



Roundtable on Substance Misuse and Addiction

11th October, 2017

27 Tavistock Square, London, WC1H 9HH

Present

Anna Smith – *One25*

Chris Panikkou – *CFE Research*

Hazel Alcraft – *Clinks*

James Ward – *Changing Lives*

Karen Blatherwick – *Turning Point*

Jo Wilson – *CFE Research*

Lissa Anderson – *Forward Leeds*

Louise Scherdel – *Addaction*

Mike Trace – *The Forward Trust*

Rachel Haseloff – *Clinks*

Richard Foley – *EDP Drug & Alcohol Services*

Richy Cunningham – *Fulfilling Lives*

Sarah Robinson – *CFE Research*

Sunny Dhadley – *Service User Involvement Team*

Trevor Urch – *Inside Recovery*

1. Welcome and introductions

1.1. Richy Cunningham introduced the [Reducing Reoffending Third Sector Advisory Group \(RR3\)](#).

1.2. Richy Cunningham discussed the aim of the roundtable: to enable Richy to reflect the views of the substance misuse sector at RR3 meetings; and to produce a recommendations paper on substance misuse in the criminal justice system.

2. Recording and understanding service users' needs:

2.1. Gathering data:

2.1.1. There is a lack of reliable data on service users' needs. Rapid changes in needs can also mean that Health Needs Analyses become out of date quickly.

2.1.2. Those collecting the data do not necessarily understand the complex needs of service users. There should be further consideration of using a social rather than a medical model for understanding needs.

2.1.3. The assessment process needs to be accurate and appropriate to ensure that the service is designed around the service user's needs. Organisations suggested that peer research may be a more accurate way of understanding need.

2.1.4. Individual service users need to have their story moving with them, rather than having to re-tell their story to each service provider. One example of what this could look like is the Personal Child Health Record, a national standard health and development record given to parents/carers at a child's birth. This would enable service users to have one electronic record which can follow them on their journey.

2.1.5. Substance misuse issues must be addressed throughout a person's time in prison. While information is gathered on the first night in prison, this is not usually the right

time to ask people about the complex issues and trauma that many people's substance misuse is rooted in.

2.2. Using data:

2.2.1. It is important to identify the trigger points for substance misuse; to address the underlying issues behind using drugs through trauma-informed support.

2.3. Measuring impact:

2.3.1. Forms and quality of measurement do not capture the human element of the recovery process.

2.3.2. It's difficult to measure indicators of success beyond re-offending. We are not reviewing people's journey through the criminal justice system.

2.3.3. The National Drug Treatment Monitoring System limits what outcomes services are measured against and does not provide a recovery-focused system of measurement. A reporting system that is more recovery focused could help providers to more accurately identify the reasons behind substance misuse.

2.3.4. It is difficult to provide data on the outcomes/effectiveness of programmes in prisons, particularly when people are transferred between prisons. Understanding what works isn't just about treating the addiction but understanding the cause of the addiction – we don't have the data to do this at the moment.

2.3.5. A standard assessment and shared database should be introduced as soon as possible.

3. Early intervention, diversion and community services:

3.1. Early intervention:

3.1.1. There is a lack of investment in community services, meaning that service users can end up in prison due to not having access to the care they need.

3.1.2. Health services don't always effectively address dual diagnosis. There should be a national standard for dual diagnosis services.

3.1.3. Drug laws channel people into the criminal justice system by focusing on prohibition rather than health and human rights.

3.1.4. Services are siloed, rather than working together for the benefit of the individual.

3.2. Diversion:

3.2.1. There should be a focus on diverting people from the criminal justice system. However, funds for this are being rapidly reduced across the sector. In some areas there has been a 50% reduction in funding for community treatment services.

3.2.2. Consideration should be given to what kinds of diversion are appropriate. For example, if offered a choice between prison and a rehabilitation service, many will opt for rehabilitation even when they are not ready to effectively engage with this service.

3.2.3. Rehabilitation is an alternative to prison but is not adequately invested in. The government should conduct a cost benefit analysis of providing services such as training, housing and therapy in the community for people with substance misuse issues, rather than sending them to prison.

3.2.4. While the National Probation Service assesses people at court stage, they often do not have services to refer to when substance misuse needs are identified. There is a need for 'crisis beds' for people with substance misuse issues to go to. The lack of services in

the community means that Community Rehabilitation Companies are not incentivised to offer Drug Rehabilitation Requirements.

3.2.5. There should be substance misuse assessments prior to sentencing.

3.3. Resettlement:

3.3.1. There is a lack of resources for people coming out of prison. Probation workers are overloaded and do not meet service users at the gate.

3.3.2. There is a lack of accountability for resettlement of an individual.

3.3.3. Prisoners should be able to meet someone from the community while in prison, to guide them through their journey. This person should guide them through their journey and support them in attending their appointments in the community.

3.3.4. There are limited meaningful employment opportunities for people coming out of prison. People need to earn an income to support themselves. Not receiving benefits for six weeks on release and being expected to attend various mandatory appointments in different locations are all trigger points for relapse.

3.3.5. Prisons need to build better links with communities so that the service user has a network in the community and is able to contribute when they are released. In particular, people who are on substitute scripts need to be able to access timely appointments in the community after release, in order to ensure continuity of treatment. Organisations highlighted some instances of people re-entering prison in order to access treatment.

3.3.6. Peer programmes can aid rehabilitation through a shared experience. We need to overcome barriers to people speaking out about their experience, including among prison staff.

3.3.7. There should be flexibility in breach procedures.

3.3.8. There should be a joint meeting of service providers, looking at how to support the person being released with co-ordinated appointments, medication etc. It would be beneficial for services to be housed in one building. The 'departure lounge', run by Lincolnshire Action Trust at HMP Lincoln, is a good model. Workers see prisoners a week before they are released, gathering information from service providers to make a release pack which puts all the information in one place for the service user.

3.3.9. Release plans can begin too soon, meaning that service users' needs have changed by the time they are released. There should be a structured review process.

3.3.10. Support and treatment depends on the location. There should be consistency across the country.

3.3.11. It takes too long for people to be able to access community substance misuse services after release. This can take weeks even when the prison substance misuse team has made a referral.

4. Prison

4.1. Substance misuse in prison:

4.1.1. Imprisonment fails to address the causes of addiction and can increase the flow of drugs into prison.

4.1.2. More than half of people given custodial sentences arrive to prison with a drug problem.

4.1.3. Punitive approaches to drug use in prison prevent people from being open about their drug use and seeking support. This disincentive to engage with support benefits those who sell drugs in prison and allows them to profit from selling drugs to those with substance misuse issues and controlling them through debt.

4.1.4. The implementation of the smoking ban in prisons is causing increased pressure, especially for those on short sentences.

4.2. Services in prison:

4.2.1. Available care for people with substance misuse issues depends on the prison and the length of sentence. There are different protocols around treatment in each facility. There is a need for consistency alongside flexibility, so that services can take an individualised approach.

4.2.2. Short sentences are problematic as there is not enough time to make progress with the service user. Short sentences are generally damaging to the individual. Sentences should not be increased; alternatives to custody should be considered.

4.2.3. High levels of bullying and violence in prison can be a cause and a consequence of substance misuse.

4.2.4. A key element of the success of drug recovery wings in prison is the sense of community between staff and prisoners.

4.2.5. Vetting can mean people with lived experience often cannot work in prisons. There are too many people automatically excluded due to their sentence history. This should be mitigated against with a risk assessment based on recovery criteria, looking at how a person's life has changed.

4.3. Prison staff:

4.3.1. Service users in prison are more likely to trust service providers rather than prison officers.

4.3.2. The ratio of staff to prisoners is important to ensuring that staff have enough time to build relationships and trust with people in prison.

4.3.3. Staff in prisons should recognise the value of the work of the voluntary sector.

4.3.4. Prisons are taking on young, inexperienced prison staff with no complex needs training.

4.3.5. Staff in prison should be trained in understanding substance misuse issues. Without this understanding, staff can make assumptions about drug-seeking behaviour and fail to recognise the underlying issues, leading to punitive responses.

4.3.6. Staff training could be carried out by people with lived experience.

4.3.7. Cynicism among prison officers towards the effectiveness of treatment schemes and a lack of understanding of the complexity of the causes of addiction. Prison officers don't see the value of the recovery plan. This is partly because they only see those who return to prison, not those who successfully recover.

5. Quality of substance misuse services

5.1. Culture:

5.1.1. Substance misuse treatment services have a central role to play in supporting rehabilitation and reducing reoffending, but are not always valued as such.

5.1.2. There is a clash of agendas between the criminal justice sector and recovery services. Organisations noted that statutory staff did not necessarily value or respect the work of voluntary sector providers, meaning that they had less influence.

5.2. Staff skills:

5.2.1. There is a lack of awareness in the sector of the specific needs of black, Asian and minority ethnic people and women. The sector should try to recruit more people from BAME backgrounds.

5.2.2. Frontline staff are over-worked. They should be provided with resilience and self-care training.

5.3. Service user engagement:

5.3.1. Understanding the incentives for people to engage with treatment is important. For example, pregnant women tend to engage well with services as they need the access to healthcare and support.

5.3.2. Organisations highlighted the low numbers of BAME people they engage with and suggested that more needed to be done to ensure that BAME people are able to access treatment.

5.3.3. Service users need to build a trusted relationship with one worker. It can take a service user a long time to make progress to work through complex issues. Lack of trust can disrupt this cycle.

6. Commissioning:

6.1.1. Organisations highlighted the difficulty in joining up services due to having separate commissioners for health services in the community and in prison. Services in the prison should be commissioned by the local authority director of public health, as in the community.

6.1.2. There is a lack of continuity for service providers, due to having to re-tender and compete with each other for contracts. This can impact on information sharing and partnership work, as well as re-tendering being costly for both providers and commissioners.

6.1.3. Co-commissioning with NHS England and the MoJ should be mandatory.

6.1.4. Longevity of projects is a problem. There needs to be a broader commitment around healthcare for vulnerable people. Organisations highlighted the positive development of some areas shifting to five year contracts.

6.1.5. More consideration should be given to the use of co-commissioning.

7. Service user involvement

7.1. Good practice in service user involvement should be highlighted and shared.

7.2. Governors should work with people with lived experience.