PNC). This showed that of the clients accessing treatment solely for alcohol in 2012, 44% could be matched between the NDTMS and the PNC.[23]

25. Alcohol is also often implicated in drug-related deaths which are otherwise often recorded as overdoses. Alcohol is a central nervous system depressant and compounds the effects of other central nervous system depressant substances, including illicit and prescribed drugs (such as opioids, benzodiazepines and gabapentinoids). In addition to being associated with drug use, the longer-term impacts of alcohol often lead to comorbid mental and physical health problems which can result in death.[24] Such concerns will be amplified in the offender population, where the average life expectancy is far lower than in the general public.[25]

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[20] Prisons and Probation Ombudsman. (2017) 'Approved Premises – Substance misuse', *Learning Lessons Bulletin: Fatal Incidents Investigations*, 14: 1-12

[21] Independent Officer for Police Conduct (2021) *Deaths during or following police contact: Statistics for England and Wales 2020/21.* Available at deaths_during_following_police_contact_202021.pdf (policeconduct.gov.uk) [Accessed:25/03/2021]

[22] Her Majesty's Inspectorate of Probation (2020) *2019/2020 Annual Report: Inspections of probation services.* Available at: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2020/12/2019-2020-Annual-Report-Inspection-of-probation-services.pdf [Accessed: 25/03/2021]

[23] Ministry of Justice and Public Health England (2017) The impact of community-based drug and alcohol treatment on re-offending. Available at: PHE-MoJ-experimental-MoJ-publication-version.pdf (publishing.service.gov.uk) [Accessed on 03/09/2021]

[24] Royal College of Psychiatrists (2020) *Detainees with substance use disorders in police custody: Guidelines for clinical management (fifth edition)*. Available at: college-report-cr227.pdf (fflm.ac.uk) [Accessed: 13/09/2021]

[25] Independent Advisory Panel on Deaths in Custody & The Royal College of Nursing (2020) Avoidable natural deaths in prison custody: putting things right. Available at: 200929+IAP-RCN+-+prevention+of+natural+deaths+in+custody+-+final+for+publication.pdf (squarespace.com) [Accessed: 13/09/2021]

Insight from scrutiny bodies

26. The PPO's 2019/2020 annual report[26] indicated signs of early promise in the impact of the 2019 HMPPS drug strategy on substance-related deaths. It suggested that this could be due to the requirement for prisons to develop their own local strategies to combat substance misuse.

27. The same report, however, highlighted the continuation of deaths relating to psychoactive substances (PS) which, in addition to causing physical reactions, have also been linked to the deterioration of mental health and eventual acts of self-harm and suicide. 'PS', in broad terms, refers to drugs intended to imitate the main effects of common drugs, such as cannabis, stimulants and hallucinogenics, and are often sold in prisons under names such as 'Spice' or 'Black mamba'. The PPO explains that these drugs vary in strength and effect, often resulting in unpredictable behaviour. Even a small dose of PS can prove fatal. One man died having had his cigarette 'spiked' by others who wished to gauge the impact of it before taking it themselves.[27]

28. The PPO's 2020/2021 annual report highlighted that during the pandemic there has been no reduction in the use of drugs in prison, and despite the COVID-19 lockdown the supply of substances has shown little evidence of slowing.[28]

29. The impact of substance abuse on those in the criminal justice system can lead to problematic debt levels, worsening mental health and bullying. There is also a collateral impact on staff, ranging from the need to attend to emergency situations involving those under the influence of drugs to the responses required to address violence caused through debt. This frequently means staff cannot undertake planned activities or respond to other demands.

30. A thematic analysis of 18-months' worth of scrutiny body reports evaluated search terms associated with substance misuse and indicated that 'debt' was the most commonly cited. Reports, particularly from prison Independent Monitoring Boards (IMBs), suggest that aside from worsening mental health, debt levels also lead to violence towards other prisoners and staff as individuals look to be placed in segregation to avoid repercussions. One prisoner, responding to the IAPDC 'Keeping Safe' consultation in 2017, has previously explained:

> " …*debt causes bullying and bullying causes stress and stress causes irrational thinking which causes self-harm*"[29]

31. Another respondent set out the impact on individuals and their families:

> *"I have no power! I can't take away all the phones that keep the drug trade going inside here giving everyone concerned problems which include family, friend etc*

[26] Prisons and Probation Ombudsman (2020) *Annual Report 2019/20*. Available at: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/11/6.6752_PPO_Prisons-and-Probation-Ombudsman-Annual-Report-2019_20_v8_WEB.pdf [Accessed 09/12/2021]
[27] Prisons and Probation Ombudsman (2015) 'New Psychoactive Substances', *Learning Lessons Bulletin: Fatal incident Investigations*, 9: 1-5
[28] Prisons and Probation Ombudsman (2021) *Annual Report 2020/21*. Available at: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/6.7333_PPO_Annual-Report-and-Accounts-202021_v5_WEB.pdf. [Accessed 09/12/2021]
[29] Independent Advisory Panel on Deaths in Custody (2017) *Keeping safe - preventing suicide and self-harm in custody: Prisoners' views collated by the IAP*. Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ed5178d95645801a7a5e321/1591023614282/Keeping+Safe+-+FINAL+-+Dec+2017.pdf [Accessed: 25/03/2021]

who are sent text demanding money for Spice that there loved ones have built up to pay so they don't get a beating. So when the visits come and your sat on the visit trying to explain why your in debt and leaving the visit with so much guilt you can't cope anymore and if by chance you get out without too many problems, you are then faced with the addiction you got while in prison."[30]

32. A further issue raised in the analysis of scrutiny reports was the trading and diversion of prescription medication – for example, anti-depressants and anti-psychotics – between prisoners. To combat this, prisons such as HMP Featherstone have started random checks[31] on those holding medication.[32] There is a tension between adhering to the principle of 'equivalence' and wanting to provide prisoners with their medication to look after themselves, with the requirement to minimise the impact on safety aspects associated with misuse of prescription medication.

33. The impact of the COVID-19 pandemic on drugs in prison has apparently been mixed. While some IMBs have reflected positively that reduced drug circulation has resulted in less violence and better wellbeing, some have commented that it has increased the production of illicitly made alcohol and, in some cases, led to a greater number of drugs being smuggled into prisons through a variety of methods including in parcels being thrown over the wall or by soaking letters, including mail disguised as Rule 39 articles, in psychoactive substances. Her Majesty's Inspectorate of Prisons (HMIP) has reflected that in-person drug treatment services were greatly reduced due to COVID-19, although support staff attempted to engage with their service users through alternative means such as distributing 'treatment packs' to complete[33].

34. While scrutiny bodies are concerned about the availability of drugs within the estate, and the impact of their circulation, positive examples of practice are also provided. These include the use of therapeutic groups, engagement with external drug projects, peer support and the introduction of drug free units. The use of naloxone, a drug used to reverse the impact of opioid overdose, has been praised, particularly regarding the offer of training in its use prior to release. In some prisons this is extended beyond opiate users[34]. Trials in Scotland relating to similar uses of naloxone have previously had positive results[35].

35. The 2019/2020 HMI Probation report suggested that, in many cases, insufficient services are available for those service users deemed to have substance misuse issues. HMI Probation also raised ongoing issues relating to partnership working and information sharing between probation and substance treatment services, particularly when treatment is not stipulated through a court requirement and probation staff have made a referral from their own

[30] Ibid.
[31] Many prisons do random checks on in-possession prescriptions. However, such inspections require close collaboration between security and healthcare staff in-order for the checks to be consistent. This is not always possible with short staffing levels.
[32] Independent Monitoring Boards (2021) *Annual Report of the Independent Monitoring Board at HMP Featherstone: For reporting year 1 November 2019 – 31 October 2020.* Available at: https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2021/01/AR-Featherstone-2019-20-for-circulation.pdf [Accessed: 25/03/2021]
[33] HM Chief Inspector of Prisons (2020) *Report on a scrutiny visit to HMP Whitemoor*. Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/09/Whitemoor-web-2020-1.pdf [Accessed: 25/03/2021]
[34]Independent Monitoring Board (2020) *Annual Report of the Independent Monitoring Board at HMP Springhill: For reporting year 1 January - 31 December 2019.* Available at: https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/05/Springhill-2019-Annual-Report-for-circulation.pdf [Accessed: 25/03/2021]
[35] NHS Scotland (2015) National Naloxone Programme Scotland – Monitoring Report 2014/15. ISD Scotland.

assessments. This lack of communication meant that escalating behaviour which was indicative of an individual's substance misuse was not always picked up and shared between agencies.

36. While the pandemic has seen reductions in services and testing, the inspectorate highlight positive work from staff, such as through delivering medication and facilitating meetings, and examples such as the Heroin-Assisted Treatment scheme, a Durham-Tees Valley scheme for the self-administration of diamorphine, and Through the Gate services in Humberside and Merseyside.

37. In August 2021 HMI Probation and the Care Quality Commission (CQC) published a joint thematic inspection[36] into drug treatment for those on probation. The inspection focused on 60 probation cases with known drug problems. Of these, 50 people were known to drug services but only five had a sentence plan which had been shared between both probation and the treatment service. The review also reported that 94% of the probation providers interviewed suggested that semi-specialist staff who work with substance misuse would be a positive model, as it would increase the knowledge and confidence of staff to work with other agencies.

38. Coroner written Prevention of Future Death (PFDs) reports can provide a detailed level of information as to how a death occurred during or following a period of incarceration. Reports written since March 2020 have highlighted the prevalence of Spice and psychoactive medication, the difference between drug treatment in England and Wales[37] and a lack of communication between AP and pharmacy staff as being relevant in deaths[38].

39. All relevant scrutiny bodies have recommended the establishment of a system-wide strategy that helps to tackle the availability and abuse of drugs and alcohol.

> *"… many individuals are forced to detox when they are clearly not ready and when others struggle with their addiction, they are offered no help or support. I feel that individually tailored treatment and care is a luxury that can no longer be afforded in these times of austerity. Many more will lose their lives as prisons are being used as human warehouses and these drug infested environments are not conducive to rehabilitation."*[39]

Recommendation: The use of naloxone as a form of harm-reduction for opioid abuse should be expanded, with training provided to prison staff (and members of the public) to raise awareness of overdose response. The use of naloxone would help prevent deaths associated with opioid overdose in the general public and promote a greater awareness of risks relating to drugs. The rollout of staff training in the use of naloxone is already in place in most Approved Premises. **Relevant substance misuse commissioners and community providers** should work together to encourage its use.

[36] Her Majesty's Inspectorate of Probation and Care Quality Commission (2021) A joint thematic inspection of community-based drug treatment and recovery work with people on probation. Available at: A joint thematic inspection of community-based drug treatment and recovery work with people on probation (justiceinspectorates.gov.uk) [Accessed on 03/09/2021]

[37] Coroner's Officer (2020) *Regulation 28: Report to Prevent Future Deaths*. Available at: https://www.judiciary.uk/wp-content/uploads/2020/06/Dean-George-2020-0104-Redacted.pdf [Accessed: 25/03/2021]

[38] Coroner's Officer (2021) *Regulation 28: Report to Prevent Future Deaths*. Available at: https://www.judiciary.uk/wp-content/uploads/2021/02/Michael-Dent-Jones-2021-0041-Redacted.pdf [Accessed: 25/03/2021]

[39] Quote from *Dame Carol Black's Review of drugs: Part Two* (2021)

The need for a whole-systems approach

40. A 2010 Department of Health Report[40] highlighted the importance of establishing an integrated care pathway and emphasised the need for support upon release. It called for the recovery process to start from the beginning of a prison sentence, with support networks coming from mutual aid, peer and family support, and community services to help an individual set achievable goals. It recommended that, upon release, such individuals should be supported to maintain their links with these networks.

41. In her recently published *Review of Drugs: Part Two*, Dame Carol Black argued for a whole systems approach to tackling drug problems. She made it clear that problem drug users require not only detoxification from drugs but also opportunities for work and housing to truly recover. It recommends that multiple departments, including the Home Office, Department for Education, Department of Health and Social Care, Department for Work and Pensions, Department for Levelling Up, Housing and Communities and the Ministry of Justice, should work together to invest in and improve treatment and opportunities for people with addictions in the criminal justice system. Dame Carol Black further recommends that funding and budgets should be ring-fenced, with cross-departmental priorities managed by a central team and overseen by a single, responsible minister whose role it is to report upon outcomes.

> *"The government should establish a central Drugs Unit with strong analytical capacity which would develop a National Outcomes Framework and hold departments to account"*[41]

42. The criminal justice system is increasingly used as a setting to offer treatment directly or as a gateway for referral to treatment in the community[42]. Dame Carol Black described how a third of adults in custody are there for issues relating to substance misuse and, in the first part of her Independent Review of Drugs[43] highlighted how short prison sentences, where the median time served in prison is six weeks, increased the risks of drug misuse as service users are provided with little sustained time in treatment. PHE guidelines state that pathways into and out of treatments should be especially clear for patients who transfer quickly to another setting[44] to help prevent relapses.

43. In regard to community transition, Dame Carol Black noted how only one third of people referred for community treatment after release go on to receive it within three weeks. This lack of engagement goes against the guidelines on Clinical Management of Drug Misuse and Dependence (the "Orange book")[45] which identifies the period immediately following release as a time of considerable vulnerability. There is an increased risk of relapse or overdose and self-harm or suicidal behaviours for people who experience a delay or interruption in the delivery of treatment caused by transitions between criminal justice settings. The Orange book, which is due to be updated, recommends effective communication across drug and alcohol services in prison and the community to minimise this delay, providing integrated and collaborative delivery of care. A close working relationship between services is central to this

[40] Department of Health (2010) *The Patel Report: Reducing Drug-related Crime and Rehabilitating Offenders*. London: Department of Health.
[41] Quote from prisoner letter sent to the IAPDC Keeping Safe consultation (2017)
[42] Department of Health and Social Care (2017) *Drug misuse and dependence: UK guidelines on clinical management*. London: Department of Health and Social Care. pp. 128
[43] Home Office. (2020) *Review of Drugs: Phase one report*. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report [Accessed: 06/04/2021]
[44] Public Health England (2021) *Injectable opioid treatment: commissioning and providing services Guidance.* London: Public Health England
[45] Department of Health and Social Care (2017) *Drug misuse and dependence: UK guidelines on clinical management.* London: Department of Health and Social Care

provision of ongoing care post-release. This includes continued treatment provision and assessments of at-risk individuals[46] alongside social support upon release from prison to recognise the close association between drug related deaths, poverty, and deprivation.[47]

> *"On release from prison, prisoners must have ID and a bank account and the ability to claim benefits on the day of release. Those with drug dependence should be helped to continue drug treatment in the community as soon as possible."*[48]

44. Through sentencing options or engagement with Liaison and Diversion (L&D) teams, opportunities exist to divert vulnerable individuals away from prison at the court sentencing stage. Dame Carol Black highlighted how the number of Court-given Drug Rehabilitation Requirements (DRRs) and Alcohol Treatment Requirements (ATRs) have fallen significantly over the last seven years. The CSTR programme is currently being trialled within magistrate courts in a limited number of test sites within England and Wales. The programme aims to promote the use of community disposals given to address drug, alcohol and mental health issues within a court sentence by promoting the assessment for these complex needs at court stage and supporting community treatment.

45. Evidence from test sites suggest that uptake has been positive with increased treatment requirements being given by the courts.[49] The IAPDC, together with the Magistrates Association, calls for continued and increased ambition in this rollout.[50] The latest figures show that opportunities to divert those with pre-existing substance misuse issues are being missed, with only 6% of community orders made for alcohol (3.1%) and drug (3.2%) treatment requirements.[51]

46. Dame Carol Black highlights the financial incentives for focusing on the causes of addiction rather than solely the consequences of criminality which may emerge from it. She points out that, while the societal costs of drug misuse cost £20 billion per year, during 2020 and 2021 only £650 million was spent on treatment. Alcohol alone costs the NHS £3.5 billion per annum, with 59% of all alcohol costs attributable to 9% of people with alcohol dependence. Such 'high-need high-cost' individuals often have multiple unmet health and social needs. Trials using Assertive Outreach Treatment (AOT), a model of care for multiple complex needs, with these attendees have demonstrated a greater than threefold reduction of hospital admissions for those who had AOT. This represents an annual £10,500 net saving per patient in inpatient costs.[52]

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[46] National Institute for Health and Care Excellence (2017) *Drug misuse prevention: targeted interventions*, NICE guideline [NG64] pp. 6.
[47] Home Office. (2020) *Review of Drugs: Phase one report*. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report [Accessed: 06/04/2021]
[48] Quote from Dame Carol Black, *Review of Drugs: Phase two report* (2021)
[49] Department of Health and Social Care. (2019) *Community Sentence Treatment Requirements Protocol: Process Evaluation Report*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810010/cstr-process-evaluation-report.pdf [Accessed: 12/04/2021]
[50] Juliet Lyon CBE and Beverley Higgs JP to Rt Hon Steve Barclay MP, 27 August 2021. Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/612e2bc5e777ea499dcd78a5/1630415813940/210827+Juliet+Lyon+and+Beverley+Higgs+to+HMT+-+CSTRs.pdf.
[51] Ministry of Justice. (2020) *Offender Management Statistics quarterly* (Probation: April to June 2021). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1028326/Probation_Q2_2021.ods [Accessed: 12/01/2022]
[52] National Institute for Health Research (2019). *Assertive outreach for high-need high-cost alcohol-related frequent NHS hospital attenders: The value-based case for investment.* Available at: https://www.clahrc-southlondon.nihr.ac.uk/files/Assertive%20outreach_May_2019.pdf [Accessed 15/09/2021]

47. A whole systems-approach will be essential to a successful criminal justice drugs strategy. This should aim to bridge the gap between prison custody and community treatment, ensuring that treatment is joined up and equivalent in both areas. Preventive strategies should target those who are at particularly increased risk. This includes interventions such as treatment and harm reduction programmes for substance use and ensuring continuity of care is provided.

> *"I am supposed to get the same treatment as I would outside. My doctor would never detox me."*[53]

48. The government's new ten-year drug strategy, which accepts all of Dame Carol Black's key recommendations, recognises the need for a joined-up approach.

Recommendation: While funding has been sourced for the rollout of some Court-based Liaison and Diversion services (L&D) and Community Sentence Treatment Requirements (CSTRs), additional resources are still required to ensure greater coverage. Both initiatives help divert individuals with substance misuse problems away from short custodial sentences into treatment and help prevent deaths. However, for these to be effective, community drug and alcohol services need to be adequately resourced by the **Ministry of Justice, NHS England and NHS Wales** and the **Department of Health and Social Care** to ensure full coverage and reduce the waiting times between court sentence and treatment starting. Courts need to be informed about the availability of treatment in the community and provided with updates on treatment outcomes and evaluation.

Recommendation: Drug and alcohol misuse is often associated with, or caused by, wider social and economic issues. A streamlined approach which encourages services to be collaborative, and ideally co-located, is required to enable services to work in an integrated way in response to multiple social needs (including housing, employment, mental and physical health and the effects of prior trauma) and not just achieving abstinence. **HMPPS, Ministry of Justice** and the **Department of Health and Social Care** should consider collaborative commissioning of providers, so they become 'catch-all' services rather than providers of a collection of different parts of an individual's recovery.

[53] Quote from prisoner letter sent to the IAPDC for the Keeping Safe consultation (2017).

Part two: IAPDC and RCGP expert roundtable substance misuse-related deaths and treatment in the criminal justice system

49. As part of a shared initiative, on 15 April 2021 the IAPDC and RCGP convened an expert roundtable event on substance misuse-related deaths in the criminal justice system. The roundtable brought together professionals, experts and interested parties to discuss how treatment in prisons and on release into the community can be optimised and how the investigation process following a death can be improved. The findings from this event have since been complemented and added to by further conversations with key experts unable to attend the event. A list of contributors to this report can be found in Annex A.

Improving treatment in prisons and on release

Sentencing

50. Liaison and Diversion (L&D) schemes should be available at an **early stage to divert individuals from the criminal justice system** and prevent them from being criminalised further. At the Court stage, funding for L&D and alcohol and substance misuse treatment providers should be easily accessible to help ensure those with substance misuse problems are being identified and not being sent to custody unless their offending is so serious that there is no alternative. Short prison sentences, which are often used in cases relating to acquisitive offending, offer no benefits in providing true stability regarding treatment for substance misuse and in many cases are actively disruptive to continuity of care.

51. To replace these short custodial sentences, **reliable, effective, and progressive alternatives** are required**.** Although Community Sentence Treatment Requirements (CSTRs) provide positive alternatives, they are currently not, or not consistently, used.[54] Funding should be allocated to achieve a greater level of access across England and Wales and magistrates given training on their use. These initiatives should be systematically evaluated in terms of impact and outcomes and results published.

The transition between the community and prison

52. If an individual is given a custodial sentence and has been engaging with treatment in the community, then **their service provider should aim to ensure the continuation of care on discharge**. This can include ensuring that people are not in danger of 'detoxing' too quickly and making sure that information relating to prescriptions is accurate. Ideally, a comprehensive health assessment should take place upon reception at custody to pick up areas of concern. Information on treatment occurring in the community should be readily available in the reception into prison to allow the continuation of treatment. In turn, this should link back to the same provider upon release where appropriate to provide continuity.

[54] IAPDC and Magistrates Association (2019). *Effective community sentences and the role treatment requirements can play in preventing deaths in custody.* Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5d760017df09514a97a4f6ce/1568014366659/MA+IAP+survey+final+270619.pdf.

53. For alcohol treatment, NICE guidelines[55] recommend a **five to ten-day detox with frequent assessments**. Ideally the location for this would normally be in inpatient facilities in the community, where extra care and observation is available and provided by appropriately trained and qualified staff. In some cases in prisons where the patient is co-dependent on alcohol and opiates, detoxification must be undertaken simultaneously. This is both complex and requires closer observation not currently available due to regime limitations in accessing people in prison at night. Furthermore, patients with complexities relating to their physical health, including pregnancy and long-term conditions, may also benefit from closer observation during the detoxification period not currently available to them. Treatment for alcohol withdrawal should include nutritional supplements such as thiamine and Pabrinex ® in accordance with the appropriate guidance.[56] Following treatment, a period of case management should be undertaken as aftercare by properly trained staff.[57]

54. There are a number of factors that influence prescribing and treatment decisions when comparing substance misuse provision in secure settings against that provided in the community. There is no clear evidence base that the provision of substance misuse treatment in prison reduces the use of illicit substances, such as Spice, in prisons, nor whether those people who were misusing prescribed medications, such as pregabalin, in the community and whose medication was stopped after coming into prison are more likely to misuse illicit substances. Time and resource constraints also limit the potential for shared discussions and decision-making between prisons and community prescribers.

<u>The transition between prison and the community</u>

55. Transition into the community from prison for people with complex needs can be a high-risk period. In the months before release, staff should be aware of, and plan for, relapse risks the individual will face in the community. This includes properly planning for an individual's release, which should take place between Monday and Thursday if possible. Should that date fall on a Friday when services will be closing for the weekend, the commissioning of essential out of hours cover, such as the greater involvement of Integrated Offender Management schemes and use of telephone support, should be explored. Pre-release work should involve **greater outreach from prisons to community services**; this has a direct positive impact on someone's compliance post-release and improves staff awareness of support available in the community.[58] GPs based in secure settings should be able to have more of an input to someone's care plan for when they are released. These GPs often have the best knowledge of the risks of combining treatment with other non-prescribed dependency-forming drugs. It is likely this knowledge is not as readily available in community healthcare.

[55] National Institute for Health and Care Excellence (2011). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence*. Available at: https://www.nice.org.uk/guidance/cg115/resources/alcoholuse-disorders-diagnosis-assessment-and-management-of-harmful-drinking-highrisk-drinking-and-alcohol-dependence-pdf-35109391116229. [Accessed on: 28/05/2021]

[56] National Institute for Health and Care Excellence (2010). *Alcohol-use disorders: diagnosis and management of physical complications*. Available at: https://www.nice.org.uk/guidance/cg100/resources/alcoholuse-disorders-diagnosis-and-management-of-physical-complications-pdf-35109322251973. [Accessed on: 05/08/2021]

[57] National Institute for Health and Care Excellence (2021). *Interventions for harmful drinking and alcohol dependence*. Available at: https://www.nice.org.uk/guidance/cg115 [Accessed on: 13/09/2021]

[58] It is recognised that prison healthcare services are not currently commissioned to allow this.

56. An individual treatment plan should be developed for every prisoner in need of further support. An individual's plan **should be person-centred, measurable and realistic** – both for the individual and for the staff members who will be working with them. They should not be governed by service-level targets.

57. **Just over 60% of individuals who leave prison with an appointment for treatment fail to attend or engage**.[59] A recently released person may fail to pick up their prescription for a number of reasons. They could have multiple appointments to keep or they might not be able to afford travel fares to keep them. In other cases, the dose someone is offered in the community is not always an increase on the amount they were receiving in custody, meaning they may not view the appointment as being worthwhile. For such cases, dose optimisation before release may assist with engagement. At the same time, prisons have been criticised for higher titration prior to release, as it is a practice which does not appear to support abstinence.

58. When someone is released into the community, the substance misuse service in the prison should contact their community counterpart. Links should be made with the community Probation Officer and other services or specialist NGOs. A 'joined-up approach' is vital. Consideration should be given to implementing (and evaluating) transitional roles which bridge the prison and community, such as Through the Gate provision and **'bridging liaison roles'**, similar to the disability liaison roles that currently work across the community and prisons. Just as it would be ideal for prison substance misuse services to 'outreach' to community services, it would be even better if community services 'in-reached' and assessed the clients they will soon be taking over upon release. Involving those with lived experience can be highly beneficial. These bridging roles would aim to assist the engagement with community services, helping people to adjust to this provision and ensuring that they know where and when to attend treatment in the community. Arrangements should be made for the individual to be seen as quickly as possible after release in order to determine their care plan, decide dose and make any early referrals for support.

59. In addition, '**special point of contact' (SPOC) roles** should be developed by training a member of staff who has knowledge of all services in the community and prison. This person would bring together a range of disciplines and services and assess which pathways are suitable for an individual. This would be much more difficult in the women's estate, where fewer prisons mean catchment areas are large and can even cross national boundaries. A women-specific approach should be adopted to treatment for substance misuse in the criminal justice system. This should also consider the specific needs and vulnerabilities, for example relating to domestic violence and coercion, of this cohort.

60. Information-sharing is key to keeping people safe. This can sometimes be hampered by over-cautiousness or confusion in relation to patient confidentiality, GDPR, and clinical concerns, even among those working in the same establishment (for example prison security departments not sharing relevant information with the healthcare department). **Better, more confident communication and smoother access to information is required**. Information-sharing agreements would aid the flow of information between teams, establishments, organisations, and stages of the criminal justice pathway. Transition points are key and the

[59] Public Health England (2021). 'Official Statistics: Alcohol and drug treatment in secure settings 2019 to 2020'. Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-in-secure-settings-2019-to-2020/alcohol-and-drug-treatment-in-secure-settings-2019-to-2020-report#treatment-outcomes [Accessed on 26/05/2021]

ready sharing of information between police, courts, prisons and community services is needed. A more consistent approach to obtaining consent to share information from patients is also of vital importance.

61. **Prolonged-release buprenorphine injection**[60] is a new preparation which could help smooth transition to the community, reduce the use of methadone prescriptions and address issues with client engagement. Slowly released over an extended period, these injections mean reduced requirement for immediate service contact at a time when individuals have a range of pressing concerns, such as securing income and safe housing, and also help cover the relapse risk period immediately following release. Prolonged-release buprenorphine, when given at a suitable dose and prior to release, could also help significantly reduce the need to use opiates and help to reduce the risk of overdose and death. Recently, in Scottish prisons, the introduction of Buvidal® as an Opioid Substitution Treatment (OST) has led to high levels of compliance from almost all patients and positive feedback from healthcare staff. A motivation to reduce the use of methadone was the lack of a requirement to attend a pharmacy daily, which provided greater opportunity to pursue other activities that could raise self-esteem and were not associated with relapse.[61]

62. OST is a type of harm reduction initiative that offers people who are dependent on opioids an alternative, prescribed medication. The **use of OST should be monitored not only in relation to compliance, but also safety.** Buprenorphine products, for example, are associated with less opioid toxicity and deaths when compared to other OSTs with higher efficacies. While just one of the harm reduction interventions available, naloxone should be made available within and beyond the criminal justice system in the event of a response to an overdose and its usage **supported by increasing awareness, information and training for both staff and prisoners.**

63. There remains a lack of supported housing for people leaving prison. Anecdotally, prison releases to residential rehabilitation centres often provide more support and greater opportunities for recovery, **but there is little in the way of current best practice guidance in this area**. Evidence, such as successful referrals to housing providers, should be interrogated to examine how individuals who have lived in residential centres cope with assimilating back into the community compared to a general prison leavers population.

64. **Evaluation of what works best during transitions between prison into the community is required.** This has existed elsewhere with prison leavers. In 2017, a study into transitional case management demonstrated that adult prisoners with severe mental illness needs engaged far more with subsequent mental health treatment when their transition into the community was supported by a holistic care plan.[62]

Recommendation: **NHS England and NHS Wales, HMPPS** and the **Ministry of Justice** should set out a specific approach to substance misuse treatment for women in the criminal justice system and wider community health to account for the large catchment areas of

[60] Currently Buvidal® is the only approved depot or implant form of buprenorphine in the U.K.
[61] Scottish Government (Population Health Directorate), *Coronavirus opioid substitution treatment in prisons*, July 2021. Available at https://www.gov.scot/publications/evaluation-opioid-substitution-treatment-scotlands-prisons-covid-19-contingency-patient-experience-follow-up-report/. [Accessed on: 10/8/2021].
[62] Shaw J, Conover S, Herman D, Jarrett M, Leese M, McCrone P, *et al.* 'Critical time Intervention for Severely mentally ill Prisoners (CrISP): a randomised controlled trial'. *Health Serv Deliv Res* 2017;5(8)

women's prisons and the specific needs and vulnerabilities of women, for example relating to domestic violence and coercion.

Recommendation: People are at particular risk of substance misuse-related death when they are in transition between prison and the community. The introduction of 'bridging liaison' roles, created jointly by **HMPPS** and **NHS England and NHS Wales**, would reduce the risk of professionals working in silos and ensure continuity in treatment plans. Pre-release work should involve greater outreach from prisons to community services. This has a direct positive impact on an individual's compliance post-release and improves staff awareness of support available in the community.

Recommendation: The increased use of the newly available formulation of prolonged-release buprenorphine as an opioid substitution therapy (OST), given as weekly or monthly injection, would help to reduce risk and improve the continuity of treatment to service users as they move between community and prisons. **Substance misuse commissioners and community providers** should work together to ensure continuity in its use.

Services – quality, focus and access

65. In recent years, cuts to drug and alcohol and mental health services have had a damaging impact on outcomes. Services need to be funded to appropriate levels based on prevalence of need or disease. **Drug and alcohol teams were once present in each prison,** and this allowed for important proactive work and engagement prior to release. Many services have been destabilised due to these cuts.[63] Drug and alcohol treatment is already a difficult area to work in, notwithstanding the problems brought about by funding cuts. When an individual is willing to engage with treatment services, they need to be adequately funded to ensure this motivation is met with adequate support.

66. Funding is often distributed in pockets to separate operators providing drug and alcohol services in custody and the community. This results in people in prison, and in particular on release, attending a number of different services. **A streamlined approach which encourages services to be collaborative, and ideally co-located, is required to enable services to work in an integrated way in response to the multiple social needs** (such as drug use, safe housing, signing onto benefits) an individual might have. This includes issues of comorbidity between substance misuse and mental health which are not always clear. Levels of funding should reflect the prevalence of substance misuse in a given area, in order to better meet the overall needs in both prisons and the community. This has not been achieved to date.

67. Greater availability of, and investment in, counselling and psychological therapies both in prison and the community is required.[64] Recent years have seen a change from therapeutic working and psychotherapy to 'key working'. These relationships are important and help to keep people safe. However, they do not address the complex needs of some individuals, such as those who have experienced trauma. **Genuine therapeutic work pre- and post-custody can offer work which is solution or recovery focused instead of based on**

[63] BBC, 'Drug and alcohol services cut by £162m as deaths increase'. (May 2018) Available at: https://www.bbc.co.uk/news/uk-england-44039996. [Accessed on 02/08/2021]
[64] This was a point frequently highlighted at the Justice Select Committee evidence session on mental health in prisons held on 22 June 2021.

immediate need. Key work needs to be trauma informed, while counselling and psychological therapies should be trauma responsive.

68. Greater attention should be given to **reducing the barriers to transfers from prison to hospital in times of clinical need**. Significant organisational constraints make it difficult for clinicians to make decisions about prioritising referrals. There have been reports of barriers between healthcare and operational staff in securing a consistent approach to the transfer of people from prison to hospital. The rollout of telemedicine in the English prison estate in 2020 offers an opportunity to enhance the lines of communication between primary and secondary care for people in prison, as a benefit from the response to the COVID-19 pandemic. Specific funding has been allocated to extend this programme to include substance misuse services and improve communication between prisons and the community.

69. **Substance misuse services need to be more accessible for those who wish to refer themselves during their stay in prison**. People who become dependent on opiates within a prison during their sentence, whether that is buprenorphine, heroin or other opioids, cannot always access prison substance misuse services as these are targeted towards people who have either been maintained on or initiated on OST on arrival.

70. It should be respected that **some people will not wish to engage with services** they are referred to. It is important to listen to the individual and understand why this might be the case, such as because of previous trauma. Staff and agencies should recognise that all treatment is optional, and some people may want rehabilitation, others abstinence, and some may want company or harm minimisation opportunities, such as the use of needle exchanges or safe zones.

<u>Staffing – communication, training and leadership</u>

71. Optimising treatment requires training and sufficient funding to increase overall workforce support. A better trained workforce reduces reliance on an individual's opinion to determine who is deserving of treatment. **Training in understanding trauma and mental wellbeing should not just be given to healthcare staff but made available to all staff** who work with people with complex needs. This workforce pool should be suitably diverse to reflect the needs of its clients.

72. There are lessons to be **learned from COVID-19 working protocols**. The virtual nature of meetings has meant that attendance from both service users and different types of professionals has been possible, though only on certain platforms, at multi-disciplinary meetings, where previously this may not have been the case.

73. **The recovery from COVID-19 presents an opportunity to reset organisational culture to one which promotes health and wellbeing in all services.** Leadership at all levels, across provider boundaries, is key to this. There should be a leadership approach that supports people-focused, consistent, trauma-informed care based on knowledge and values and empowers junior staff to make effective decisions without undue organisational pressures. This leadership directive should be supported by national guidelines.

74. **Staff retention is vital**. Experienced employees will hold knowledge of their area and have strong relationship and communication networks with others. While agency staff plug gaps in services, they do not offer the local knowledge needed to avoid siloed working. Expanding

the bank system of available nurses could also ensure that there is less reliance on agency staff in the future.

Siloed working

75. **Professional work is too frequently carried out in silos**. While this might be evident between agencies within prisons and the community, it also exists within institutions, for example, with healthcare and security staff not having the appropriate time and resources to work more collaboratively together.

76. IT systems and the ability to communicate between them needs to improve in order to ensure that information, such as details on prescriptions, is updated when someone leaves custody or transfers between areas. Colleagues in health and justice need to ensure they collaborate. This is not just about the money invested but also having sufficient systems, space, and time, as well as the health, security and probation staff, to adopt **a better approach to, and culture of, multi-disciplinary working**.

77. Systems need to be in place in order to better address the identification of, and actions taken, following non-fatal overdoses in order to avoid death at a later date. This includes the need for **accurate record-keeping and sharing**. This is frequently flagged as an area of concern in PPO reports, particularly in relation to healthcare and ACCT information which still does not consistently 'follow' a prisoner through the system.

Improving investigations after a death

Learning lessons from investigations

78. Historically deaths in the criminal justice system which have occurred whilst someone is on a period of probation supervision in the community have not received the same level of scrutiny as those in prison, though the PPO have recently received approval to expand their remit to cover a selection of post-release deaths.[65]

79. There is currently no consistency in the length of a coronial investigation, and the time between a death and the end of the coronial investigation is often very long. Staffing, including at senior levels, can change in that time, meaning that little is remembered from the event itself or that the culture of the service has changed through churn. **Consistent and well-communicated timeframes** would assist in ensuring attention is still given to an event which could have happened one or two years ago, and often longer.

80. **The clinical review(s) should clearly communicate what has been found** and what needs to be achieved and learned from it.

81. **Jury findings** should be made available to highlight concerns regarding substance misuse-related deaths not covered by coroner-written Preventing Future Deaths reports (PFDs), or where the coroner does not go on to make a PFD. NHS England and NHS England should

[65] Prison and Probation Ombudsman, *The Investigator*, May 2021. Available at https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/05/The-Investigator-May-2021-Hard-Copy-PPO-Final.pdf#page=%5B3%5D. [Accessed on: 10/08/2021]. This request is currently awaiting ministerial approval.

report publicly on action taken in response to inquest findings and PFD reports. This is of great importance to bereaved families.

82. Guidance on how changes could be made to prevent future deaths should be produced for the recipients of reviews, recommendations and prevention of future deaths reports issued by coroners. Following an investigation, recommendations made often do not get sent to the appropriate agencies nor can be accessed easily by new staff who might have started working at an establishment following a death. This ensures that learning from a death is unlikely to be shared. The establishment of **a central database, perhaps managed by commissioners,** to store the multiple recommendations which are made would help ensure lessons can be learned from all investigations. In addition to this database, a triage system should be established to cascade recommendations to the relevant providers and agencies. A national oversight body could be established to brigade findings and recommendations in addition to monitoring their implementation.

83. Greater clarity is required over the categorisation of deaths by the responsible agencies**. Conclusions on a case can differ between professional reports**. For example, it is not always possible to say how many self-inflicted deaths are due to substance misuse or how many alcohol-related deaths are categorised as natural.

Focus of investigations

84. It is vital to learn from all deaths in custody in order to prevent such tragic deaths in future. Some agencies and staff believe that investigations should start from an exploratory perspective with a focus on learning. This could promote a culture where transparency is encouraged, and staff are supported to be open and honest. Investigators and scrutiny bodies **should expect a duty of candour** as they examine the circumstances of a death in custody and establish lines of accountability.

85. During the inquest itself, **state lawyers could operate in an inquisitorial manner**. Presently, their approach is often not counterbalanced by a consistent process which would ensure experts are properly involved in proceedings and able to provide opinions in their specialist area.

86. **Non-means tested legal aid** – as recommended in both the Harris Review on self-inflicted deaths in custody of 18-24 year-olds[66], the Angiolini Review of deaths and serious incidents in police custody[67], and most recently by the Justice Committee in its inquiry into the Coroner Service[68] – would enable bereaved family members to be fairly represented.

87. Currently much focus of an investigation on a death in custody falls on the prison and prison staff only. **More focus should be given to healthcare received,** not just in detention but

[66] Lord Toby Harris, *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds*, July 2015. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/439859/moj-harris-review-web-accessible.pdf [Accessed on 24/05/2021]
[67] Rt. Hon. Dame Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody*, October 2017, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf. [Accessed on 24/05/2021]
[68] Home of Commons Justice Committee, *The Coroner Service*, May 2021. Available at: https://committees.parliament.uk/publications/6079/documents/68260/default/. [Accessed on 03/06/2021]

also prior to incarceration, and to what improvements can be made in both areas. In addition, the reasons for why an individual is in custody should be explored, pre-sentence reports examined and any diversion schemes which could have been used identified.

88. **Prison and healthcare staff could be invited to contribute to the sequence of components feeding into an investigation following a death**. This would help reduce the flow of second-hand information and, through their knowledge and clinical records of the patient, would help place the pathology in the appropriate context and improve understanding of, and inform, toxicology investigations.

The quality of reports and investigations

89. Coroner guidance states the input of a forensic pathologist is not mandatory at an inquest. The expertise of such professionals is invaluable, and **guidance should be developed which improves the use of experts** in inquests into suspected drug or alcohol-related deaths.

90. There needs to be improvements in the collaborative analysis of how a death occurred and the subsequent sharing of information. This includes a more open use of information sharing (see paragraph 56) and greater use of multi-agency reviews consisting of GP, coroner, probation and healthcare input. Currently too many investigations following a death are written in silo. **One central investigation** could be run, with multiple reviews feeding into it.

91. Limitations in the expertise of clinical reviewers at times impairs the quality of the investigation overall. Examples have been given of clinical reviewers with no experience in substance misuse or the prison environment working on investigations following a drug-related death. The PPO has no control over who is appointed and their suitability to undertake the investigation. **There is currently no 'gold standard' of quality assurance for the use of clinical reviews.** While guidance does exist, it is open to regional variation. There is a limited number of individuals who are available for the roles, meaning breadth of experience can be narrow. Additionally, even where good reviewers exist, systems for training and quality control are not well developed. **A framework allowing quality to be measured would assist in achieving a greater, more consistent, standard of reviews.**

Recommendation: To enable the learning of lessons by services and establishments following a substance-related death, independent recommendations made by **investigators and scrutiny bodies** should be given to specific owners and made with the clear appreciation as to what changes are realistically possible. Greater attention needs to be paid to communication with, and the respectful involvement of, bereaved families. Recommendations and their responses should be centrally stored by **HMPPS** so that they can be easily accessed by both operational and policy staff so future deaths can be prevented. This should include jury verdicts as well as matters of concern raised by coroner-written PFDs. The establishment of a national oversight body would serve to ensure timely compliance with recommendations made by coroners and scrutiny bodies.

Recommendation: **Investigators of substance misuse-related deaths** should take into account both the clinical and security factors relevant to the incident. Where possible, scrutiny bodies should identify where there had been missed opportunities for diversion. Staff from the relevant agencies should be supported by their organisations during the investigation process.

Recommendation: **NHS England and Health Inspectorate Wales** should work in collaboration with investigators to ensure commissioned independent clinical reviewers who assist in investigations into substance misuse-related deaths are qualified and experienced in the subject area. Experienced reviewers should also be involved in investigations into deaths in Approved Premises, where they are currently not utilised.

Next steps

92. Aiming to add to the growing literature on substance misuse in the criminal justice system, this report offers the unique perspective of how responses to drug and alcohol misuse can prevent deaths. It demonstrates how government work to address substance misuse must retain protecting lives and the prevention of deaths as its key priority.

93. This report makes recommendations relating to:
    - improving the data associated with substance misuse related deaths;
    - a whole systems approach to recovery which considers the social problems an individual might have rather than just reaching abstinence;
    - refocusing investigations to encourage learning and make use of suitably experienced clinical reviewers; and
    - promoting wider collaboration between prison and community staff to encourage the continuation of treatment.

94. In June 2021 we shared the draft of this briefing paper with HM Prison and Probation Service (HMPPS) to inform its review of the drug strategy. For these recommendations to be properly implemented, a cross-government approach is required. The IAPDC and RCGP will work with relevant departments, as well as the cross-government Joint Combating Drugs Unit, to progress recommendations and develop further solutions.

Annex A: Contributors to IAPDC / RCGP roundtable event – 15 April 2021

Speakers (in order of appearance):

Juliet Lyon CBE	Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)
Prof Amanda Howe OBE	President, Royal College of General Practitioners (RCGP)
Jane Trigg	Head of Drug Strategy Development (HMPPS)
Kate Davies CBE	Director of Health & Justice (NHS England)
Chris Barnett-Page	Safety in Custody Lead (HMPPS)
Amy Rees	Director General of Probation, Wales and Youth (HMPPS)
Deborah Coles	Executive Director (INQUEST)
Sunny Dhadley	Lived Experience Senior Advisor (NHS England)
Dr Michael Kelleher	Consultant Psychiatrist
Dr Nat Wright	Clinical Research Director (Spectrum)
Dr Bernadette Hard	GP Specialist in Addictions (Kaleidoscope Wales)
Ian West	Governor (HMP/YOI Swinfen Hall)
Nigel Meadows	HM Senior Coroner
Dr Ashley Fegan-Earl	Consultant Forensic Pathologist
Sue McAllister CB	Prisons and Probation Ombudsman
Professor Jenny Shaw	University of Manchester and member of the IAPDC
Dr Jake Hard	RCGP Secure Environments Group

We also wish to thank the following individuals who, along with others who attended the event, contributed significantly to this paper:

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Caroline Stevenson	University of Manchester
Nicola Worthington	University of Manchester
Leanne Heathcote	University of Manchester
Emily Arthorne	Unlocked Graduates