Her Majesty's Inspectorate of Probation

A joint thematic inspection of community-based drug treatment and recovery work with people on probation

A joint inspection led by HM Inspectorate of Probation

August 2021

Acknowledgements

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Foreword

Illicit drugs are a huge driver of crime and a major issue for the whole of the criminal justice system. Half of all acquisitive crime may be drug related and it's estimated that this costs the public and the public purse over £9 billion a year. Drug-related deaths – at over 4,500 a year – are at record levels and almost half of all people in custody and on probation have drug problems. There has been a huge increase in the sophistication with which drug suppliers have saturated the market, drawing young and vulnerable individuals into organised criminal activities.

Given the scale of these links, I find the loss of focus on and investment in this issue across the criminal justice system in recent years deeply distressing. Although this report focuses on the probation service, this applies across the whole system. Programmes and structures previously put in place to identify and refer offenders with a drug problem to treatment have withered on the vine. As a result, far too few people are receiving the help they need, at huge cost to wider society in terms of continuing offending and the ongoing costs to the NHS and other public services of unaddressed chronic, chaotic and harmful drug use.

Probation services have an important role to play in supporting positive change for individuals caught up in drugs, and their supply. Probation staff cannot do this alone: they rely on the skilful work of drug services and police forces, along with a host of voluntary organisations to treat and support people to stabilise and recover from drug misuse. When it works well, people build productive lives and fewer victims are created.

Even though we inspected during the pandemic and could see the huge impact that Covid-19 has had on services, it was abundantly clear that, even before the pandemic, the current system was not working well, and this inspection has found the drug services provided to be inadequate. Far too few people on probation are being referred for help and two-thirds of people leaving prison in England who need ongoing treatment don't engage with it. Of the 60 cases we inspected of people on probation with a serious drug problem, 50 were known to drugs services, but only five had treatment plans that had been shared between probation and a drugs agency and only 10 were being drug tested to see if they were staying off drugs. Probation managers were unable to tell us how many class A drug users they had on their caseloads or how many were in treatment – a major information gap. Even where people had been referred to treatment, our inspectors were unable to find out if appointments had been kept or drug tests carried out.

Our joint inspection with the Care Quality Commission and Health Inspectorate Wales found that the national government strategy to combat drug-related crime is not sufficiently embedded in the probation service. Leadership in probation services on this matter has not been strong enough to drive positive outcomes.

Local partnerships have become weakened over recent years, particularly in England, where there has been disinvestment in provision for drug users. Services have been commissioned in a fragmented way, without a guiding mind to organise and control progress. Devolution in Wales has helped to protect the investment in drug services, and we found a stronger partnership approach there. English and Welsh systems need to share learning more effectively, particularly as more probation regions in England, such as Greater Manchester, are working with elected bodies with devolved powers.

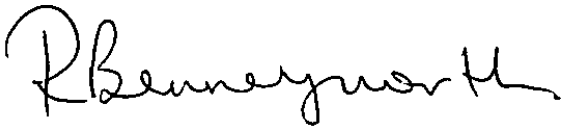
Sentencers are very exercised about the harms created by drugs and want to sentence effectively. But nearly six out of 10 of the 449 magistrates who responded to our survey were 'not very' or 'not at all' confident that probation was delivering drug misuse services well. They told us that not enough probation reports recommend structured drug treatment and testing and we found that a majority of the cases in our sample of drug users were sentenced without pre-sentence reports. The number of people on probation getting drug treatment has fallen dramatically over the past decade. This needs to change.

Many people enter prison with a serious drug problem and get treatment there to stabilise and reduce their dependence on drugs. But too many of these people fall out of treatment once they re-join society. Currently, only one in three stay in treatment after prison (Public Health England, 2021). Our inspection found systems were too weak to tackle this problem head-on. The Welsh Government has overseen effective commissioning arrangements, which have joined up prison and community arrangements. These need to be examined further. Wales has also led the way with new medicines to treat opiate addictions.

I welcome Dame Carol Black's recent call for an additional £552 million of ringfenced government funding per annum for drug misuse treatment within five years. People on probation should be an urgent priority for any future increase in investment, which would cut crime, save lives and more than pay for itself in the long run.

While the probation service focuses, quite rightly, on the harms from crime, it should also ensure that people managed within public services are kept safe. More people are dying from drug-related deaths than ever. Probation and drug service staff do not work together enough to share information to learn from serious 'near-miss' events or deaths. We urge a national review of the arrangements to safeguard vulnerable people managed by public services, and to learn lessons and share good practice from the tragic, untimely deaths of people under probation care.

Justin Russell
HM Chief Inspector of Probation



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Chief Inspector of Primary Medical Services and Integrated Care
Care Quality Commission

Contextual facts

48%	Percentage of people with drug problems under probation supervision, from inspection core programme information.[1]
4,411	Number of drug rehabilitation requirements ordered at court (January – December 2020). This makes up less than four per cent of all requirements.[2]
65%	Percentage of people who fall out of treatment when they leave prison (England). Based on the figures for those who do not attend within three weeks of release from custody.[3]
£9.3 billion	The estimated cost of recorded offences committed by drug users in England (2017/2018).[4]
£2.4 billion	The estimated combined benefits of drug and alcohol treatment every year, resulting in savings in areas such as crime, health and social care.[5]
£17,917.50	Estimated annual cost savings generated per person from heroin-assisted treatment.[6]
29%	Percentage of incidents in which the victims of violent crimes believed the perpetrator(s) were under the influence of drugs.[7]
4,561	Number of drug-related deaths in England and Wales registered in 2020.[8]
1,094 in 2018/2019, 1,002 in 2019/2020	Number of people dying under probation supervision.[9]
526 in 2018/2019, 458 in 2019/2020	Number of people dying under post-release probation supervision (all causes). 2018/2019 was the worst year on record, with numbers falling since.[9]

[1] HM Inspectorate of Probation. (2020). *2019/2020 Annual Report: inspections of probation services*.

[2] Ministry of Justice. (2021). *Offender management statistics quarterly (October to December 2020)*.

[3] Public Health England (PHE). (2021). *Alcohol and Drug Treatment in Secure Settings 2019 to 2020: Report. Official Statistics.*

[4] Black, C. (2020). Review of drugs: phase one report. London: Home Office. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report.

[5] Cost estimated by the Local Government Association in Comprehensive Spending Review 2020: LGA submission. (2020). Available at: https://www.local.gov.uk/publications/re-thinking-public-finances#care-and-health-inequalities.

[6] Poulter, H. Crow, R. and Moore, H. (2021). *Heroin assisted treatment (HAT) Pilot Evaluation Report. Teesside University.* Available at: https://research.tees.ac.uk/en/projects/evaluation-of-the-middlesbrough-heroin-assisted-treatment-pilot.

[7] Office for National Statistics. (2020). *Crime Survey for England and Wales: year ending March 2020*. Available at: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/natureofcrimetablesviolence. Table 9A

[8] Office for National Statistics. (2020). *Deaths related to drug poisoning in England and Wales: 2020 registrations*.

[9] Ministry of Justice. (2020). *Deaths of Offenders in the Community, annual update to March 2020.* Available at: Deaths of Offenders in the Community, annual update to March 2020 - GOV.UK (www.gov.uk).

Key findings

Of the 60 cases of people on probation with a drug problem that we inspected:

- 54 had a clear history of trauma; but this was considered properly in the assessment, planning and interventions that followed for only around one-third of this group
- more than half (33) did not benefit from a pre-sentence report before sentencing
- five out of 24 people sentenced to a drug rehabilitation requirement (DRR) had their consent to the requirement clearly recorded
- 50 were known to drug treatment services
- only six included enough involvement of drug agencies in the planning process
- just five out of the relevant 46 had sentence plans shared between probation and the drug treatment agencies
- work delivered by drug agencies was only noted for 10 individuals
- resettlement work to make sure people accessed community drug treatment on release from prison was insufficient for nearly two-thirds (16 out of the relevant 26 people)
- only nine people got enough intervention to build on recovery work achieved in custody
- half were clearly mandated to receive drug testing to measure compliance, but this only happened in 10 cases
- just over one-third (21) reduced their drug use during their time under supervision
- none reduced their offending.

Of the professionals we surveyed about drug treatment, the following key points emerged:

Magistrates told us (449 responses):

- 42 per cent were unsure of the local drug services and the arrangements for drug testing under DRRs
- only one-third could use a drug review court in their area
- confidence in Community Rehabilitation Companies to deliver drug work well had fallen, with 57 per cent not very, or not at all, confident.

Commissioners told us (15 responses):

- one English area had seen a budget reduction of over 40 per cent and most had experienced cuts of 25 per cent or more over the last 5 years
- all the Welsh Area Planning Boards (APBs) had enjoyed budget increases, but this contrasts with feedback from HMPPS and Police and Crime Commissioners in Wales, who have seen freezes or reductions
- five did not commission specific criminal justice pathways.

Probation providers (125 responses) told us:

- 89 per cent did not have semi-specialist staff working with drug misuse
- 94 per cent thought it would be beneficial to operate this specialism
- 86 per cent operated without any co-location with drug services
- 35 per cent had specific services for women
- only 28 per cent had specific services for people with dual diagnosis[10]
- only 11 per cent had specific services for sex workers
- only four per cent had specific pathways or arrangements for people from a black, Asian or minority ethnic background.

[10] Dual diagnosis is a term to describe co-existing mental health and alcohol and drug misuse problems.

Executive summary

The thematic inspection in context

Drugs and crime are inextricably linked. Almost half the people on probation are thought to have a drug problem, and crime committed by class A drug users costs society over £9 billion a year. A recent review[11] of the UK drug market highlighted the role of organised drug gangs and effective supply lines. The use of social media has extended the channels available to market and sell drugs. Drugs in prison are a huge issue and Her Majesty's Prison and Probation Service (HMPPS) has a strategy in place to reduce the supply, manage the demand and build recovery for people battling drug problems.

The Covid-19 pandemic stands as a stark backdrop to this inspection. All criminal justice and drug agencies were contending with increased health and safety considerations and reduced staffing. Probation providers agreed exceptional delivery models with HMPPS and much of the face-to-face work normally conducted with individuals by probation and drug agencies was scaled back drastically. Similarly, drug services were permitted derogations from some drug testing and face-to-face activities.

To add further complexity, the National Probation Service (NPS), Community Rehabilitation Companies (CRCs) and some supply chain providers are moving to a new delivery model, as services unified into a new organisation in June 2021: the Probation Service. The mobilisation activity for the new organisation has put a strain on managers and staff, and the impact of this change should not be underestimated.

Additionally, changes in patterns of drug use have emerged in response to the pandemic. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2020) reviewed the impact of Covid-19 on patterns of drug use and drug-related harm in Europe. Preliminary findings suggest that there was an overall decline in drug use, or some forms of drug use, during the first three months of the pandemic (March to June 2020). This could be explained by national confinement measures and the disruption of street drug markets. The use of cocaine and MDMA (Ecstasy) appears to have been most affected, largely linked to the closure of the night-time economy. There is a more mixed picture for cannabis use. Local shortages of heroin have been reported and have led to reductions in use in some countries. An increase in the use of prescription medications (especially benzodiazepines) has been seen. However, EMCDDA's most recent report (2021) concluded that, despite the disruption caused by the pandemic, the drug market has been remarkably resilient. While there was some initial disruption to the street-based retail drug markets, both buyers and sellers appear to have adapted by communicating through technology, including encrypted messaging services, social media and other online sources. The report also noted that the initial disruption seen during lockdowns disappeared rapidly as social distancing measures were relaxed, although there is still less of a market for drugs associated with recreational events, such as MDMA, but a higher demand for drugs that can be used in the home.

There has been a significant shift in resources for drug treatment since 2000. A pooled treatment budget drove a range of programmes. These included the Drugs Intervention Programme (DIP), which took a strong multi-agency approach to cutting crime and helping people deal with addiction and move towards recovery. It was set up in 2003, and the Home Office decommissioned it as a national programme in October 2013. The DIP received funding in excess of £900 million in its lifetime.[12] At its zenith, over 4,500 people entered treatment through DIP each month and eight out

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[11] Black, C. (2020). *Review of drugs: phase one report*. London: Home Office. Available at: www.gov.uk/government/publications/review-of-drugs-phase-one-report.

[12] Home Office. (2011). *Drugs intervention programme operational handbook*. Available at: www.gov.uk/government/publications/dip-operational-handbook.

of every 10 individuals were retained in treatment for 12 weeks or more. Figures showed a reduction of nearly one-third in recorded acquisitive crime.[13]

Many of these programmes foundered in England, after the National Treatment Agency was subsumed into Public Health England and the central focus was lost. From 2013, local authorities picked up public health responsibilities, including commissioning of drug services, and cuts to the public health grant began to unravel the fabric of local drug and crime partnership work. Austerity led to cuts in investment in the police and probation services too, compounded by the removal of the local authority ringfenced grant that had partially protected spending on substance misuse treatment up to April 2019.

In 2013, the *Health and Social Care Act* transferred responsibility for commissioning substance misuse services from primary healthcare trusts to local authorities in England. In Wales, ministers have powers under Sections 2 and 3 of the *NHS (Wales) Act 2006* in relation to tackling substance misuse.

In England, local authorities commission detoxification and residential rehabilitation alcohol and drug treatment services on either a spot-purchase or block contract basis (Care Quality Commission, 2017). The public health grant (£3.2 billion in 2018/2019) funds core public health services (including drug and alcohol services) commissioned by local government. Between 2015/2016 and 2020/2021, the public health grant will have decreased by 23 per cent in real terms (by 7.5 per cent in cash terms) (Health Select Committee, 2019).

More recently, with the number of drug-related deaths continuing to climb and serious threats emerging from the increasing sophistication of the drug markets, the UK government has renewed its interest in this policy area. It has established a crime and justice taskforce, undertaken a major review of drugs, and made £80 million of extra investment available in early 2021 for one year only.

A new cross-government drug strategy is believed to be imminent, following the publication of the *Review of Drugs: phase two report* (Black, 2021), which called for a serious overhaul of the drug treatment and recovery systems and increased resources to support these moves.

Methodology

The fieldwork for this inspection was completed between January and March 2021. Due to the Covid-19 pandemic, the inspection was done remotely using video conferencing technology such as Microsoft Teams. We included six NPS regions and five separate CRCs, providing a spread of metropolitan, urban, rural and coastal locations.

We reviewed 60 cases of people on probation known to have a drug problem or to be recovering from drug addiction, including people sentenced to DRRs, or under licence conditions. We spoke with probation practitioners and drug workers, where relevant. We interviewed a wide range of stakeholders, including senior managers from the local delivery units, lead managers for drug misuse, and local partners such as the Police and Crime Commissioner, Community Safety Partnership, Safeguarding Adults Board and a local judge from each area.

We conducted three electronic surveys, asking magistrates, probation providers and drug service commissioners for their views on sentencing, provision of drug misuse services and the effectiveness of partnership working. The organisation Choice Support secured 12 in-depth interviews for us with people on probation with drug misuse problems.

Data analysis work was carried out to support this inspection with HMPPS, Public Health England (PHE), and NHS Wales Informatics Services, which has since become Digital Health and Care Wales. A detailed breakdown of our approach can be found in Annexe 2: Methodology.

Strategy, policy and leadership

We found no coordinated strategy to address drug misuse for people on probation in England across the Ministry of Justice and the Department of Health and Social Care. This has caused drift in England, although HMPPS has recently published a Drug and Alcohol Strategy in Wales (2020).

Within HMPPS, the strategy for probation lags behind that for prisons, and the beginnings of more cross-departmental work have yet to bear fruit.

Since the responsibility for public health functions in England moved to local authorities in 2013, there have been pressures on commissioning budgets and, in many areas, criminal justice-specific pathways have been reduced or disbanded in favour of a universal service. The model for the unified probation service provides an opportunity for probation and commissioners to re-start the discussion about which services are commissioned. Wales has been leading the way: there is now more joined-up commissioning between prison and the community, with contracts commissioned jointly by HMPPS and Police and Crime Commissioners. We urge the Ministry of Justice and Department of Health and Social Care to think about what can be learned from the Welsh example and from local innovation, as devolution gathers pace in Greater Manchester and regional probation directors look to commission services to complement those provided by health services and Police and Crime Commissioners and from local authority budgets.

Many staff we spoke to cited a lack of training regarding drugs. Few had received recent input on the subject. Only a small percentage of the probation practitioners we spoke to were familiar with the concept of recovery in drugs work, and this needs to be addressed. Workload pressures will also need to be tackled, to ensure that the complexity of need that many drug users face can be managed.

We welcome the renewed focus on drugs and criminal justice and recent funding to support services. Departmental leadership by the Ministry of Justice, Department of Health and Social Care and Welsh Government will need to drive work across government with energy and clarity, to shift the trajectory of drug supply, drug-related offending, low numbers in treatment and rising drug-related deaths.

Partnership and court work

Drug misuse work is multi-faceted, crossing justice, health and social care. Partnership work is crucial to effective practice.

The partnership arrangements we reviewed in this inspection were strained from the Covid-19 pandemic taking effect from March 2020. The reorganisation of probation services through the *Transforming Rehabilitation* reforms seven years ago also appears to have fractured partnerships. Probation organisations have been involved in a lot of internally facing activity to set up new organisations and deliver probation services. This has squeezed capacity for external work with partners. The probation service's contribution is further limited as probation case databases do not collect information about the profile of drug users, which could be used to inform commissioning decisions.

More positively, drug misuse providers had good relationships with commissioners and other stakeholders. We found greater partnership activity in Swansea and the beginnings of improving partnership practice in Greater Manchester, where services are devolved.

Sentencers deal with drugs and crime frequently. They told us that they hear few recommendations from probation court teams for specific interventions to address drug misuse as a driver of people's offending. This is consistent with the steep decline in the use of DRRs (Ministry of Justice, 2005-2020). We argue for an increase in court-ordered interventions to enable people to access treatment and benefit from the oversight that drug testing can bring. Sentencers also valued the opportunity for ongoing, face-to-face reviews of progress by people on DRRs, but these are now only used in Crown courts and too seldom.

Casework and interventions

Aggregate data from our core inspection programme showed that only 47 per cent of people on probation for whom drug use was identified as a priority factor received an intervention for it (HM Inspectorate Probation, 2019). While we saw some excellent practice in this inspection, and many dedicated and tenacious staff determined to achieve real progress with the people they were

supervising, the picture was inconsistent and relied too much on the interest of individual practitioners. The cases reviewed showed that assessment and plans for people on probation require significant improvement. The assessments, plans and service delivery in these cases required better information exchange between agencies. People's diverse needs were not taken into consideration sufficiently either.

There was a broad consensus that strong multi-agency work, with more specialist and co-located staff, is effective. The cases held by Integrated Offender Management teams were some of the best we saw. The benefits of this model are clear and should be replicated to create effective work with drug users. It is our contention that this approach could improve the level of joint planning and bring a cohesion to the work that is delivered across the probation and drugs services.

DRRs have become watered down in recent years and, in the majority of cases we inspected, there was little to distinguish them from standard community orders. The treatment component of these requirements needs to be reconsidered and clear expectations put in place to ensure these interventions are delivered and monitored effectively.

Recording systems and practice need improvement to enable a clear view on needs, wellbeing, offence-related work and drug tests. The reviewing work we saw was done, almost exclusively, in isolation, with drug and probation agencies rarely coming together with service users to review progress and next steps.

Resettlement

The arrangements for people leaving custody are complex. A four-way information exchange needs to take place – with drug services in the community and in prison, and probation-led rehabilitative services in prison and in the community – in order to fully integrate and inform a resettlement and treatment plan for every person leaving prison.

Too many people are falling through the net. We found that people were not always released with a prescription arranged for opiate substitution medications where needed and, in England, two-thirds of people drop out of treatment and do not attend for community treatment within the first three weeks of their release. There is a stretch target to improve the continuity of people's care, and the prime minister has set out his intention for services to ensure that at least 75 per cent of people are retained in treatment once they return to the community after prison.

Use of licence conditions is highly variable. We welcome more consistent use of a guidance tool to support probation practitioners. The Probation Service needs to do more to ensure that practice is proportionate and effective in managing those who need drug treatment and testing on release.

Reducing drug harms

This inspection looked at drug-related deaths for people known to probation services, which have been increasing steadily over the past two decades. We concluded that the reviewing systems for deaths under supervision are too process-focused and, in localities, not enough information exchange or joint reviewing is taking place. Agencies have much to learn from each other to minimise untimely deaths. We note the progress in recording these deaths, and the increased funding from government to enhance practice and address the issues.

We also looked at the vulnerabilities that beset people who have drug problems. We observed high levels of mental health problems, and accommodation and ancillary needs. Again, the pandemic has caused real pressures, and it was heartening to see the heroic efforts staff went to in order to help people in need, with food, clothes and mobile phones to keep them in touch with services.

However, work to prevent overdoses has been curtailed by the pandemic and probation staff told us they felt such work was not their remit. Brief interventions and medicines to reverse potential overdose need to be more widely deployed.

Overall, we found that probation and drug services staff are not proactive enough when it comes to safeguarding the adults they work with and that the threshold to receive adult social care services is

very high. Leaders need to support staff with training and developing knowledge, and work with local safeguarding arrangements to ensure that adults at risk are kept safe in the community while they are helped to turn away from crime.

Recommendations

The Ministry of Justice should work with the Department of Health and Social Care and the Welsh Government to:

1. commission a structured evaluation, including costs and benefits, of integrated health and justice co-commissioning models for drug treatment and recovery services across England and Wales and implement best practice
2. ensure that there are joined-up strategies and policies to address drug misuse for people on probation
3. legislate to extend the ability of the probation service to drug test people on probation, so that the service is able to test a greater proportion of its caseload, to help assess and identify people with a drug problem who might benefit from treatment.

The Department of Health and Social Care and the Welsh Government should work with the Ministry of Justice to:

4. provide adequate funding for drug treatment and recovery for people on probation and following release from custody
5. ensure directors of public health in England and area planning boards for Wales provide responsive drug treatment and recovery provisions for people on probation and following release from custody.

Her Majesty's Prison and Probation Service should work with local government commissioners and drug services to:

6. increase the use of drug rehabilitation requirements by ensuring that drug-misuse assessments at court are carried out by appropriately skilled practitioners, and that they comment on suitability and motivation for treatment and help set the expectations for defendants
7. establish the proportion of people on probation in each locality who are dependent on drugs and would benefit from specialist treatment and ensure that this treatment is available for all people on probation that need it
8. ensure that every person leaving custody needing ongoing treatment receives it, supported by effective handover arrangements
9. ensure that evidence-based and recovery interventions are commissioned and delivered
10. enact a plan of work to build a joint working culture between the relevant professional organisations, and ensure this includes effective use of information exchange provisions
11. measure and publish outcomes for people on probation with a drug problem, such as completion of psychosocial interventions; reduced illicit drug use; reduced offending; improvements in mental health; improvements in education, training and employment outcomes; and improved accommodation outcomes
12. improve the safety of people on probation by:
    a. increasing access to and provision of naloxone
    b. reducing the number of people who die from drug-related causes by improving systems to review drug-related deaths, including near-miss reviews, and strengthening dissemination of meaningful learning between agencies

c. developing learning programmes that enable staff to deliver effective harm reduction and overdose prevention work to people with drug problems

d. ensuring that all frontline practitioners understand and take steps to safeguard adults at risk.

The Probation Service should:

13. launch and implement an effective drugs strategy and related policies to:

    a. ensure effective governance drives effective and responsive practice to tackle drug misuse

    b. improve data and information systems to collect the profile and needs data for people on probation, to support effective commissioning of drug services at a local level. This should include changes to the OASys assessment tool to allow probation managers to extract the number of individuals on probation caseloads who are class A drug users and to track how many of them are currently in treatment. A specific field should also be developed in nDelius to record drug test results

    c. commission appropriate services to tackle drug addiction and support recovery

    d. increase the use of regular drug testing, in relevant community orders and licences, as a tool for initial assessment, monitoring and compliance, including exploring the potential for piloting drug tests at first appointment to measure the extent of under-reporting of class A drug use

    e. ensure that test results for all drug rehabilitation requirements are made available to court, where mandated

    f. introduce a drug semi-specialist model so that probation practitioners working with drug rehabilitation requirements develop more confidence and knowledge of local arrangements and better relationships with partner agencies

    g. improve training to staff on drugs, how to work with trauma and how to support people towards recovery.

The Probation Service and Local Criminal Justice Boards should work with local health departments to:

14. ensure that suitable local governance arrangements are in place so that all relevant partners, including Health and Wellbeing Boards and local services, are involved in planning, commissioning and delivering effective joint services for people with drug problems, as a major contribution to local crime reduction.

1. Introduction

1.1. Why this thematic?

Drug misuse is a key driver of offending and the time is right to inspect this topic. Legislatively, the UK government has set out its intention to 'reset' drug testing in its white paper, *A Smarter Approach to Sentencing* (2020). Dame Carol Black published *Review of drugs: phase one report*, in February 2020, and *Review of drugs: phase two report*, which considered prevention, treatment and recovery, in July 2021. The review sets out the problems with an under-funded system and calls for a coordinated approach, significant investment, research, increased training and professionalisation to improve treatment, recovery and societal outcomes.

"There's a strong 'invest to save' case for drug treatment … Although Part 1 of the review showed that the societal costs of drug misuse are £20 billion each year, in 2020 to 2021 only £650 million was spent on drug treatment. Every £1 currently spent on harm reduction and treatment gives a combined health and justice return on investment of £4. Failure to invest will inevitably lead to increased future pressures on the criminal justice system, health services, employment services and the welfare system." – Dame Carol Black (2021)

HM Inspectorate of Probation last reviewed drug use in its joint thematic inspection of new psychoactive substances (2017), conducted with the Care Quality Commission (CQC). There has been no broader look at drugs since 2006, when we published *Half Full and Half Empty. An inspection of the National Probation Service's substance misuse work with offenders*. Prior to that, we reported on drug treatment and testing orders in 2003.

In the period since we last took a detailed look, the drugs intervention programme (see 'Background' section below) for identifying drug-involved offenders and referring them to treatment has fallen out of use, treatment orders and requirements have decreased markedly and there has been a shocking rise in drug-related deaths in England and Wales. In this same period, interest in the recovery agenda has grown and has strong parallels with the more recent desistance theory.

The unified probation delivery model will bring changes to commissioning arrangements, with the regional probation directors able to purchase 'commissioned rehabilitative services', including 'dependency and recovery' interventions. It is hoped that the findings of this review will help shape future delivery.

1.2. Background

The relationship between substance misuse and offending

Although the link between substance misuse and crime is complex, there is evidence to suggest that a significant number of those entering prison have problematic drug use. Palmer et al. (2011) put this number at between 30 and 50 per cent.

Drug-related offences, such as selling or storing drugs, or acquisitive crimes such as theft, burglary or prostitution, are often committed to fund a drugs habit. Due to the prevalence of the use of illegal drugs in prisons, the number of people who leave custody and require treatment for substance misuse is likely to be substantial (Pierce et al., 2015).

Current and recent drug treatment overview

The number of people in drug treatment and the budget for these interventions has decreased significantly in England since 2013, when the National Treatment Agency was dissolved.

There is widespread recognition that the drug treatment sector is now underfunded in England and, with the worsening outcomes for people with drug problems, the UK government responded by commissioning a review of drugs in England from Dame Carol Black, which has recommended

additional ring-fenced funding for treatment is needed, rising to £552 million per annum over the current baselined budget. The UK government also made an additional £80 million available to improve drug treatment and criminal justice pathways in early 2021; however, this funding is only secured for one year and the future of drug treatment, particularly for people in the criminal justice system, remains precarious.

Figure 1 sets out the decline in funding and numbers receiving treatment in England between 2014 and 2019.[13]

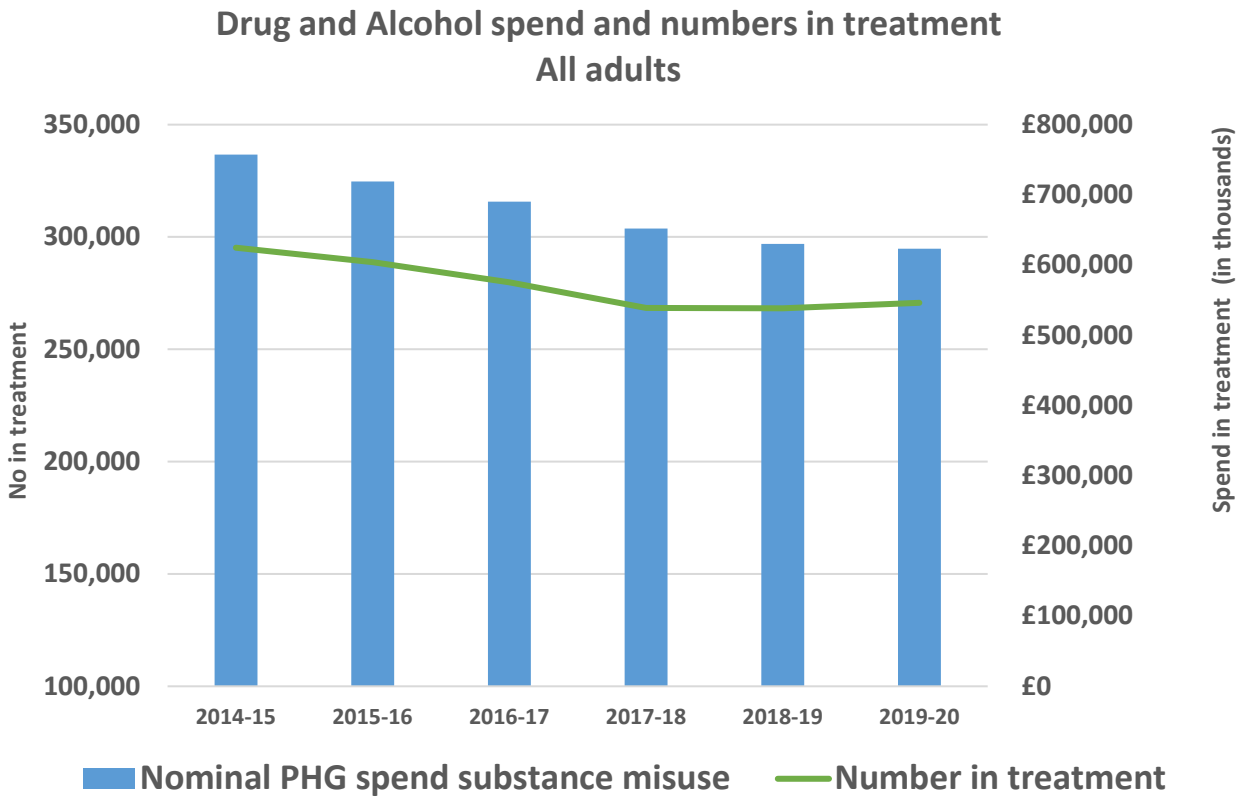

Figure 1: Drug and alcohol spend and numbers in treatment[14]

In 2017, the median spend on drug misuse treatment and prevention per resident in upper tier councils in England was £7.64 (a reduction of £2.60 since 2015) (Local Government Association, 2019).

Wales has seen a small increase in its open access spending, as shown in Figure 2. However, HMPPS and Police and Crime Commissioner (PCC) funding had generally decreased, leaving the people on probation with under-funded services.

[13] Black, C. (2020). *Review of drugs: phase one report*. London: Home Office. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report.

[14] PHG refers to the public health grant.

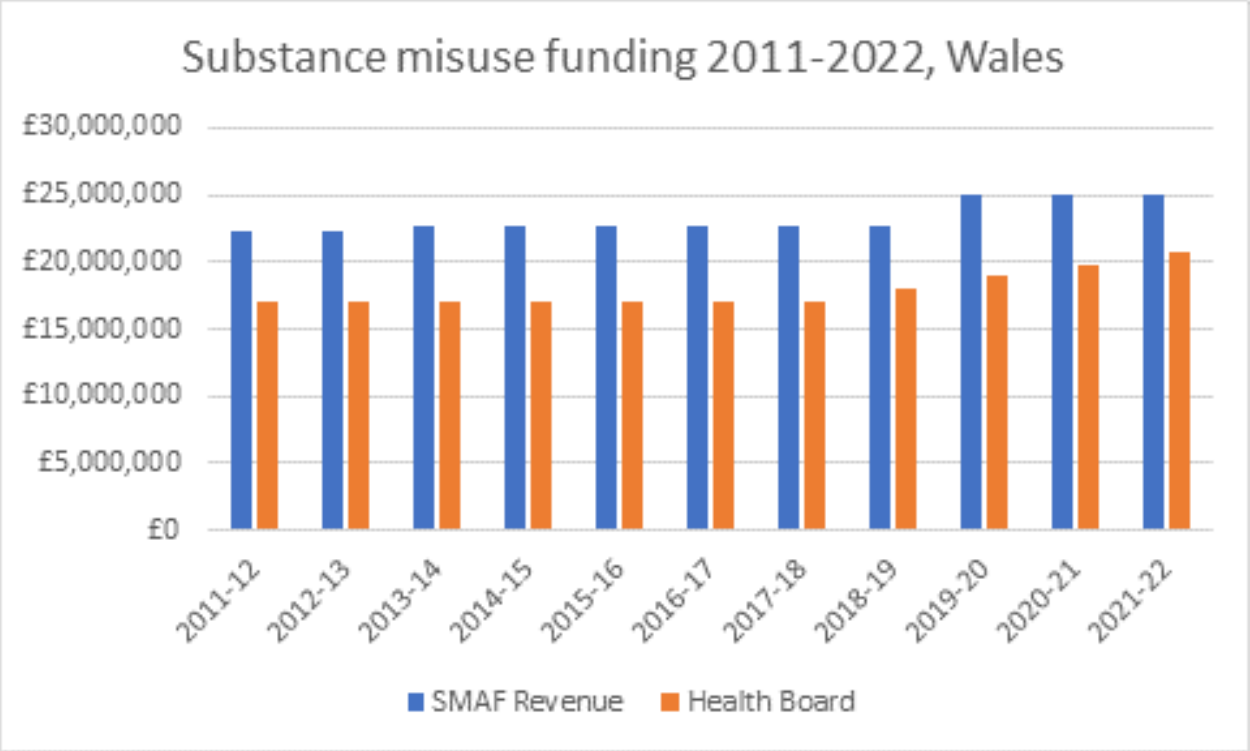

Figure 2: Substance misuse allocated funding (SMAF), Wales, 2011/2012 to 2020/2021[15]

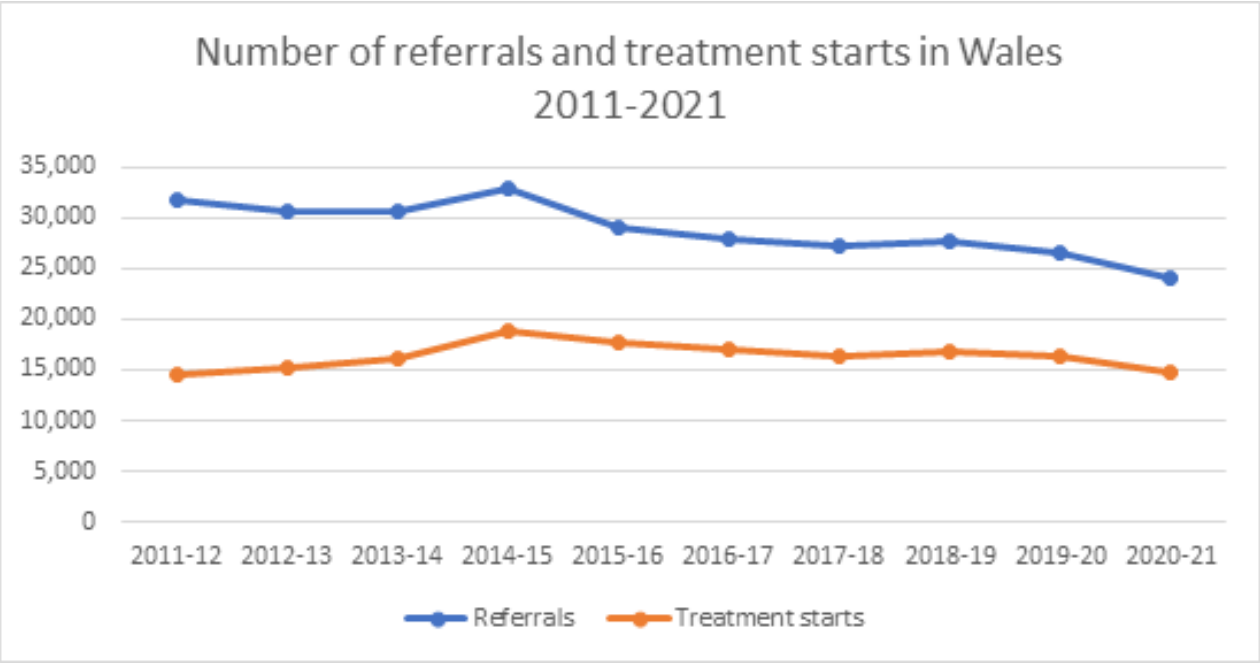

Figure 3: 'Number of people referred for and starting drug treatment, Wales, whole population, 2011/2012 to 2020/2021[15]

Further information on funding is provided in Annexe 3.

Overall, there is a problematic picture of disinvestment. Concern was also expressed in the British Medical Journal about the 2017 UK Government Drug Strategy and the lack of a statutory requirement (and associated resources) for local authorities (LAs) to provide community substance

[15] Data provided by HMPPS Wales, unpublished

misuse services.[16] Black (2020) estimates that English local authorities have had to manage reductions of up to 40 per cent in the public health grant allocations.

In 2013, 195 residential rehabilitation and detoxification services were registered with the CQC in England; by 2019, this had fallen to 132 active centres.[17]

Figure 4 gives an overview of drug treatment across the last two decades.

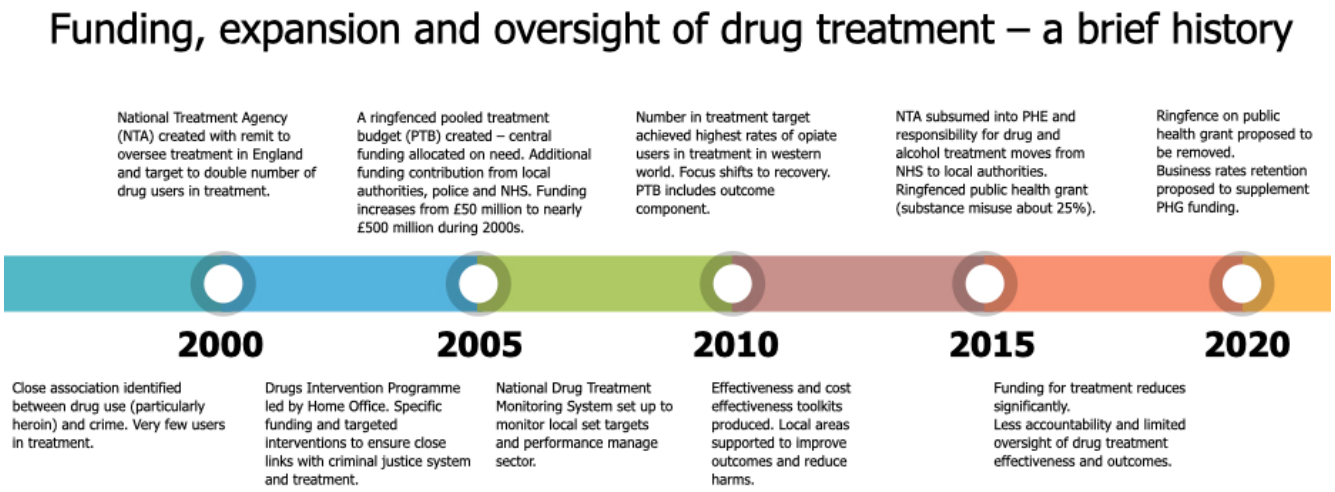

Figure 4: A brief history of drug treatment, England[18]

In recognition of the situation in Wales in 2014, the National Offender Management Service in Wales (now HMPPS in Wales) was granted special dispensation to retain governance of substance misuse funding for the provision of statutory drug and alcohol treatment services. The decision was made in support of the ambition to jointly commission substance misuse treatment services with the four PCCs and local Area Planning Boards (APBs), in order to develop and deliver an integrated substance misuse treatment pathway across Wales. Agreement was also secured to extend the prisons' drug substance misuse services contract to allow the opportunity to align recommissioning of custody-based services with the South Wales area community drug and alcohol treatment provision. Figure 5 sets out the current budgets in Wales, as provided by HMPPS.[19]

Probation delivery unit	Contract cost	HMPPS contribution
North Wales	£1 million	£500,000
Gwent	£5 million	£550,000
Dyfed	£1.5 million	£270,000
Powys	£950,000	£53,000
South Wales	£3.5 million	£1.5 million

Figure 5: Current HMPPS/PCC co-commissioned budgets for criminal justice specific substance misuse treatment in Wales, rounded[19]

[16] BMJ. (2017). 'Drug strategy will fail without new money'. *BMJ* 2017;358:j3460. Available at: www.bmj.com/content/358/bmj.j3460/rr-0

[17] King, A. (13 July 2019). 'Residential addiction services in England cut by a third amid drug overdose and funding crisis, figures show'. *The Independent*.

[18] Black, C. (2020). *Review of drugs – evidence relating to drug use, supply and effects, including current trends and future risks*. London: Home Office. Available at: www.gov.uk/government/publications/review-of-drugs-phase-one-report.

[19] Data provided by HMPPS Wales, unpublished.

It is HMPPS in Wales's priority to ensure consistency of provision across Wales; however, services have been recommissioned under five separate contracts (North Wales, Gwent, Dyfed, Powys and South Wales) to allow for local variation in commissioning arrangements and service delivery models. Although the system in Wales is better funded, leaders have highlighted pressures on funding. HMPPS in Wales and a number of the PCCs are concerned that the increased clinical costs are not sustainable.

Operation ADDER (addiction, diversion, disruption, enforcement and recovery) is a new Home Office project, which brings together partners in local law enforcement, the justice system and public health and treatment services to deliver interventions in a 'whole-system' response to drug problems. It has been launched in five sites – Middlesbrough, Blackpool, Swansea Bay,[20] Hastings and Norwich – with £28 million of funding, as set out in Figure 6 below. The English sites received a higher amount, but as health is devolved to the Welsh Government, the ADDER contribution was lower for Swansea, and targeted at disrupting crime.

Areas funded by Project ADDER[21]	£
Blackpool	£4.8 million
Hastings	£4.35 million
Middlesbrough	£4.58 million
Norwich	£4.8 million
Swansea Bay	£1 million

Figure 6: Operation ADDER funding allocations

The ADDER project is supported by a wider £148 million funding package in 2021/2022 for reducing crime, including £80 million to enhance drug treatment, focused on reducing drug-related crime and halting the rise in drug-related deaths. This represents the biggest increase in drug treatment funding for 15 years. It should be noted that the allocations are different, and lower, for Wales, as health matters are under the purview of the Welsh Government. Consequently, only crime-related initiatives can be funded under this scheme in Wales.

All local areas are eligible for the wider funding, and the bulk of it will be allocated by the Department of Health and Social Care (DHSC) and PHE, taking account of levels of deprivation.

The wider crime reduction funding gives extra resources to the police and the National Crime Agency to dismantle organised criminal gangs and tackle the supply of drugs.

To monitor outcomes, PHE's National Drug Treatment Monitoring System will produce monthly data on:

- naloxone provision and coverage
- residential and inpatient treatment
- offenders entering treatment
- offenders who leave prison and are successfully engaged in community treatment.

Across Wales, seven APBs are responsible, within their regions, for assessing need, and commissioning and monitoring delivery of substance misuse services, using funding allocated by the Welsh Government. The Welsh Government publishes key performance indicators quarterly.

The membership of the APBs should include representatives from the responsible authorities involved in the Community Safety Partnership, for example local authorities, local health boards and

[20] For the purposes of this report, Swansea Bay refers to the areas of Swansea, Neath and Port Talbot.

[21] Home Office, Prime Minister's Office, 10 Downing Street, DHSC. (2021). '£148 million to cut drugs crime'. Available at: www.gov.uk/government/news/148-million-to-cut-drugs-crime, accessed July 2021.

the police to ensure a link between their substance misuse responsibilities and to enable them to discharge their statutory duty under the *Crime and Disorder Act 1998*.

In contrast to the disinvestment in England, funding in Wales was increased by over 10 per cent in 2019/2020 to support APBs. The Welsh Government invested almost £53 million during this period to meet commitments in the substance misuse agenda, as set out in its Substance Misuse Delivery Plan 2019-22.[22] While investment in drug treatment has declined in England, Wales has protected the drug treatment budget. APBs separately commission substance misuse services that are open access and not restricted to criminal justice cases.

Further, criminal justice substance misuse services are co-commissioned through five separate contracts (North Wales, Gwent, Dyfed, Powys and South Wales). These contracts are co-commissioned by HMPPS and PCCs.

Recent history

Drug Action Teams (DATs) were multi-agency partnerships created as part of the UK's national drug strategy in 1995. DATs were responsible for coordinating local initiatives and programmes on drug and alcohol use and reporting how these programmes supported the national strategy to national public health agencies.

The National Treatment Agency for Substance Misuse (NTA) was established in 2001 to improve the availability, capacity and effectiveness of drug treatment. It allowed services to be commissioned and effective partnerships to flourish.

The Drug Interventions Programme (DIP) was set up in 2003. Home Office funding was given to community justice integrated teams (CJITs) through the DIP main grant, to work with a caseload of people whose offending behaviour was linked with the misuse of heroin and cocaine/crack cocaine. Between 2003 and 2010, funding was allocated directly from the Home Office to local authority based DATs. From 2010 to 2013, 60 per cent of the funding was routed via the National Treatment Agency's pooled treatment budget and the remainder was retained by the Home Office. The Home Office portion of the funding was then passed on to the newly established PCCs, while the pooled treatment funds were rolled into the public health grant (PHG) following the demise of the NTA. Neither PCC nor PHG funding was ringfenced for drug treatment. The funding amounted to over £900 million over the course of the programme. In terms of governance, DIP reported to the Integrated Offender Management (IOM) National Strategic Board.[23] Within Wales, the DIP reported to the All-Wales Drug Interventions Programme Performance Management Board.[24]

Drug testing on arrest at police stations was also introduced for all offenders arrested for 'trigger offences', which generally involved stealing, fraud or drugs. At its peak, in 2009 and 2010, nearly 250,000 drug tests were being conducted on arrest each year.[25] Over the 10 years from 2004 to 2013, almost 1.7 million drug tests were conducted on arrest, and 22 per cent of these tests had a positive result for opiates like heroin or for combined cocaine and opiate use. Additionally, as part of the joined-up contracts in Wales, test on arrest and drug misuse interventions are carried out in police custody suites, with information following defendants to court.

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[22] Welsh Government. (2019). *Substance misuse delivery plan 2019-2022.* Available at: https://gov.wales/substance-misuse-delivery-plan-2019-2022-0.

[23] The Board comprised: Home Office, Communities and Local Government, Ministry of Justice, Department of Health, Association of Chief Police Officers, National Treatment Agency, Department for Children, Schools and Families, Prime Minister's Delivery Unit. The Board provided strategic leadership for the Prolific and other Priority Offender (PPO) Programme and DIP.

[24] Home Office. (2011). *Drugs intervention programme operational handbook*. Available at: www.gov.uk/government/publications/dip-operational-handbook.

[25] Morgan, N. Heap, D., Elliott, A. and Millar T. (2016). *New opiate and crack cocaine users: characteristic and trends*. Home Office. Available at: www.gov.uk/government/publications/new-opiate-and-crack-cocaine-users-characteristics-and-trends.

In May 2010 in Wales, *Guidance for Establishing Substance Misuse Area Planning Boards* was published. In it, the Welsh Government advocated that partner agencies establish substance misuse APBs in each local health board area. Revised guidance was published in August 2012. This provided additional information on the status of the APB and established the requirement for a 'regional banker'. This guidance was further updated in January 2018 in light of the *Well-being of Future Generations (Wales) Act 2015* and the *Social Services and Well-being (Wales) Act 2014*. APBs also work closely with substance misuse services commissioned by PCCs and HMPPS. In many areas, this is through joint contracts.

The DIP identified and intervened with people to address their class A drug misuse needs and offending, to reduce crime and help them access treatment and other support. CJITs worked in partnership with the police, prison CARAT[26] teams, and the probation service. In 2009, DIP was reviewed, the operational model was refreshed, and a new DIP funding model was established.

After DIP ceased to be funded in 2013 in England, police forces described a significant decline in the use of drug testing on arrest (DTOA). Forces further reduced their use of DTOA as drug treatment funding declined and the availability of drug treatment services for anyone testing positive for drugs was reduced.

In 2013, the NTA became part of PHE and substance misuse funding transferred from the NHS to local authorities, though it remained ringfenced within the broader public health grant.

Objectively, the arrangements to tackle illicit drug use were much more robust 10 years ago. While we welcome the renewed interest and investment in the sector, the lack of central governance and policy direction in recent years is concerning.

The Black review (2021)[27] sets out a wide range of recommendations to confront the declining effectiveness of the current systems in England. It points to the disinvestment over time and the lack of a coordinated approach. It recommends: radical reform of leadership, funding and commissioning; rebuilding of services; an increased focus on primary prevention and early intervention; and improvements to research and how science informs policy, commissioning and practice. In an early response to the review, the government announced in July 2021 that it will set up a new Joint Combating Drugs Unit, which will bring together the Home Office, DHSC, Ministry of Housing, Communities and Local Government, Department for Work and Pensions, Department for Education and the Ministry of Justice to help tackle drug misuse across society.

Current strategy

Government Drug Strategy 2017[28]

This strategy sets out how the government and its partners intend to tackle drug misuse and its wider consequences at local, national and international levels. It builds on the *Health and Social Care Act 2012*, which requires the full breadth of local partners to be represented in local priority decision-making and expects joint working in a number of areas, including education, health, safeguarding, criminal justice, housing and employment. The UK devolved administrations have their own approaches to tackling drug misuse and dependence, and so the health, education, housing and social care areas in the strategy only cover England. Those areas related to the work of the police and the criminal justice system apply to England and Wales, and the work of the Department for Work and Pensions to England, Scotland and Wales.

One key area of action is offering support to those with drug dependency to provide them with the best chance of recovery. This includes tracking progress on rates of recovery from dependency. The need for joined-up action on drugs and alcohol was identified in the strategy, as well as the need to address physical and mental health needs alongside substance misuse. Peer-led recovery support

[26] Counselling, Assessment, Referral, Advice and Throughcare (CARAT)

[27] Black, C. (2021). *Review of Drugs: phase two report*. London: Home Office.

[28] HM Government. (2017). *2017 Drug Strategy*.

was recognised as an essential component of effective recovery, and the strategy said it should be readily available before, during and after formal structured treatment. Access to employment and meaningful activity was also considered a critical aspect of recovery, as well as stable and appropriate housing, and having a supportive network.

The need for effective treatment for both drug and alcohol misuse was previously highlighted by the Home Office as part of its 2016 crime prevention strategy. In relation to drugs, getting users into treatment was seen as key, with being in treatment itself reducing levels of offending. The strategy emphasised that full recovery from dependence should be the aim, noting the importance of 'recovery capital' (p. 30), particularly housing and meaningful employment. The importance of good partnership working was also highlighted as underpinning the successful implementation of interventions, as well as the need to share data across health, criminal justice and local authority platforms to help prevent future crime.

Section 6 of the *Crime and Disorder Act 1998* states that 'responsible authorities' within a Community Safety Partnership must have a strategy for combatting the misuse of drugs, alcohol and other substances in the area.

Health

The DHSC has the following objectives in its single departmental plan: 'to improve people's health; strengthen the public health system and reduce inequalities'. It sets out the aim of delivering programmes of work to promote healthy behaviours, including on tobacco, alcohol, drugs, sexual health and physical activity, ensuring that the programmes are consistent with the prevention objectives in the NHS Long Term Plan.

Operationally, in England, most community drug treatment is now commissioned by public health departments in local authorities. There has been a steady disinvestment in drug treatment services. The overall size of the ringfenced public health grant has been reduced, and ringfenced monies have been pooled into local authority main budgets. Overall, cuts have squeezed commissioners' abilities to maintain services, and criminal justice pathways have been removed in some areas, leading to a universal service approach that may not work as well for people on probation. English commissioners told us that most had experienced budget reductions in the past five years with nearly half of respondents reporting over 25 per cent in cuts.[29] While all APB commissioners who responded to our survey in Wales reported an increase in budgets, HMPPS has withstood budget freezes, which, when factoring in cost rises, effectively means that services supporting people on probation have been squeezed in Wales too. One PCC has increased spend in this area, but others have made reductions. Of the commissioners we surveyed, one-third did not commission any criminal justice pathways.

National Probation Service health and social care strategy 2019-2022[30]

Recognising that people in contact with the criminal justice system often have multiple and complex health and support needs, the NPS developed a health and social care strategy in 2019, which covers both England and Wales. This strategy outlines core commitments to addressing the vulnerabilities of people in contact with the criminal justice system to improve their health and wellbeing, as well as detailing seven priority areas to deliver the overall strategy.

The NPS recognises that substance misuse presents a substantial barrier to efforts to rehabilitate individuals under probation supervision, and so the strategy sets out three primary objectives to address this:

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[29] HM Inspectorate of Probation. (2020) survey of commissioners, unpublished.

[30] HMPPS. (2019). *National Probation Service: Health and Social Care Strategy 2019-2022*. Available at: www.gov.uk/government/publications/national-probation-service-health-and-social-care-strategy-2019-22.

- identify individuals with substance misuse problems as they enter the criminal justice system and support appropriate sentencing, including the use of community-based sentences and treatment requirements
- work with partner agencies to strengthen local referral pathways for those who may benefit from substance misuse services, including improving pathways into the community for those receiving substance misuse treatment in prison
- stay vigilant to changing drug misuse patterns (particularly psychoactive substances) and increase training and awareness of these patterns based on local intelligence and data.

Initially, no additional monies were identified to support this strategy, but following the UK government spending review in 2020, the DHSC made £80 million available to improve treatment pathways in criminal justice, and £1 million of this money was earmarked for the approved premises drug strategy.

The funding secured contributes to delivering the three main priorities for substance misuse, with:

- investment into the Community Sentence Treatment Requirement (CSTR) programme
- funding to public health directors focused on continuity of care for prison leavers, as well as CSTRs
- funding for the first approved premises drug strategy, which has prompted staff training and awareness, including on psychoactive substances.

While sound in its approach, the strategy has not yet delivered better outcomes, and operational plans to drive the strategy are not yet embedded. Numbers of DRRs have dropped since the strategy was implemented. The probation service needs to redouble its efforts to meet its stated objectives in relation to drug misuse. It will require resources to do this.

"An extra £5 million per year is needed by MoJ for probation health and justice co-ordinators so that they can play a full part in local area partnerships." – Dame Carol Black (2021)

Wales

Substance misuse services in Wales have been described as 'citizen-centred' (Welsh Government, 2019). They adopt a strengths-based public health approach, with an emphasis on harm reduction, prevention and treatment, and ensuring that individuals stay well. This reduces the harms associated with substance misuse and sustains recovery.

A Healthier Wales: our plan for Health and Social Care [31]

The Welsh Government's plan *A Healthier Wales* sets out a whole-system approach to health and social care, outlining a 'wellness' system that aims to support and anticipate health needs, to prevent illness, and reduce the impact of poor health and inequality. The substance misuse agenda requires the health and social care sector to work together, alongside other partners, to give each individual the most appropriate help, based on their needs and circumstances.

The 2019-2022 delivery plan is structured under four key aims:

- preventing harm
- supporting individuals – to improve their health and aid and maintain recovery
- supporting and protecting families
- tackling availability and protecting individuals and communities via enforcement activity.

[31] Welsh Government. (2019). *A healthier Wales: our plan for health and social care*. Available at: https://gov.wales/healthier-wales-long-term-plan-health-and-social-care.

The Welsh Government recognises that primary care, as the first point of contact for most citizens, has a key role in maximising the opportunities for prevention and self-management, including around substance misuse management.

Partnership working is recognised as being crucial and underpins the work set out in the plan. The scope of all commissioning strategies should include action to address the more 'traditional' substances, as well as those that have emerged in the last few years, such as new psychoactive substances, and steroid and performance- and image-enhancing drugs.

Substance Misuse Delivery Plan 2019/2020 (Wales)[32]

The Welsh Government's Substance Misuse Delivery Plan builds on the progress made during the 2008-2018 strategy *Working Together to Reduce Harm*. It outlines priorities for the next three years and sets out the priority areas for reducing the harms associated with substance misuse.

In line with the delivery plan, HMPPS published a revised drug and alcohol strategy for Wales in December 2020, covering prisons and probation. It intends to improve the strategy in relation to community settings and publish a new strategy in the coming months.

Pathways from custody to the community

A PHE review of drug misuse treatment in England (2017) highlighted the vulnerability of prisoners to drug-related deaths in the first few weeks after release[33], as well as the risk of relapse and reoffending in this population. It emphasised the need for a 'robust and integrated pathway' (p.11), covering drug treatment in prison and community-based treatment. The Home Office drugs strategy (Home Office, 2017a) likewise emphasised the need for better continuity of treatment for offenders on release into the community. Work is being undertaken with local commissioners to develop community-based health treatment pathways to support offenders to access appropriate treatment at any point of their journey through the criminal justice system, from police station through community/custodial sentence and after release from prison.

Integrated commissioning in Wales has enhanced this pathway, with higher pick-up rates of people maintaining their treatment as they transition between custody and the community.

Recovery and social capital

When considering what is meant by recovery, Best (2019) refers to the Betty Ford Institute (2007) and the UK Drug Policy Commission (2008), which suggest that recovery from addiction involves three factors:

i. control over or cessation of problematic substance use
ii. improvements in global health and wellbeing
iii. active participation in and a contribution to community or society.

The construct of 'recovery capital' refers to the sum of resources necessary to initiate and sustain recovery from substance misuse (Best and Laudet, 2014) or the resources that are available to a person to support them in their recovery journey (Granfield and Cloud, 2001). It also reflects a shift in focus from the pathology of addiction to a focus on the internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems (White and Cloud, 2008).

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[32] Welsh Government. (2019). *Substance misuse delivery plan 2019-2022.* Available at: https://gov.wales/substance-misuse-delivery-plan-2019-2022-0.

[33] An unpublished review by the Ministry of Justice (2021) found that almost two-thirds of reported 'self-inflicted' deaths were drug related.

Three types of recovery capital have been identified (White and Cloud, 2008):

i. **Personal recovery capital** – including physical capital such as health, financial assets, safe shelter that is conducive to recovery, clothing, food, and access to transport; and human capital including an individual's values, knowledge, educational/vocational skills, problem-solving capacities, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of meaning and purpose in life, and interpersonal skills.

ii. **Family/social recovery capital** – including intimate relationships, family relationships, and social relationships, indicated by the willingness of intimate partners and family members to participate in treatment, the presence of others in recovery within the individual's family and social network, and access to outlets for sobriety-based leisure activities.

iii. **Community recovery capital** – encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and drug problems. This includes a good range of addiction treatment resources, interventions and community support institutions, active efforts to reduce the stigma of drug misuse, and visible and diverse local recovery models.

It is interesting to note, however, that gender appears to play a role with regards to the factors which will most positively sustain recovery. In a review of the mechanisms of action of 12-step mutual aid groups, Kelly (2017) concluded that, while for men the most important influence is typically changing social networks, for women, it is about growing self-belief that recovery is possible.

Statistics

Drug-related deaths

- The most recent analysis from the Office for National Statistics (ONS, 2001) shows that in the population as a whole in 2020 there were 4,561 deaths from drug-related poisoning in England and Wales. Rates of drug-related poisoning were 60.9 per cent higher in 2020 than they were in 2010. The rate has increased every year since 2012. The 2020 figure is the highest number recorded since records began in 1993 (2,178), with numbers more than doubling since this time.

Substance misuse and crime

- Phase one of Dame Carol Black's Review of Drugs[34] showed that a cohort of around 300,000 heroin and crack users are responsible for nearly half of all acquisitive crime and homicides.
- The Crime Survey for England and Wales[35] provides some data on the involvement of substances in violent crime. The latest figures (year ending March 2020) show that victims believed that the perpetrator(s) was under the influence of drugs in 29 per cent of incidences.[36]

[34] Black, C. (2020). *Review of Drugs: phase one report*. London: Home Office

[35] Office for National Statistics. (2020). *Crime in England and Wales: year ending June 2020.*

[36] Office for National Statistics. (2020). *Crime Survey for England and Wales: year ending March 2020*. Available at: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/natureofcrimetablesviolence; Table 9A

- A 2012 NHS study[37] (n=1,796 users in treatment) estimated that regular users of heroin, crack or cocaine commit a total of 133 acquisitive offences per year per user, on average, at an annual average cost to society per user of £26,074.
- This study estimates that 34 offences per person per year may be prevented through effective drug treatment and that £1 spent on drug treatment saves £2.50 in costs to society; the Black review (2020) estimated a higher return on investment, of £3.50 for every £1 spent.

Probation referrals into substance misuse treatment

- National Statistics related to substance misuse and treatment – from PHE's drug treatment monitoring system (NDTMS) – indicate that of a total community-based probation caseload of around 180,000 in 2019/20 there were only 2,890 recorded referrals into treatment for those under probation (including DRRs and those under CRC supervision): 1,149 (opiate), 826 (non-opiate), and 915 (non-opiate and alcohol).[38]

Figure 7 below shows the probation referrals into treatment (new presentations to treatment), for England, 2008/09 – 2019/20, with data obtained from PHE adult substance misuse treatment statistics.[38]

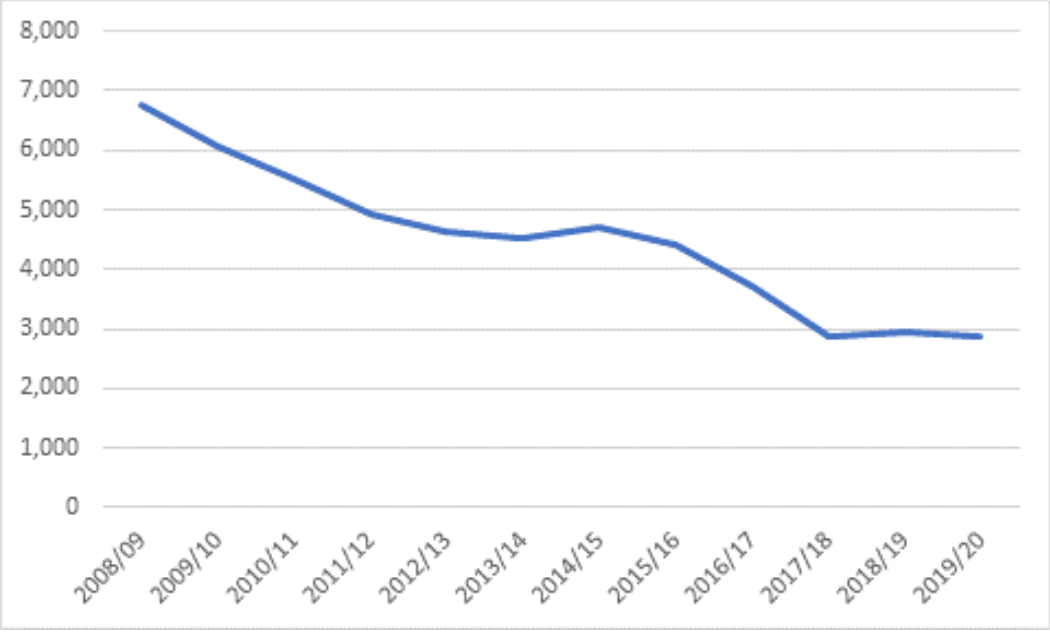

Figure 7: probation referrals into treatment (new presentations to treatment), for England

- Figures from the Public Health Outcomes Framework website,[39] covering England, indicate that in 2019/2020, 8,708 (35 per cent) of adults with substance misuse treatment needs successfully engaged in community-based structured treatment within three weeks following release from prison. This suggests that at least 65 per cent are not receiving the required treatment.

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[37] NHS. (2012). *Estimating the crime reduction benefits of drug treatment and recovery*. Available at: www.drugsandalcohol.ie/17540/1/NTA_Estimating_crime_reduction_benefits.pdf.

[38] Public Health England. (2021). *Alcohol and drug misuse and treatment statistics*. Available at: www.gov.uk/government/collections/alcohol-and-drug-misuse-and-treatment-statistics.

[39] Public Health England. (2021). *Public Health Outcomes Framework*. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.

- An HM Inspectorate of Probation Research and Analysis Bulletin (2019) reported that interventions for drug misuse were delivered in only 47 per cent of relevant inspected cases for drug misuse.
- Offender Management Statistics for July to September 2020 indicate that only three per cent of community orders and four per cent of suspended sentence orders included a drug treatment requirement.
- An analysis of National Drug Treatment Monitoring System data for HM Inspectorate of Probation shows a significant reduction in referrals of opiate users to treatment by probation in England over the past 10 years and that the ratio of successful completions of treatment by this group to new referrals has significantly declined over time.

How many people are referred for treatment and what are the outcomes?

In England, in the 15 years of treatment data starting from 2005 to 2006,[40] a total of 1,011,762 different people has been in contact with drug and alcohol treatment services. By 31 March 2020:

- 144,805 (14 per cent) were still engaged in treatment
- 402,518 (40 per cent) had left before they completed their treatment and had not returned
- 464,439 (46 per cent) had completed their treatment and not returned.

Figures 8 to 10 below set out the picture for people with opiate problems. They depict the declining numbers of referrals from probation sources; the number who remain in treatment up to the 12-week point; and the proportion of successful outcomes from probation referrals compared with other referral sources.

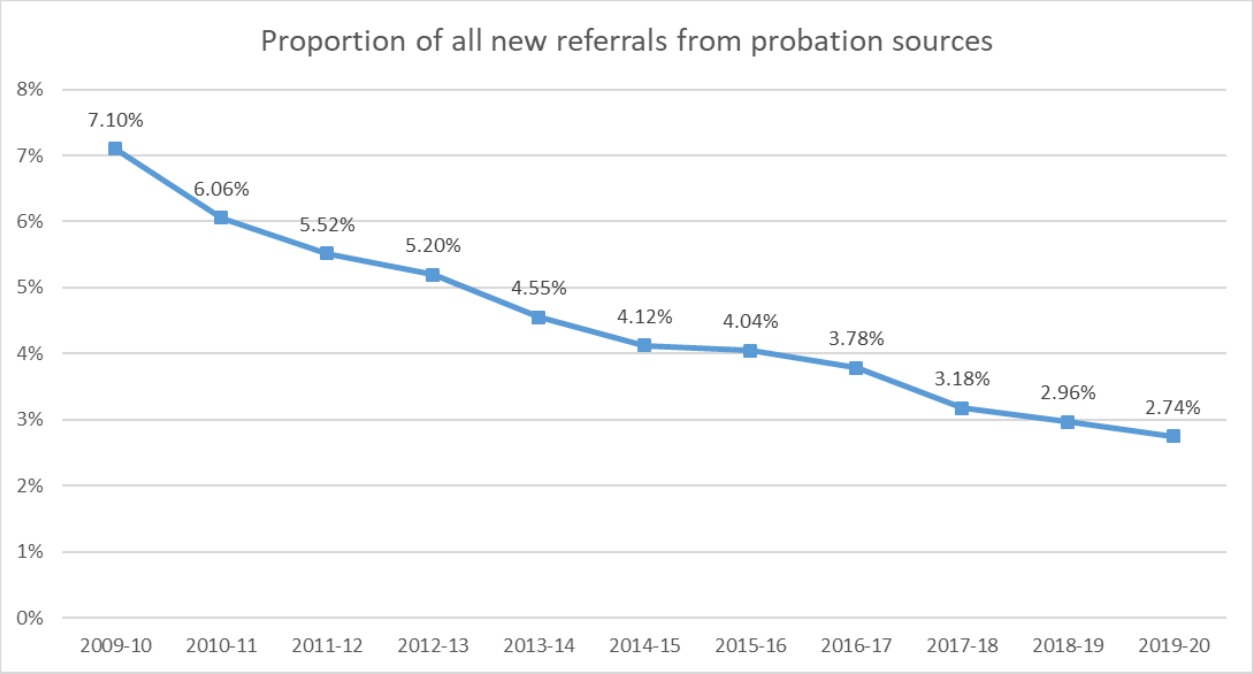

Figure 8: Trends in the proportion of new referrals from probation for opiate treatment, 2009/2010 to 2019/2020

[40] Public Health England. (2020). *Adult substance misuse treatment statistics 2019 to 2020:* report. Available at: www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020/adult-substance-misuse-treatment-statistics-2019-to-2020-report#treatment-outcomes.

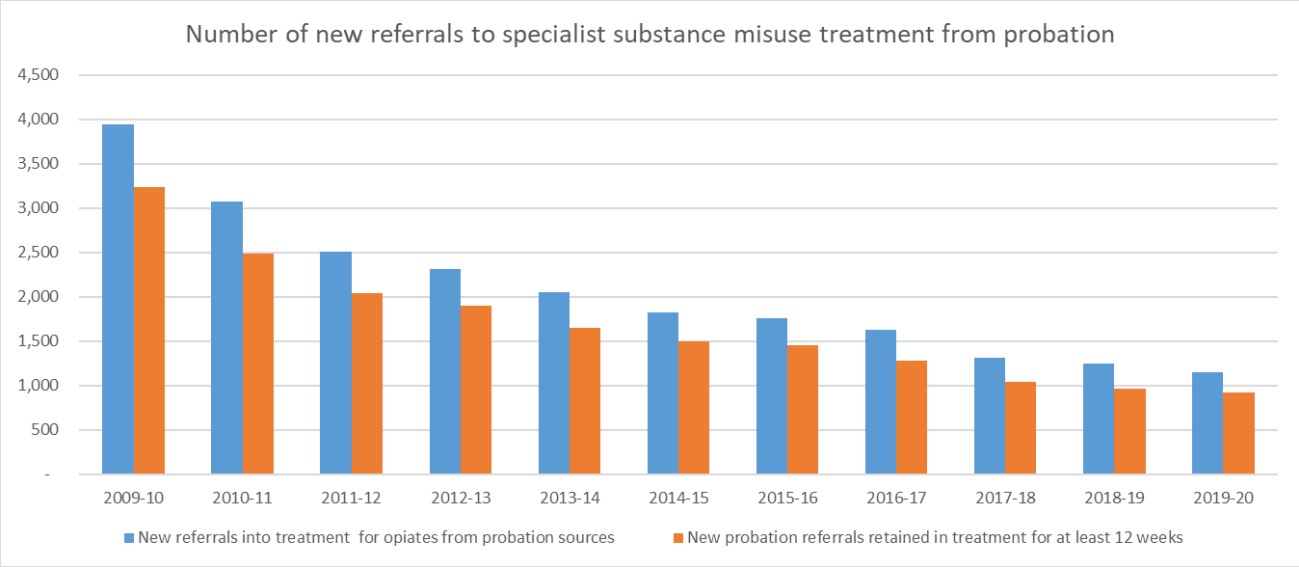

Figure 9: Trends in the numbers of probation referrals and retention in treatment for at least 12 weeks for opiate treatment, 2009/2010 to 2019/2020

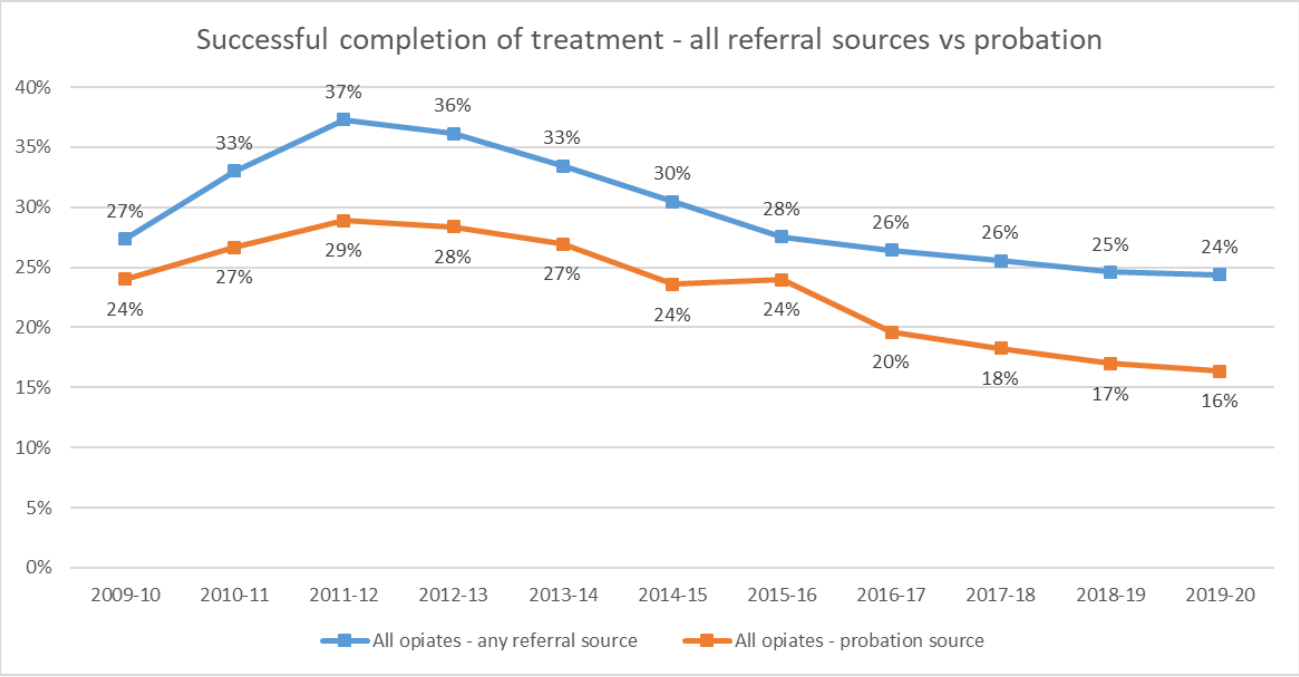

Figure 10: Trends in the proportions of successful opiate treatment completions by referral source for England, 2009/2010 to 2019/2020

Substance misuse treatment in prison

PHE's National Drug Treatment Monitoring System provides statistics for substance misuse in secure settings in England[41]:

- between April 2019 and March 2020, there were 51,006 adults in treatment for substance misuse within a prison setting. Of these, 52 per cent were for opiate use, 19 per cent non-opiate only, 19 per cent non-opiate and alcohol, and 10 per cent alcohol only

[41] Public Health England. (2021). *Alcohol and Drug Treatment in Secure Settings 2019 to 2020: Report*. Official Statistics.

- of those taken into custody, 62 per cent started treatment immediately, 28 per cent started within three weeks, and for 11 per cent treatment did not start for over three weeks
- of the adults leaving prison with an appointment for community treatment, only 35 per cent successfully engaged in community-based structured treatment within three weeks of release from prison.

Ethnicity and substance misuse

- In 2019/2020, 270,705 adults were in substance misuse treatment in England; this is similar to 2018/2019 (268,251).
- 83 per cent of those in treatment are white British.
- Four per cent of those in treatment are white other – the second largest ethnic category in treatment.
- Black, Asian and minority ethnic categories accounted for nine per cent of people on probation.
- No non-white group accounted for more than around one per cent of users of drug treatment services.

1.3. Aims and objectives

The inspection sought to answer the following questions:

1. Does the leadership of the organisation support and promote the delivery of high-quality, personalised and responsive drug misuse, recovery and associated support services for all individuals?
2. Are staff within the organisation empowered to deliver a high-quality, personalised and responsive drug misuse and recovery and associated support services for all individuals?
3. Is there a comprehensive range of high-quality drug treatment, recovery and associated support services in place, supporting a tailored and responsive service for all individuals?
4. Is timely and relevant information available and appropriate facilities in place to support a high-quality, personalised and responsive approach to the provision of drug misuse and associated support services for all individuals?
5. Does the pre-sentence information and advice provided to court support its decision-making?
6. Are Through the Gate services personalised and coordinated, and do they support drug treatment and recovery, and associated support needs?
7. Is assessment of drug misuse, recovery and associated support needs well-informed, analytical and personalised, actively taking account of both vulnerabilities and positive factors, and involving individuals?
8. Is planning to address drug misuse, recovery and associated support needs well-informed, holistic and personalised, actively involving individuals?
9. Are high-quality, well-focused, personalised and coordinated drug treatment, recovery and associated support services delivered, engaging the individuals?
10. Is reviewing of progress in addressing drug misuse, recovery and associated support needs well-informed, analytical and personalised, actively involving individuals?

Scope of the inspection

The scope of this inspection covered the work of both the NPS and CRCs, including community sentences and post-release licences. We looked at work done with individuals who were:

- subject to a community sentence that included a DRR
- released from custody with a licence condition/s to comply with drug treatment and/or testing
- subject to a community sentence or licence where they were assessed as having a high need in relation to their drug misuse.[42]

Our approach was to look at the needs of people with drug problems and the quality and appropriateness of the services provided for them. We reviewed probation and drug services records and spoke to those people in services who gave consent. Consequently, the insight we have gathered is likely to be more positive than a more representative response would have produced.

1.4. Report outline

Chapter	Content
2. Strategy, policy and leadership	Strategy and policy Leadership Staffing Resources, premises and access
3. Partnership and court work	Overview Commissioned services Information flow Sentencing at court Community Sentence Treatment Requirement pilot
4. Casework and interventions	Assessment and planning Service delivery and interventions Drug rehabilitation requirements Drug misuse, trauma and trauma-informed practice Meeting diverse needs Drug testing Review and evaluation
5. Resettlement	Leaving custody Licence conditions Outcomes for prison leavers
6. Reducing harm from drugs	Drug-related deaths Overdose prevention Heroin-assisted treatment Safeguarding adults Modern slavery and county lines

[42] The high-need cohort was defined as individuals with a minimum score of five or above in section eight (drug misuse) in OASys or equivalent assessments.

2. Strategy, policy and leadership

This chapter reviews the national strategy and policy on drugs. We look at the achievements won through effective leadership and think about where the gaps and challenges are. Areas with devolved powers are highlighted, along with learning, across the system.

2.1 Strategy and policy

As highlighted in section 1.2, drugs strategy and policy comprise both criminal justice and health considerations and span multiple government departments and agencies across England and Wales. Across government there has been a renewed focus on drugs and criminal justice.

HMPPS and probation drug misuse strategy

There is no current probation drugs strategy. HMPPS published a prison drug strategy in 2019, largely in response to the burgeoning problem of synthetic cannabinoid drugs, often referred to as 'spice' or 'mamba', in prisons. The strategy focuses on three key aims: improving continuity of care between the prison and community settings; increasing the proportion of individuals engaged in post-custody treatment, and tackling the supply of drugs coming into prisons.

HMPPS is working on a revised drugs strategy to include probation operations, with an intention to publish it in 2021. The three key aims will be retained, and an aim to reduce drug-related death is likely to be added. We firmly support this proposed change. To underpin the new strategic aim, policymakers have commissioned evidence-based reviews from international experts and the Correctional Services Accreditation and Advice Panel. These will look at how drug testing can support a reduction in drug-related crime. We welcome any addition to the evidence base in this area.

The NPS also published a high-level, three-year health and social care strategy in 2019.[43] Its aims were to:

- identify individuals as they enter the criminal justice system and support sentencing, including the use of community-based and treatment requirements
- work with partner agencies to strengthen local substance misuse referral routes in the community and for those receiving treatment in prison
- stay vigilant to changes in drug misuse patterns, and increase staff training and awareness, based on local intelligence and data.

Having a joined-up care pathway for those moving from prison to the community is essential for supporting those with drug misuse issues, both for their recovery and desistance from crime. Far too many people fall out of treatment when they leave prison and re-join the community, with PHE data showing that only 35 per cent[44] of people keep their appointment for treatment within three weeks of leaving prison. There are likely many more people who do not receive appointments for the care they need, making the treatment gaps even wider. Wales and England measure these rates differently and it is not currently possible to compare the two sets of data directly. On the face of it, Wales is doing much better in the rate of people picked up in community treatment after they leave prison. However, strategically, the Westminster and Welsh governments are not collaborating closely enough to be able to form a view on what is working best.

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[43] HMPPS and NPS. (2019). *National Probation Service Health and Social Care Strategy 2019-2022*. Available at: www.gov.uk/government/publications/national-probation-service-health-and-social-care-strategy-2019-22.

[44] Public Health England. (2021). *Alcohol and Drug Treatment in Secure Settings 2019 to 2020: Report*. Official Statistics.

PHE's service specification relating to public health services for those in secure and detained settings in England (Public Health England, 2018) emphasised the need for Through the Gate interventions, including the expectation that substance misuse teams will contribute to resettlement plans in conjunction with CRCs, the NPS and youth offending teams (YOTs). Probation providers have a duty of care through the prison gate, but they have no contractual responsibility for healthcare and no levers to influence health providers, except the discretionary support they might offer people in setting up appointments.

Health and drug misuse strategy

In England, the DHSC is working to the priorities set out in the government's Home Office led Drug Strategy (2017a). It has three key strands: reducing demand, restricting supply and building recovery. In our view, these aims are still fit for purpose.

It has supported positive moves in its strategic work, cross-departmentally with the Ministry of Justice and HMPPS, to address drugs in prison.[45] There is an aspiration to widen this work to cover community justice, but senior leaders within the DHSC acknowledged that the pandemic had disrupted progress.

Additionally, DHSC received £80 million to tackle drug misuse in 2021/2022. Most of the funding (£65 million) has been awarded to local authorities to support the delivery of services specifically for the offender cohort. This funding will be used to introduce specialist criminal justice drug and alcohol workers, based in police stations, courts or prisons, with a remit to identify individuals and where needed to refer them into treatment.

NHS England leads sustainability and transformation partnerships and integrated care systems programmes in the community to bring partners together.

All inspected drug misuse providers delivered services that supported the national health plans. This included continuing to improve substance misuse services, for example, through piloting innovative clinical and psychosocial treatment and sharing findings.

2.2 Leadership

Probation

We found little evidence of leadership of the drugs agenda at a national level, in the NPS. This work has not been prioritised since *Transforming Rehabilitation*, because of the stronger NPS focus on public protection. Across CRCs, leadership approaches were not uniform, and this was to be expected with the different operating models in place during our fieldwork. The lack of leadership of the drugs agenda was evident in much of the casework we reviewed but was further exacerbated by the Covid-19 pandemic and associated pressures.

The vision for local services was not well developed in the English fieldwork sites, but it was impressive in Wales. Wales has devolved powers to manage health and social care, and strong leadership of the drugs agenda has resulted in co-commissioning of services by HMPPS and local PCCs. The Welsh spend on drug services and protection of bespoke pathways for people in the criminal justice system has been maintained.

However, the interventions on offer in all the fieldwork sites were not sufficient to realise the strategic vision, although we recognise that the pandemic had impacted on face-to-face delivery and drug testing. The use of DRRs has fallen sharply in recent years, with a 36 per cent reduction in the past year.[46] The probation service's leadership has allowed these interventions to become

[45] HM Government and NHS England. *National Partnership Agreement for Prison Healthcare in England 2018-2021*. Available at: www.gov.uk/guidance/healthcare-for-offenders#national-partnership-agreement-for-prison-healthcare-in-england-2018-2021.

[46] Ministry of Justice. (2021). *Offender management statistics quarterly* (October to December 2020).

diluted to the point that they are indistinguishable from community orders without structured treatment requirements.

The fragmentation of offender management, as a result of *Transforming Rehabilitation*, has added complexity to partnership working in the drugs arena. The new Target Operating Model[47] for the unified probation service identifies high-level outcomes in relation to dependency and recovery. These include being better able to manage high-risk situations, and that specialist support is accessed.

Drug misuse service providers

We found that the inspected drug services largely demonstrated effective leadership, appropriate governance and suitable partnership arrangements. These included partnerships at a strategic level to support the delivery of joined-up service provision. However, the arrangements to join up with probation services were variable. All drug misuse providers had governance and clinical leads in post, which supported their compliance with the necessary regulations when carrying out regulated activities.

All inspected drug misuse providers delivered services that aligned to clinical excellence standards as contained in:

- National Institute of Clinical Excellence (NICE) drug misuse pathway, available at: http://pathways.nice.org.uk/pathways/drug-misuse
- NICE quality standards for drug disorders at: http://www.nice.org.uk/Guidance/QS23
- drug misuse guidelines at: https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

These included the requirement to continue to improve substance misuse services, such as piloting new innovative clinical and psychosocial treatment and sharing findings.

Across all areas, drug misuse providers had a good relationship with commissioners and other stakeholders, and managers regularly had quality assurance meetings with commissioners. However, the partnership work, between commissioners and probation, and the drug service providers and probation, was often undertaken in isolation from each other in England, albeit work was underway to improve relationships in Manchester. The co-commissioning relationship in Wales was much more functional.

More positively, in Blackpool, probation leaders had been particularly good at focusing on drugs, despite the pressures of the pandemic. There were partnership arrangements in place at a strategic level to support the delivery of joined-up care. In Blackpool, work on Operation ADDER was the most advanced we had seen. Local leaders had built on learning from other initiatives, such as the Fulfilling Lives programme.[48]

Good practice example

In Blackpool, leaders synthesised learning from earlier projects and took this forward. By 'standing on the shoulders' of earlier work from Fulfilling Lives and other programmes, they were the most advanced of the Operation ADDER sites we visited. We viewed this as a town showing an organisational memory and systems learning across its partnership work. Because of this, the Blackpool partnership had a peer support service, staffed with lived-experience experts in place, within a few weeks of additional government funding being made available.

[47] HMPPS. (2021). *The Target Operating Model for probation services in England and Wales*.

[48] Fulfilling Lives was a multi-year programme, funded by the Big Lottery, to develop approaches to supporting people with multiple and complex needs.

2.3 Staffing

Just over half of staff interviewed (29) during the inspection felt that their workload was manageable and enabled them to deliver a quality service to people with drug problems. This echoes our findings from recent research on caseloads and workloads, which outlines how excessive caseloads impact on effective casework (HM Inspectorate of Probation, 2021). It is also reinforced in the Justice Select Committee's report on the future of probation (Justice Select Committee, 2021).

Four-fifths of probation practitioners interviewed (43) were positive about the management oversight and support they received. Managers in drug services supported staff to deliver a range of interventions. Staff treated people in the criminal justice system as equal to the other people accessing services, and managers supported the delivery of effective and personalised criminal justice drug treatment and recovery services.

However, training was insufficient, with only 35 per cent of probation practitioners (18) having specific training in drug treatment and interventions. Training in and understanding about recovery were worse: only 13 per cent of probation practitioners had had specific input on this concept and how to build it into practice. Despite the lack of training cited by officers, most felt they had the knowledge and skills to undertake the necessary work. In our view, in probation, there is a fundamental lack of knowledge about drug misuse and especially recovery. Few staff understand the possibilities of recovery, relevant approaches and how to build recovery steps into planning, in order to support individuals to move forward.

The NPS has a trauma-informed toolkit available for staff, but we saw no direct use of it in the casework we reviewed. Less than half of the probation staff we spoke to had incorporated the impact of trauma into their practice, and there is scope for improvement. The case for trauma-informed work is set out in our HM Inspectorate of Probation's Academic Insights paper (McCartan, 2020).

In drug services, we found staff with a range of skills, qualifications and experience that enabled them to deliver drug treatment and recovery services for people on probation. However, the understanding of trauma and how it impacts on individuals was variable across the staff group. All the drug misuse services had a training matrix that included mandatory training, such as safeguarding, alongside professional development. This is in line with that specified for those carrying out a regulated activity and is compliant with the *Health and Social Care Act (2012)*.

Almost two-thirds of the staff interviewed understood the referral arrangements for DRRs, although this varied markedly between areas, with Swansea and Middlesbrough staff the most confident in this area (17 out of 19 probation practitioners).

People on probation were largely positive about staff and talked about how telephone contact had worked well as an alternative to seeing them face to face during the pandemic. However, some also commented on the number of different workers they'd been supervised by.

> *"She understands me better than I understand myself. I feel confident they know how to support me. And have done many times over. I've not got a good memory and if I forget an appointment or something, she will always be in touch to see if I need any help."*

> *"I've had four different probation officers since I got this sentence, three different IOM workers but it's all been OK really, apart from that one worker who I did not like. They all shared information with each other, and I didn't need to go back over anything with any of them because they had all been put in the loop so to speak."*

2.4 Resources, premises and access

HMPPS has produced a good set of resources in its drugs in prison (DiPP) guidance (unpublished). The guide is available to all HMPPS staff and is held in the information and process repository,

Equip. It includes drug factsheets, emergency response information, Covid-19 advice, and an index of articles and reference materials. We welcome wider use of these materials in practice. We also found resources in all CRCs to support good practice with drug users.

People on probation need to be able to access premises with dignity across the probation estate. Two of the premises we visited were not fully accessible to wheelchair users (Swansea and Hastings probation offices). Many drug services struggled to offer evening appointments to fit with employment, although Lambeth offered late opening one day per week to respond to the needs of workers. In one setting, probation staff told us that individuals were required to attend before 9am, often having to queue outside to access limited drop-in spaces, despite the local drugs service offering multiple points of access, including a wide network of general practitioner surgeries. Overall, our view was that the people with the most chaotic lives struggled the most to access the help they needed.

Physical co-location of agencies is not happening consistently, although this is widely regarded as desirable and best practice.

By contrast, the pandemic has prompted some very creative approaches to meeting individuals' needs, such as doorstep visits, food parcels and distribution of mobile phones. Throughout the inspection, many leaders commented that use of online electronic meetings had made connection more possible. People on probation explained that most of their contact had not been face to face and so they had not needed to visit services. Those who did felt supported.

> *"At the moment it is working for me. I don't have to go to the office anymore because of what's going on with lockdown and Covid. I'm not in the best of health so I like that it's all done by phone now and I don't have to put myself in danger venturing outside."*

> *"My officer has helped me so much to change my ways, introducing me to self-help groups online and cannabis anonymous meetings online, which have been great during this pandemic and a real big help to me."*

2.5 Conclusions and implications

National statistics paint a stark picture of the growing sophistication of the drugs markets, the underuse of treatment and the rising number of drug-related deaths. There is a lot of strategic activity on drug misuse and we welcome the renewed interest in this agenda across government. Strategy now needs to be embedded in policy and practice if outcomes are to improve for people on probation and for wider society. In England, the lack of a coordinated strategy and leadership of drug misuse across HMPPS and the DHSC has allowed drift. In Wales, devolved powers and clear leadership have resulted in co-commissioning of services, for example between HMPPS and local PCCs.

The strategy for probation lags behind that in prisons, and the beginnings of more cross-departmental work have yet to bear fruit. A strong grip is required across England and Wales, with effective programmes of work and effective monitoring systems to track progress.

Most staff have not had enough training and many lack knowledge, and together with the lack of strategic drive in this area, it is easy to see why people experiencing addiction and drug problems are not achieving more positive outcomes.

Systems learning

There are considerable differences between the English and Welsh approaches to this policy area, but little infrastructure to learn across these systems. Important lessons, such as the benefits of joint commissioning and building specific pathways to meet the needs of people in the criminal justice system, need to influence decision-making in the devolution of co-commissioning arrangements – in Greater Manchester, for example.

3. Partnership and court work

Partnership work is crucial to effective practice on drug misuse. In this chapter, we look at how probation and drug agencies work together, and how wider partnerships work to provide the right analysis of need and put the right services in place. We consider how well information flows across partnerships and where systems can be strengthened. We take note of sentencers' views, and the use of specialist and pre-sentence reports in court to tackle drug-related crime. Further, we review a pilot scheme to increase the use of these specialist interventions.

3.1 Overview

As noted, drug misuse is a complex area with justice and health components.

Commissioning of health services for offenders is divided between clinical commissioning groups (CCGs), local authorities and NHS England. NHS England is responsible for the mental health, substance misuse and physical health needs of offenders while they are in the prison, while CCGs are responsible for the mental and physical health needs of those in the community. Additionally, local authorities are responsible for substance misuse needs within the community. Increasingly, services in the community are coming together to work in Sustainability and Transformation Partnerships and Integrated Care Systems.[49]

Local authorities commission drug and alcohol services in England; Area Planning Boards undertake the same function in Wales. Essentially, these are public health arrangements for services which are provided to all people who have difficulties with drugs. When individuals offend, partnerships operate differently depending on whether the area has devolved powers (as in Swansea Bay and Greater Manchester) or not.

We found greater partnership activity in the devolved areas. Across South Wales, HMPPS and the Police and Crime Commissioner have co-commissioned 'Dyfodol' – a consortium of providers working together to provide support and intervention to people at HMP Swansea, Cardiff, Usk and Prescoed, with strong alignment at HMP Parc. This service extends to encompass clinical treatment in the community for service users involved in the justice system for up to 52 weeks. The contract provides bespoke pathways designed for people in the criminal justice system and operates in police custody suites to provide early interventions as well as in prisons and the community. We spoke with staff working at Dyfodol premises in Swansea and Neath, plus managers working across the prisons.

In Greater Manchester, the Ministry of Justice has worked with Greater Manchester Combined Authority to co-commission addiction and recovery services for probation supervisees, to complement those already commissioned by the public health department. The higher level of integration of health and justice appears promising, although it is too soon to measure outcomes.

No probation practitioners in the sites we visited worked in specialist teams focusing on drugs, and most areas were not working within a multidisciplinary, specialist partnership model. We did see better practice, in general, in the cases held by IOM teams, where a collaborative and multi-agency approach was taken.

[49] Sustainability and Transformation Partnerships and integrated care systems are partnerships between NHS commissioners, NHS trusts, local authorities and the voluntary and community sector, designed to break down barriers between the organisations that pay for services and those that provide them, between primary and secondary care, between physical and mental health, and between health and social care.

3.2 Commissioned services

At a local level, leaders acknowledged that the pressures of the Covid-19 pandemic and the priority to manage services within exceptional delivery arrangements had worsened partnership work on drugs.

As services were moving towards more normal delivery and the unified probation service, there was a lot of optimism from local leaders about the potential for reinvigorating the drugs partnership work. There are grounds for optimism as, across all areas, we found that drug misuse providers had good relationships with commissioners and other stakeholders. Drug service managers had regular quality assurance meetings with commissioners.

In England, commissioners of drug services told us that they had experienced a reduction in investment. They are keen to build locality-based partnerships that can jointly commission services in response to local, rather than nationally, perceived needs. Commissioners highlighted the following elements as key:

- co-location and cross-sector training
- earlier involvement of drug services
- clarifying drug-testing arrangements
- trauma-informed delivery models, which are central to providing individualised treatment
- specific pathways for women.

Some PCCs told us of where they commissioned services to tackle drugs and crime. In South Wales, the single provider approach was adopted to increase the potential for seamless engagement, and was designed in recognition of the fact that individuals in the criminal justice system are complex, face significant disadvantage and therefore need more time and more chances to engage. By contrast, one Welsh APB told us of problems between the different commissioning structures locally:

> *'The separate funding, commissioning and contracting arrangements currently in place can create barriers in the system for service users, as is evidenced in our most recent substance misuse needs assessment.'*

Our survey of commissioners in England, elicited the below response, reflecting the fragmented nature of the local arrangements:

> *'We would like to strengthen the experience of treatment for those on a criminal justice pathway but have found the fragmentation of probation and issues with local courts have undermined efforts to make DRRs a robust treatment option. We are willing to consider additional investment in this area (particularly with the new funding becoming available) but this needs to be met with interest and resources from probation and courts.'*

In the English fieldwork sites, there has been disinvestment in drug services. Nationally, commissioners have reported this to be up to 40 per cent of budget reduction.[50] Welsh services have been largely maintained.

We saw a mixed picture regarding the availability of services and interventions for people with drug problems. In East Sussex, staff felt constrained by having only one service to refer to within the local partnership. Drug misuse providers had some contact with other care services, and made referrals to the local mental health team, GP, social services and other key professionals as needed.

[50] Black, C. (2020). *Review of Drugs: phase one report*. London: Home Office. Available at: https://www.gov.uk/government/publications/review-of-drugs-phase-one-report.

Aside from Blackpool, we found little use of peer mentoring to support people with drug problems. In Blackpool, probation staff showed greater understanding of the work of recovery organisations, such as Acorn and the lived experience team at Empowerment. They saw the benefits of linking individuals with the resources these organisations offered. Elsewhere, we discussed with managers how services could use peer mentors within their offer. However, no peer mentors were used at the time of our inspection, due to Covid-19 restrictions. We welcome the broader use of lived-experience, peer support and recovery organisations in local partnerships to give people choice and personal ownership of their individual treatment journeys. Unfortunately, we witnessed no active work through mutual aid for any of the people whose cases we reviewed.

3.3 Information flow

Tracking and analysis of people on probation needs at a local level are patchy. The data held in the probation assessment tool, OASys, is not fully reportable. It is not possible, for example, to extract the number of individuals on probation caseloads who are class A drug users or to track how many people are currently in treatment.

In Swansea Bay, where an information-sharing protocol is written into the co-commissioned services operating framework, drug misuse service assessments were included in case notes, but these were not shared appropriately with or requested by probation practitioners, despite an information-sharing protocol that supports this practice. Overall, records in case notes of liaison between probation and drug misuse services were not detailed, and they did not evidence as much liaison as described by caseworkers or managers.

English drug misuse providers have varying protocols with probation providers, but those developed in Blackpool and Manchester appear promising. Everywhere, drug testing was recorded poorly; it was consistently unclear in case notes, with no records of individual tests to aid understanding of compliance.

Where partnership and information-sharing are effective, it can make a real difference to individuals under supervision.

> *"Yes, it was good, my doctor is even helping me out more now as well, since he got involved with the other services and they all had a big meeting. I feel things hopefully might be about to change for me now once lockdown is over with. That meeting involved probation drug and alcohol services, housing and my doctor."*

3.4 Sentencing at court

We received an outstanding response to our magistrates' survey, with almost 450 replies indicating how interested sentencers are in the effectiveness of drug interventions.

Magistrates were positive about DRRs and saw the benefits of drug testing and formal court review. However, too few pre-sentence reports were sought, and these requirements were proposed in only a small number of cases. Further, DRRs had been imposed without the requisite assessment reports in some areas. The judges we spoke to emphasised their support for DRRs and regular drug testing to monitor people in the community. This is linked to the evidence base for treatment as an effective crime-reduction approach. Treatment in England is associated with a marked reduction in convictions (47 per cent among those retained in treatment for two years or who have successfully completed treatment).[51]

Magistrates judged that, for most of the time (59 per cent) or some of the time (34 per cent), they received enough information from probation regarding defendants' drug misuse issues to help them

[51] Public Health England. (2017). *An evidence review of the outcomes that can be expected of drug misuse treatment in England*. Available at: www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes.

with sentencing. However, magistrates commented that DRRs are rarely proposed in the reports presented at court.

Concerningly, nearly half of magistrates surveyed (45 per cent) did not have, or were unsure of, the arrangements for DRRs and drug testing. Confidence in national NPS delivery of drug misuse work was higher, with 73 per cent feeling fully or somewhat confident. Nearly six out of 10 magistrates (57 per cent) were not very or not at all confident that CRCs delivered drug misuse services well, revealing a lack of confidence in local systems that needs serious attention.

Judges and magistrates highlighted the benefits of specific drug courts and review facilities to oversee DRRs. They believed such specialist courts would help magistrates to increase their knowledge and expertise.

Over half of the defendants with drug problems in our sample of 60 cases were sentenced without pre-sentence reports (33 cases). Where reports were prepared (24 cases), the large majority (22 cases) considered the link between drug use and offending. But only half of the reports analysed the links between drug use and risks of harm to others properly. Drug service assessments were only evident in seven cases, with records too unclear to tell in four further cases.

There was mixed feedback from people in relation to their court reports. Some felt that they were involved and listened to.

> *"Yes, I was involved in the preparations of my reports, it's all pretty straightforward really. They ask you questions about yourself and your views on the court case and I just answered them honestly."*

Others felt disengaged from their reports and simply wanted to engage with services, go through the process, and move on.

> *"I have never had [a] say in any court reports at all … They have never asked. I'm a prolific offender and drug user and I don't engage with that side of things. I just let them get on with it all. They know what to say, it's their job."*

Prior to the pandemic, in Swansea Bay and Lambeth, drug service providers had arranged for a drug recovery practitioner to be in court; these workers undertook assessments and could make recommendations to probation practitioners covering the appropriateness of care and treatment that their service would offer. This ensured that defendants had access to an appropriate, specialist assessment before sentencing.

Overall, we found that drug service staff carried out comprehensive assessments and recommended suitable treatment. Where contact with a recovery practitioner had been a part of the licence conditions, individuals were more likely to engage with the order requirements. Treatment referrals also included more details about what the client could expect from their treatment.

Willingness to comply with a DRR must be obtained under section 209 of the *Criminal Justice Act (2003)* to satisfy the legal eligibility criteria. Consent was clearly obtained and recorded for only five of the relevant 24 people whose cases we reviewed. This raises an uncomfortable question of whether orders are being made too expeditiously at court, without a proper legal basis established in all cases. This must be rectified urgently.

3.5 Community Sentence Treatment Requirement pilot

The aims of the joint Ministry of Justice/DHSC Community Sentence Treatment Requirement (CSTR) operating framework, launched in 2017, are to:

- reduce offending and reoffending by improving health and wider social care outcomes through speedy access to effective, individualised treatment orders
- reduce the number of short-term custodial sentences by providing access to treatment that addresses the underlying cause of the offending behaviours

- improve health outcomes by providing evidence-based interventions, alongside GP registration and supported access to community services, as necessary
- enable access to statutory community services to support individuals, both during and after the community sentence, to reduce accident and emergency visits and out-of-hours use by providing effective psychological-based treatments.

During our fieldwork, Manchester and Lambeth were operating as CSTR pilot sites, but the scheme was not showing increased numbers of DRRs in these areas. We are aware, however, of more success in other sites. Leaders told us that the lack of criminal justice pathways in some commissioned drug services can be a real barrier to promoting the use of structured DRRs.

Good practice example

In the CSTR programme, health and justice partners work together to seek greater use of drug and other treatment requirements, as part of community sentences. The programme was launched in October 2017 by the Ministry of Justice, DHSC, NHS England and NHS Improvement, HMPPS and PHE. It focuses on improving multi-agency working to ensure that the roles are clear, with the necessary treatment pathways in place. The programme promotes CSTRs through local steering groups and partnerships between health and justice agencies. Processes, governance frameworks and ways of working are agreed locally to provide the judiciary with effective community order recommendations. It aims to treat the individual to reduce their risks and protect the public, with solid partnerships and a joint working approach.

3.6 Conclusions and implications

The partnership picture on drug misuse is complicated. With different commissioning arrangements, it is difficult to see how these partnerships are being drawn together to improve service delivery.

Given that probation case record and assessment databases do not collect information about the profile of drug users, probation leaders cannot properly inform local partnership and commissioning decisions. This increases the possibility that service provision fails to meet need. While local joint strategic needs assessments will build up a picture of drug needs, probation leaders are not fully contributing to these assessments due to a lack of management information.

Pandemic pressures have affected partnerships, and a renewed focus should now be given to refreshing partnerships and moving towards a more cohesive approach. The unified Probation Service provides an opportunity to improve work with other agencies and drive better outcomes for people on probation and local communities. There is a clear need to improve the number of people who access and remain in treatment, and partnership work is pivotal to this.

Sentencers are keen to impose effective sentences to address crime. To do so, they need to be satisfied that a proper assessment has been carried out, that testing is undertaken where required, and that the individual can benefit from the order imposed. Arrangements for specialist assessments were not robust enough and almost half of the magistrates surveyed confirmed that drug testing arrangements were unclear in their area. Too few pre-sentence reports proposed structured treatment for drugs users. Court practices need to be strengthened so that defendants who have serious problems with drugs are assessed by specialists and structured interventions are proposed. Suitability and motivation for treatment must be established, and consent given by the defendant. With this clarity, drug treatment should be used more widely.

4. Casework and interventions

In this chapter, we consider the barriers that stop people getting into drug treatment successfully. We examine the quality of casework, including assessment, planning and reviewing practices. We also look at the range of interventions offered to tackle drug issues and analyse the decline in use of DRRs.

4.1 Assessment and planning

The standard of assessment and planning in relation to drugs was not good enough in around half of the cases we reviewed.

Generally, there was a record of a person's engagement with the drug misuse services, but it was not always clear. The case notes reviewed did not have a clearly devised treatment/recovery plan nor include a clear record of what engagement with drug treatment services was required. Therefore, it was sometimes unclear if contact met the requirements of the case.

The assessments were not consistently clear, and in 11 cases it was not possible to discern whether individuals were injecting their drug. The assessed drug use in our sample is shown in Figure 11 below. Some people were assessed as poly-drug users.

Number	Drug	Daily/weekly/occasionally
16	Cannabis	Daily
10	Heroin	Daily
4	Heroin	Weekly
8	Other prescription drugs	Daily
6	Crack cocaine	Daily
4	Crack cocaine	Weekly
4	Cocaine powder	Occasionally
3	New psychoactive substances/spice	Daily
3	Benzodiazepines	Daily
2	Benzodiazepines	Occasionally
2	Amphetamines	Daily

Figure 11: Assessed drug use

Assessments were weaker in relation to past drug use, with levels and frequency of drug use not clearly noted. The design of the probation assessment, OASys, does not support this at present and could benefit from revision. In our sample, there were 21 people who were daily users of heroin or crack cocaine, or both, at the start of their order or licence. Of these people, 12 were on licence, 9 were subject to DRRs, and one was managed with a community order with no treatment requirement.

Number	Drugs previously used
39	Cannabis
36	Heroin
35	Crack cocaine
17	Cocaine powder
16	MDMA/ecstasy
16	Amphetamines

15	Other prescription drugs
14	Benzodiazepines
0	Steroids
0	No substances
4	Not clear

Figure 12: Drugs previously used

While we were only able to contact individuals who were still in the community, most were positive about their experience of assessments and their relationship with their probation practitioners.

> *"She doesn't tell me what to do, she just guides me down the right path, but I always have a say in what services I think will be best for me."*

> *"She is very understanding most times and she will listen to me moan on about this, that and the other, then she helps me find solutions to stuff I'm moaning on about and helps me to sort things out."*

One person felt let down and relied on friends for support instead.

> *"I found myself homeless and sleeping rough for two nights. After two days my officer wanted to put me in some dirty bed and breakfast hotel which I refused to go into. I got help through some friends I know. Didn't think I got much help off the probation service though."*

The best intervention plans addressed different areas of the individuals' lives, not just their offending:

> *"I never used to get out of bed most days 'cos of my depression and anxiety, but since getting my probation worker now, I've been getting involved in lots of things to help with my mental wellbeing."*

> *"She has referred me to certain services that could help me in the future with, like, voluntary work and employment and stuff but 'cos of lockdown it's been very difficult to access most of these … My officer has been very encouraging to help me better myself and stay out of prison and her support has been 100 per cent."*

> *"I've started doing online courses at the moment and learning as much as I can so I can go back to working for a living and being a role model to my kid."*

Others did not always feel listened to:

> *"I really thought that that course would have been good for me, but they put me on a domestic violence course and that would cover my anger issues they told me, but I don't think it does to be honest."*

One person told us about the negative impact the service had on them when the restrictions were stricter:

> *"A week before I got out of prison, they dropped the IOM on me and what that would involve, three meetings a week with my probation worker, two visits to the office, week in week out, one home visit every Thursday. Also, police visits every week; it's all very intense, honest. And if I don't do all this, I'm in danger of been recalled back to prison. Know what I mean. It's a three-*

hour journey there and back to the probation office so that gets me down sometimes. Three hours out my day for a 20-minute chat. Middle of winter too. But it has to be done."

All the people we spoke to felt that they knew who to contact if they wanted to complain. Some people explained that they would be reluctant to complain as they would not want to cause any issues for themselves.

"Yes, I know what to do but I would not bother doing it, why cause yourself any ag. [aggravation]. That's what I say. Who is going to listen to me? They are the professionals."

4.2 Service delivery and interventions

Offence-focused and therapeutic work was underused in the cases we reviewed. In discussion with both probation practitioners and drug workers, we heard of a focus on practical support and problem-solving, particularly for housing needs. We acknowledge the importance of this and the impact of Covid-19 and the exceptional delivery arrangements that have been in place since March 2020. However, structured interventions appear to have fallen out of use. Probation providers use the Building Skills for Recovery accredited programme in tiny numbers. It is not offered in most parts of the country and does not form part of the suite of accredited programmes that all probation regions will offer from day one of the new unified probation service.

Similarly, drug workers were offering few psychosocial interventions, with the focus instead on prescriptions for people needing opiate-substitution therapy. While Breaking Free online, a digital intervention, was available in several drug services and through Cheshire and Greater Manchester CRC, we saw no use of it in the cases we reviewed.

Overall, there was little work directed towards recovery and too few probation practitioners were skilled in this work. The goal is too often maintenance in treatment, with too little aspiration for people to find work and economic stability. The danger of so-called 'script and go' services is that they do not promote change and lack enough hope to help people secure recovery, where it is possible. More connections with recovery, peer-led and family support organisations are needed so that probation practitioners are better able to foster good recovery steps.

We welcome a return to more usual operating arrangements and there is real opportunity to reset the practice approaches to drug work as this happens.

4.3 Drug rehabilitation requirements

What is a drug rehabilitation requirement?

Under section 209 of the *Criminal Justice Act 2003*, a drug rehabilitation requirement (DRR), comprising structured treatment and regular drug testing, is available to courts as a sentencing option for offences committed on or after 04 April 2005. A DRR can be made as part of a community order or a suspended sentence order.

To be eligible for a DRR, the necessary arrangements must have been, or can be, made for treatment *and* a defendant must:

- be dependent on or have the propensity to misuse illegal drugs
- require and would benefit from treatment
- express his or her willingness to comply with the requirement.

The amount and intensity of the drug treatment delivered under the DRR can be tailored to individual needs regardless of the seriousness of the offence. The clinical standard for commencement of treatment is within two days of sentence for a DRR. Under section 210 of the *Criminal Justice Act*, the court may provide for the review of any DRR and must do so in the case of requirements lasting 12 months or more. The review should take the form of a written report

presented by the NPS to the court, which includes the results of individual drug tests.[52] Figure 13 shows the lengths of DRRs in a sample of individuals sentenced between 01 January 2020 and 31 March 2020 with a DRR that had terminated by 21 March 2021. Only 11 per cent of these DRRs attract a court review, leaving nearly nine out of 10 DRRs having no ongoing court oversight.

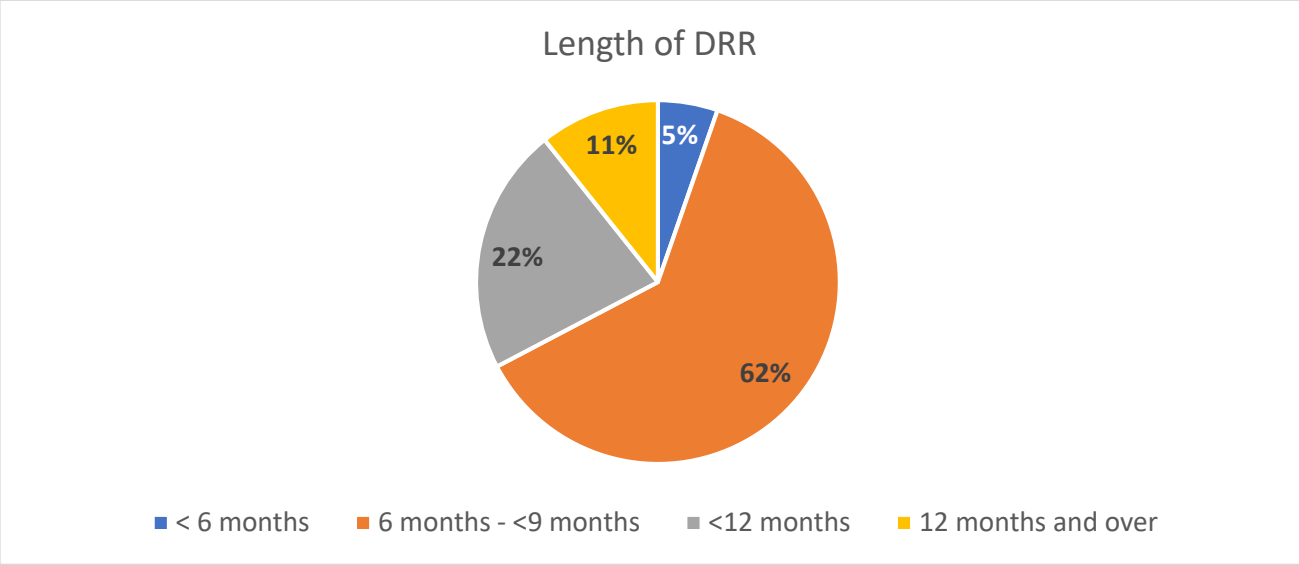

Figure 13: Length of DRRs

The national picture

The number of DRRs ordered at court is sharply declining. It has fallen from over 17,000 in 2008 to less than 5,000 in 2020, with a 36 per cent decline in the last reported year. Concern has been expressed that the introduction of rehabilitation activity requirements (RARs) may have led to a reduction in the number of other, specific requirements given[53] (HM Inspectorate of Probation, 2019). Given the figures highlighted earlier on the prevalence of problem drug use in the probation population, there seems a clear gap between the level of need and the amount of treatment that is put in place through the court process. In our view, insufficient specialist drug assessment is contributing to this decline, in favour of RARs that require no specialist assessment before sentence.

As a percentage, DRRs account for around three to four per cent of all community order requirements and have been consistently low in recent years, with only 2,643 of these requirements made in 2020.[54] This is compounded by an overall drop of around 26 per cent in all community sentences between 2019 and 2020.[55]

[52] National Offender Management Service. (2014). *Supporting Community Order Treatment Requirements*.
[53] HM Inspectorate of Probation. (2019). *Report of the Chief Inspector of Probation*. Available at: www.justiceinspectorates.gov.uk/hmiprobation/inspections/report-of-the-chief-inspector-of-probation/.

[54] Ministry of Justice (2020) *Offender management statistics quarterly: October to December 2020*. London: MoJ.

[55] Ministry of Justice (2020) *Offender management statistics quarterly: October to December 2019*. London: MoJ.

DRR trends

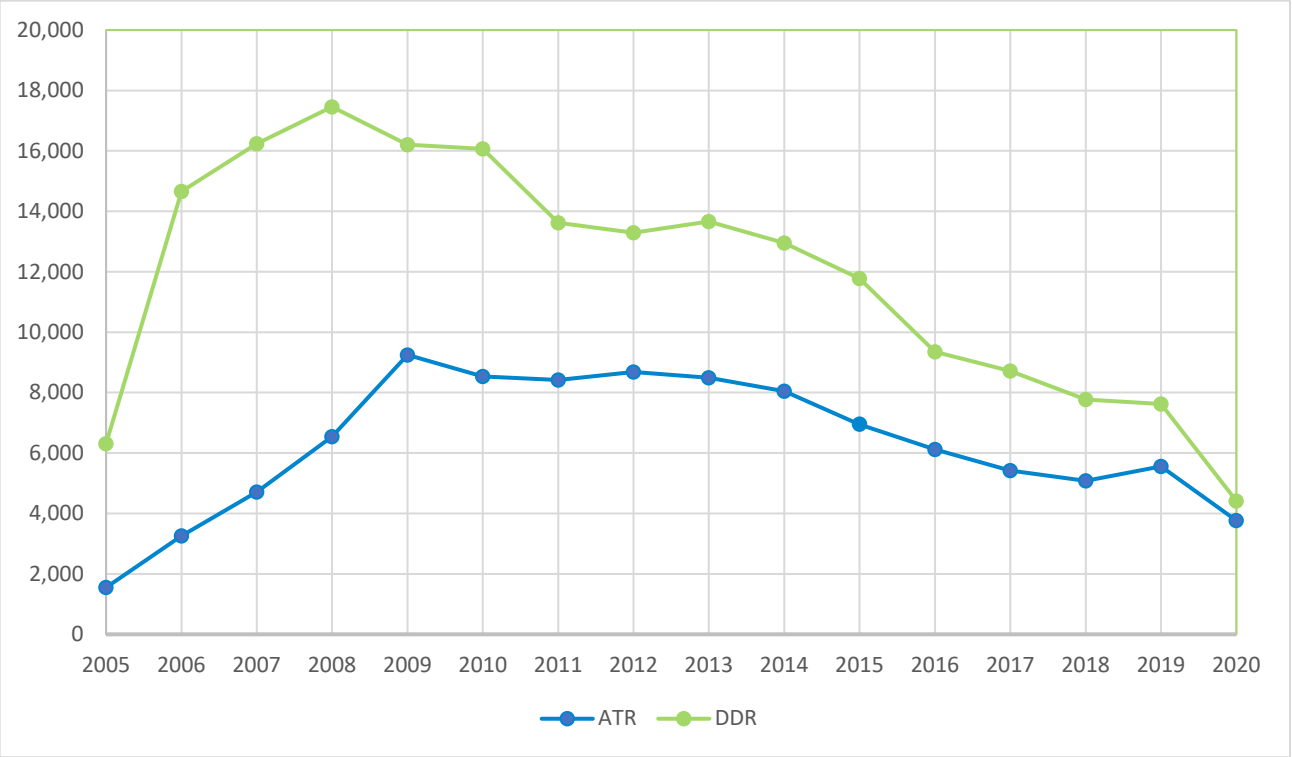

Figure 14: Number of alcohol treatment requirements (ATRs) and drug rehabilitation requirements (DDRs) commenced under community orders and suspended sentence orders, 2005–2020, England and Wales[56]

In this inspection, we reviewed the national picture on DRRs, looking at the number of individuals sentenced between 01 January 2020 and 31 March 2020 with a DRR that had terminated by 21 March 2021. The reason for the termination count will be higher as it is based on the number of events with a DRR. All other counts are based on the number of individuals. The sampled quarter contained very few DRRs and only around half of these requirements were successfully completed. Figure 15 shows a count of offenders sentenced with a DRR that has now terminated. Figures 16 and 17 refer to the same data period and show, respectively, the ethnicity and health profile of individuals subject to DRRs.[57]

[56] Ministry of Justice. (2005-2020). *Offender Management Statistics quarterly (2010-2020)* and *Probation statistics brief (quarterly – 2005-2010)*. London, MoJ.

[57] Ministry of Justice. (2021a). *Drug Rehabilitation requirements – Freedom of Information Act Request. London*. Note that the 'reason for termination' count will be higher as it is based on the number of events with a DRR.

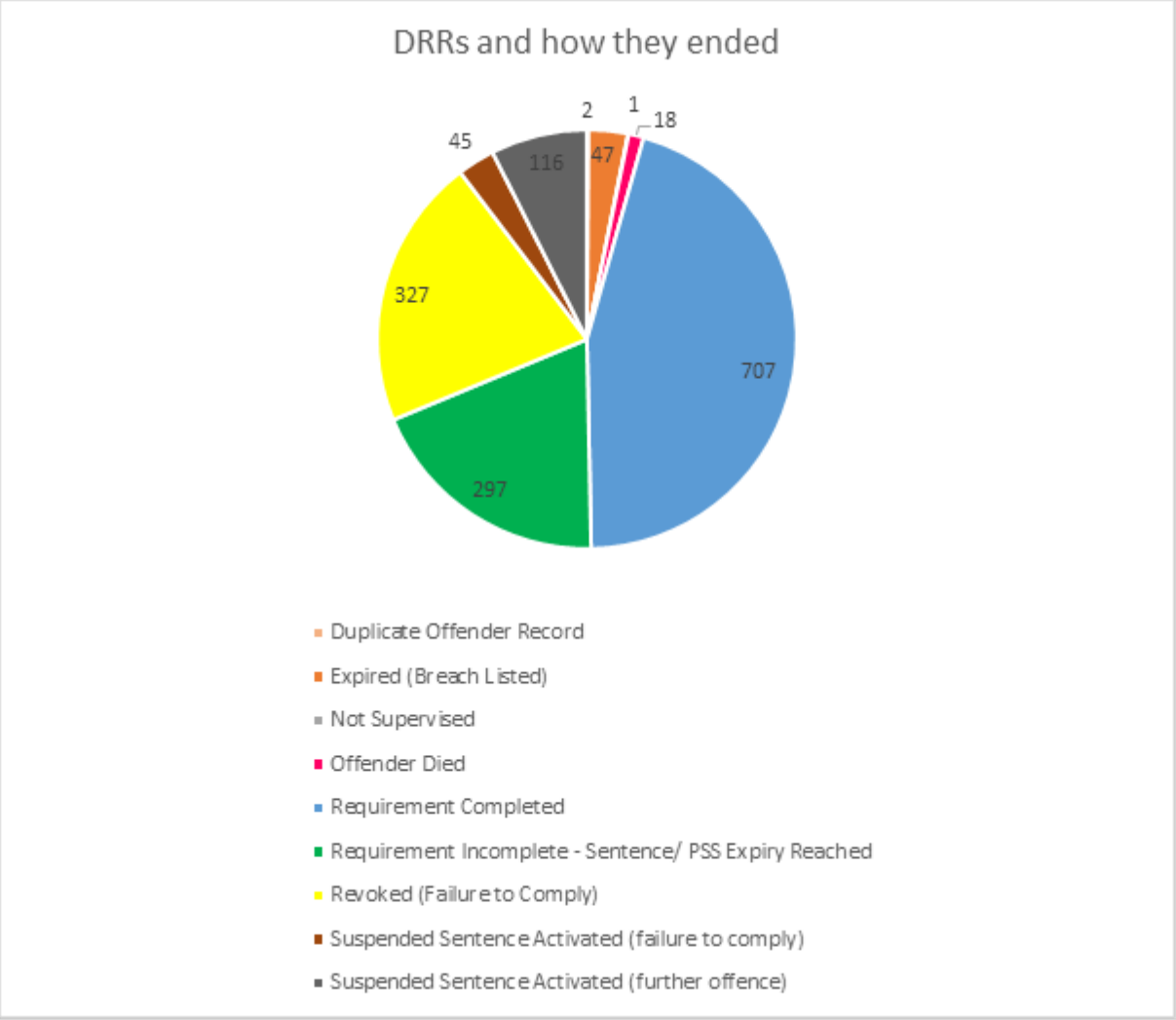

Figure 15: Numbers of DRRs and how they ended[58]

We also considered whether these requirements were used across all ethnicities proportionately. There is a low level of disproportionality shown in Figure 15, with a small underuse of DRRs for Asian people and a slight overuse for individuals with a black or mixed heritage.[59]

[58] Ministry of Justice. (2021a). *Drug Rehabilitation requirements – Freedom of Information Act Request.* London.

[59] HM Inspectorate of Probation. (2020). *Annual Report 2020*. Manchester: HM Inspectorate of Probation.

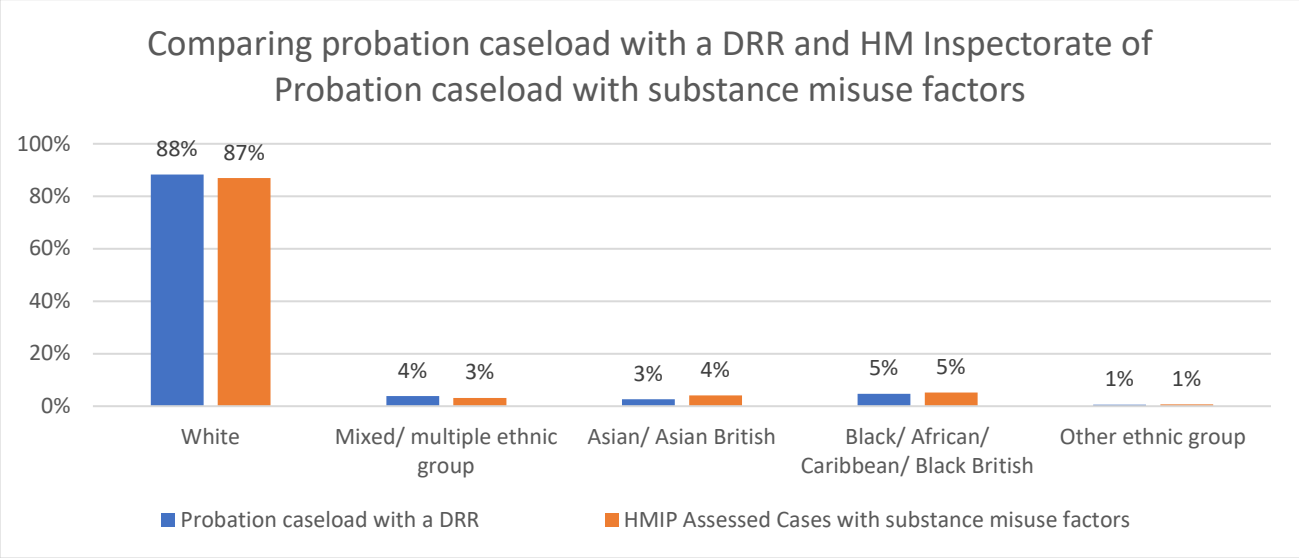

Figure 16: Ethnicity and the probation caseload with a DRR and HM Inspectorate of Probation caseload with substance misuse factors[60]

People on probation subject to a DRR often also have other physical or health conditions, with 60 per cent having one or other or both identified in the sample we analysed.

Figure 17 shows the high levels of mental health problems experienced by people with DRRs.

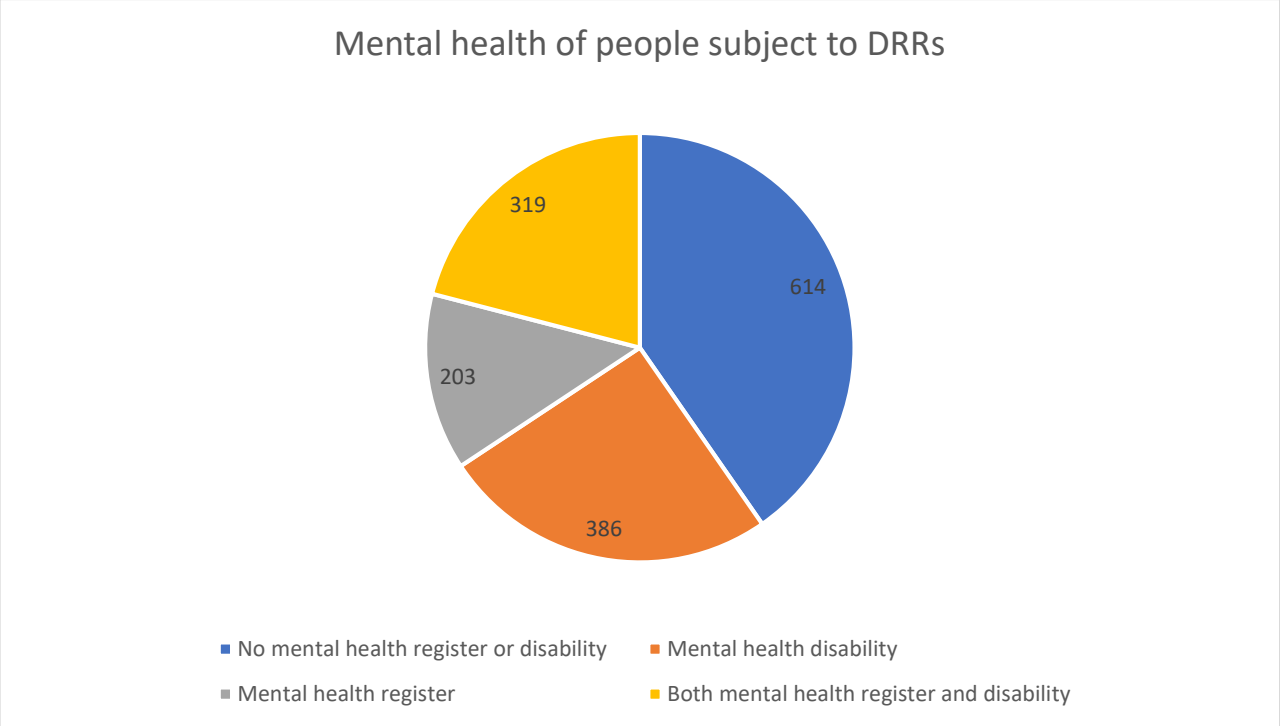

Figure 17: Mental health status of people on DRRs[60]

Inspection fieldwork findings

In our fieldwork, we inspected 23 cases with DRRs. Largely, we found that DRRs comprised little more than standard community orders. Expectations were not set properly with people on probation or jointly with drug services. Drugs agencies and probation shared information to bring about effective assessment too infrequently (only 12 cases). Roles and responsibilities were seldom set

[60] Ministry of Justice. (2021a). *Drug Rehabilitation requirements – Freedom of Information Act Request*. London.

out clearly in plans (17 cases). These plans were only shared between probation and the drugs agencies in five cases, leaving real gaps in communication and professional practice. It is hard to see how practice could be effective in such compartmentalised ways of working, especially where people are receiving ongoing medication and support services. In only six cases was there a sufficient record of what engagement was required with drug treatment services. Therefore, it was sometimes unclear if contact met the requirements of the case. From the current recording practices, it is impossible to see how many appointments have been kept with drug agencies and whether this is in line with sentence plans.

4.4 Drug misuse, trauma and trauma-informed practice

Aside from people with DRRs, many people on probation have drug misuse problems. Our inspection found a lack of specific interventions to address drug use and a very generic approach taken in the majority of cases. There is a very low use of the Building Skills for Recovery accredited programme for this group of individuals. Some probation practitioners had tailored a package of work tackling drug problems for each individual and their needs, but this was rare.

We found an over-use of RARs, and an assumption that these requirements could handle treatment needs. This is not appropriate, and, indeed, an instruction was sent recently to probation court duty officers to ensure that, where drug treatment is required, a DRR is recommended.

Exposure to traumatic experiences, especially those occurring in childhood, has been linked to substance use disorders, with high co-morbidity seen between drug misuse, post-traumatic stress disorder (PTSD) and other mood psychopathology (Bailey et al., 2019; Rees et al., 2013; Khoury et al., 2010; Morrissey et al., 2005). Drug misuse by victims of intimate partner abuse may also increase victimisation, as they may be less likely to take steps to protect themselves from further abuse (Iverson et al., 2013).

Trauma-informed practice is based on five core principles (Elliott et al., 2005):

1. trauma awareness
2. safety
3. trustworthiness
4. choice and control
5. building strengths and skills.

Experiences of trauma are widespread and, within our sample of 60 cases, we found that 54 had suffered trauma prior to contact with probation services. A trauma-informed approach provides practitioners with a framework to avoid re-traumatisation of those who use their services, promote their physical safety, and use strength-based practices, such as motivational interviewing.

UK guidance on the clinical management of drug misuse and dependence[61] states that drug services need to consider the principles of trauma-informed care and related staff competences in addressing people's needs. Probation and drug services work with many people with a history of trauma. There is a clear need to both recognise these people and to ensure suitable sensitivity and competencies to address their needs, with a treatment environment that promotes healing and prevents inadvertent re-traumatisation through working practices.

Despite this, we found that only 22 people had the benefit of a trauma-informed assessment (out of the 52 of those we judged to need it).

Many of the people we spoke to were positive about the delivery of services and felt it had been valuable to them. It should be noted that we were only able to speak to the more stable people who were engaging with services.

> *"I've had nothing but help from these services and I'm in a much better place these days and trying to get my life back on track. And that's because of all the help and support I've received through my*

[61] Independent Expert Working Group. (2017). *Clinical Guidelines on Drug Misuse and Dependence Update*.

probation officer and drug workers and other people they have signposted me to, which is helping my recovery big time."

"They are working for me. They have stopped me from wanting to throw myself off the pier and killing myself. My life was in such a mess because of the heroin and it finally took me to prison and this. But since getting my probation worker who has worked so hard in building me up again and helping me find myself. I couldn't have asked for anything more really. She's the only person who has took the time to really get to know me and it's been a pleasure to work with her."

"It's got me off the heroin for the first time in 20 years and my life is a lot better in some ways so I'm definitely grateful for that. I have had a lot of help and support by multiple agencies who have all worked well together to help with my wellbeing, but it's still a work in progress really."

"It has definitely worked for me. I've got a job now. I've got my own place to live again and it's just helped me to get my life back in order."

"I asked to go on an anger management course, but they never got around to sorting that out for me. I also asked if they would help me sort out some counselling because of the voices I hear in my head. But I never got that either. I am getting some counselling now but that's through another service I have access to."

4.5 Meeting diverse needs

Assessment, planning and delivery are all best done with effective consideration of people's back story and personal circumstances to support their engagement. Too few cases showed these hallmarks, with less than half of the cases featuring enough thought around engagement. At worst, assessment was devoid of gender, ethnicity, sexual orientation, disability and background considerations. We spoke to one probation practitioner who did not know the ethnicity of one of the people she was working with. Another had missed the fact that sexual orientation was a critical factor in one person's drug use and concomitant risky behaviours.

Poor practice example

Brandon is a foreign national, but his ethnicity is not recorded. He was sentenced to a four-month DRR and 50 hours of unpaid work for drink-driving and being in possession of drugs. This was his first UK conviction.

He has a five-year history of crystal methamphetamine use. He is an injecting drug user. It appears he uses drugs as part of the chemsex scene.[62] His drug service records indicate that he has additional health diagnoses, but his probation practitioner was unaware of these, having never properly discussed his sexuality (as a gay man) and his cultural identity. She did not consider the risks he was taking in any way.

We advocate the inclusion of people's strengths within their assessments and plans and note should be taken of accrual of any recovery capital.

[62] Sexual activity engaged in while under the influence of stimulant drugs, such as methamphetamine or mephedrone, typically involving several participants.

Lambeth had some impressive resources to help understand chemsex and how to work well with people of all sexual orientations. However, the training was not evident in the probation cases we reviewed. We commend wider use of these excellent resources, and the development of effective and responsive practice.

Those people prescribed long-acting buprenorphine (a slow-release opiate-substitution therapy administered by injection) indicated a positive response to this treatment approach. However, the medicine was given to a small number of individuals, whose cases we reviewed, and for a relatively short period. The initial findings appear promising and are worthy of further attention and analysis.

In one area, we heard that people on probation believed that they had to queue for treatment before 9am to ensure they could be prescribed medicines at a limited number of drop-in slots starting from 9am, even though some fixed appointments were available. Across all services, we support a more person-centred approach that would consider all people who struggle to commit to early mornings, and/or an opportunity to attend later in the day to support those in employment.

In Blackpool, the Operation ADDER programme (see also section 2.2) had been set up to include a young person's strand to meet the specific needs of those under 25 years old. We viewed this as responsive and effective practice.

4.6 Drug testing

Drug testing is carried out routinely in drug services, for clinical reasons. From a criminal justice perspective, testing is used as a control and monitoring measure, rather than to contribute to clinical decisions on pharmaceutical therapies. On DRRs, it is largely undertaken by probation staff, using a cheek swab. There are limitations to these, and urine tests, which are more reliable, can provide testing for a broader spectrum of drugs. In Wales, contracts have been set up for the local drug services to provide routine testing and there are good protocols in place for this. We did not, however, see accurate recording and sharing of test results across all the sites we inspected.

Testing of people released from prison on licences is also, mainly, carried out by probation service staff. Some commissioned drug services pick up this testing and provide it, according to local arrangements.

Additionally, in approved premises (AP), each resident must sign rules governing their stay. The AP manual (Ministry of Justice, 2014) sets out that:

'The AP Rules require residents to undergo drug and alcohol testing when required to do so by staff. Signing the Rules automatically amounts to consent to testing. Residents should be selected carefully for testing, based on a history of substance misuse or on reasonable suspicion. Testing on reasonable suspicion might include testing an offender where drug paraphernalia had been found in their room. Random testing of offenders who have a previous history of drug use is acceptable. Testing all residents routinely is not consistent with risk management and should be avoided.'

Drug testing in other circumstances is not permissible, and only those subject to DRRs, those with specific licence conditions, and those resident in APs can be tested for drugs, under current laws and rules.

Drug testing is being used too infrequently. The reduction is partly in response to Covid-19, but this needs to be reset as quickly as it is safe to do so. Only 10 cases out of the 60 we reviewed received any recorded drug testing, despite our sample containing 23 DRR cases.

In the probation case management system, nDelius, information on drug tests is not easily accessible, and recording practice is not consistent. It is not possible to determine the volume of drug testing currently. Unlike other items in nDelius, such as the number of unpaid work hours completed against an order, or an individual's accommodation status, drug testing results have no specific home. This needs to be rectified to enable practitioners and managers to be able to see clearly the status of people under supervision.

In April 2021, the NPS reintroduced oral fluid drug testing in five community contact centres in England and two in Wales, and has plans to reintroduce drug testing more widely in 2021. This follows a period of a year when there was little drug testing of people on probation, apart from in Wales, where leaders advised us that testing had recommenced in the autumn of 2020, and in Cumbria and Lancashire CRC (see below). We would welcome a review of the time it has taken to recommence this important monitoring facility.

The below good practice example describes work in Cumbria and Lancashire CRC to reintroduce testing to increase monitoring and oversight for people with drug problems.

Good practice example

Staff at Cumbria and Lancashire CRC approached managers in the autumn of 2020 to request the restarting of drug testing. They said that they could manage risk and public protection better if they had the ability to drug test people under their supervision. Staff volunteered to carry out drug tests and asked whether the issue could be explored further.

The responsible deputy director, senior probation officers and selected staff walked through the process for both oral and laboratory testing with the health and safety manager. From this, they identified that, with appropriate equipment – gloves, apron, mask and visor – it was possible for drug testing to be undertaken safely in the office with the probation practitioner simply opening the test kit and observing the individual administering the test on themselves. The probation practitioner then disposed of the kit.

With necessary safety systems in place, the deputy director agreed to pilot this in Accrington and Preston. This was strictly on a voluntary basis for staff, acknowledging the health and safety anxieties that, understandably, surround the pandemic. Guidance was constructed so that it could be applied to any team/office where it was appropriate. Agreement was secured from both staff and trade unions.

From November 2020, both offices recommenced and continue drug testing, with nominated probation practitioners happy to carry it out. Other colleagues can book people in for a test. Other CRC offices, including Blackpool, were exploring the same approach.

Although we spoke to only a small number of people on probation, those who had taken part in drug testing were positive and understood the reasons for it. Some people talked about the lack of testing and put this down to the pandemic.

> *"They don't test me 'cos there is no face-to-face contact now it's all done over the phone. If Covid-19 wasn't here, then I probably would have done [what] I was told."*

> *"I've never been tested by probation. I got 10 years for a drug-related crime, and I thought that would have been a regular thing once I got released but no, never been asked to do a test."*

> *"I've had a couple of tests which came back clean. Which was a great feeling for me. I wanted to show everyone I was serious about getting clean and turning my life around. That's what the testing means to me. Truth, honesty and determination to stay away from the white stuff [crack cocaine]."*

4.7 Review and evaluation

The reviewing work we saw was done almost exclusively in isolation, with drug and probation agencies rarely coming together with individuals to review progress and next steps. There is much room for improvement and joined-up working.

People on probation told us how they felt uninvolved in reviewing their progress.

> *"Not a lot happens for me, so no. I speak to my probation officer every two weeks by phone and that's about it really; she asks how I am, if everything is OK with me."*

Others felt listened to and supported, but few spoke of this being done across the agencies they worked with.

> *"I was able to put my ideas across and, if they agreed with it, they would support me with it too."*

> *"They always support me when I want to try something different and encourage me to. Which is great, but since lockdown a lot of services that help people like myself and my partner have been shut."*

4.8 Conclusions and implications

Significant improvements are required to the quality of assessments and plans undertaken with people on probation. The probation service will need to look again at the quality of its referrals to drug services to ensure that the individuals referred get the best, most expedient start to their support. Further, drug providers and probation services need to come together to review each individual's progress.

Clarity needs to be brought to the DRR offer, with courts, probation and drug providers all working together to ensure that it is a robust and meaningful sentence. Drug treatment needs should not be handled using RARs.

A wider use of evidenced-based and recovery interventions is needed urgently, to improve outcomes for people on probation.

5. Resettlement

This chapter looks at how prison staff and community-based staff work together to plan effectively for people to resettle into the community after release from prison. We look at how well the continuity of people's drug treatment is maintained, noting key differences between England and Wales. We also consider the use of licence conditions to manage drug misuse issues for, and in support of, people on release. Finally, we look at the outcomes for people leaving prison with drug problems.

5.1 Leaving custody

For people leaving custody, prison substance misuse services are expected to liaise with relevant community drug services. However, there is a built-in disconnect between the health and justice providers. While prison Through The Gate staff are often proactive, there is not enough communication to effect joined-up planning and care. There is a key opportunity to connect with family and build recovery capital to develop good resettlement plans. The pandemic had created greater difficulty, and harm reduction and overdose prevention work had been missed for several of the people we reviewed; the mistaken assumption that another agency would pick up the work was clear. The impact of this is illustrated below.

> *"…They talk about duty of care, but the prison system released me knowing I was homeless. Here you go, there's a week's benefits and a bus pass home. Your probation officer will phone you sometime today and sort you out with accommodation. It never happened. People are dying of this Covid, and I just felt let down by everyone."*

In contrast, where these links were made, community drug misuse providers developed care plans for each individual, engaged with relevant agencies, had links with other community services, made referrals and ensured that healthcare needs were met, for example with employment services, general practitioners and blood-borne virus-testing clinics.

All community drug misuse providers had a contact with prison substance misuse services in most prisons. Drug misuse staff knew that a referral could be made for a prisoner being released, but community drug provider staff we spoke with said that they did not always receive a referral. On rare occasions people released from prison would turn up at community drug services unannounced, or someone would be released from court and attend the drug recovery service without the relevant referral being in place.

In Swansea Bay, there was a coordinated custody-to-community approach, with one provider (for male services) covering Swansea, Cardiff, Parc, Usk and Prescoed prisons. The delivery of services and interventions built on the work already completed in custody. Caseworkers and managers spoke positively of these service provision arrangements in Wales.

Unfortunately, case records did not always clearly record the individual's progress from custody through to the community. Case notes in some drugs services evidenced joined-up working between custody and community treatment systems, but there were gaps in information-sharing between drug services and probation.

Overall, we found that two-thirds of the people released from custody (21) received insufficient resettlement planning that focused on drug treatment, recovery and safety needs.

People's experience on leaving prison was mixed. Some felt very supported.

> *"I got lots of support, to be honest, from the probation team and the workers at the approved address I was sent to. They helped me with accessing the benefits department, food banks, phone calls and the support was there, and it really helped me get back on my feet when I was first released. So, I feel that they did communicate with each other and it helped me to get closer to home eventually. I was fully supported by everyone involved and that felt good."*

"When I got out in November my officer was brilliant. She arranged for me to stay in a bed and breakfast hotel for women because of my past. I was homeless, I'd just lost my parents, I felt isolated, afraid and very vulnerable but she has helped me to access so many services that will help with my mental health problems and personal wellbeing, along with helping me out with housing as well. She has got all the agencies involved. She has been so helpful."

Others felt let down.

"There wasn't any support at all. I'm in a prison up in Nottingham and I live in Blackpool. The day they released me, it was coming up to 5pm just on dinner time in the jail and they come to my cell and tell me I'm getting released. They give me a train travel pass to get me back to Blackpool, no money. I didn't have anything; when I asked the prison officers how do I get to the train station they just pointed me in the right direction and I had to walk over two miles to get to the train station … it was scary walking down country roads in the dark on my own. I felt really vulnerable."

"It was crap really. At first, I was homeless for quite a while. I've got mental health issues, I'm epileptic and a heroin addict. I eventually got housed through Bromley Borough Council in this hostel I'm in now. But it's miles away from my family and friends and support networks."

5.2 Licence conditions

The application and management of licence conditions to test for and manage drug use were inconsistent.

We looked at drug-testing figures from the national probation case management system, based on people released from prison between 01 January 2020 and 31 March 2020 with a drug-testing condition that had terminated by March 2021.[63] The distribution of use ranged widely, from only one case in some smaller CRCs to over 90 in the-then NPS North East division, which showed the highest use of drug-testing conditions, even for its relative size. More than 60 per cent of the people subject to these licence conditions also had a recorded mental health problem mirroring the complex needs we found in our fieldwork, and 15 per cent were from a black, Asian or minority ethnic background. More than two-thirds of people covered by these licence conditions were recalled to custody or had their licences revoked for non-compliance.

In the data we examined from this quarter (January to March 2020), almost 50 per cent of the licence conditions were applied to people posing a high or very high risk of serious harm to others, suggesting a lower level of use in medium and low risk cases.

For drug-treatment licence conditions, it was not possible to obtain data, due to the way that conditions are recorded. There needs to be more clarity on how to record these on nDelius to enable managers to monitor the use of licence conditions separately for drug testing and for drug treatment.

Licence conditions must be both *necessary* and *proportionate*, as set out in Probation Instruction PI 09/15. Further, licence conditions relating to drug treatment or testing must adhere to guidance contained in probation instruction PI 30/14, which advises that staff should be 'guided by advice from the relevant treatment provider or other drug workers in prison, as to the offender's suitability for this condition/requirement'. The guidance is to support the probation practitioner in making recommendations to the governor and covers five criteria:

i. that the misuse by the offender of a controlled drug caused or contributed to an offence of which the offender has been convicted or is likely to cause or contribute to the commission of further offences by the offender; and,

[63] Ministry of Justice. (2021b). *Drug testing licence conditions – Freedom of Information Act Request*. London.

ii. that the offender is dependent on, or has a propensity to misuse, a controlled drug; and,
iii. that the dependency or propensity requires, and may be susceptible to, treatment; and,
iv. the prison-based treatment provider or health worker should liaise with their counterparts in the community to ensure that appropriate appointments are in place upon release. The Offender Manager will then need to confirm this before making a recommendation to the Governor or Director of the prison that the condition is applied. The Governor/Director will need to be satisfied that an appointment, with a known time and place, is identified before the condition can be applied.
v. the types of appointments offenders are required to undertake will be determined following a recommendation or referral by a health professional, with input from the probation practitioner.

We did not find this kind of rigour applied in most of the cases we reviewed. Indeed, some of the probation practitioners had lost sight of the need to be proportionate and to seek advice from the local drugs agency regarding treatment. We saw several examples where licence conditions for treatment had been added 'just in case'. This is not appropriate practice and should be revised.

The NPS has introduced the effective proposal framework 2 (EPF2) to assist probation practitioners in deciding on the most appropriate licence conditions to request for the safe release of people back into the community. CRC staff were not using EPF2 at the time of the inspection. Within the NPS, uptake of the tool was variable, and local leaders acknowledged that delays had occurred because of the pandemic but were confident that the NPS target of 75 per cent use of the tool would be achieved by June 2021.

5.4 Outcomes for prison leavers

In this group, outcomes were not positive. We took a sample of prison leavers who were in treatment in prison and looked at what happened to them over the next few months. Of the 25,000 people released with a treatment need in England, only 34 per cent were picked up in treatment and a much smaller number (12 per cent) were retained in treatment for at least 12 weeks. Sadly, nearly one per cent of all the people picked up in treatment died before the 12-week point.

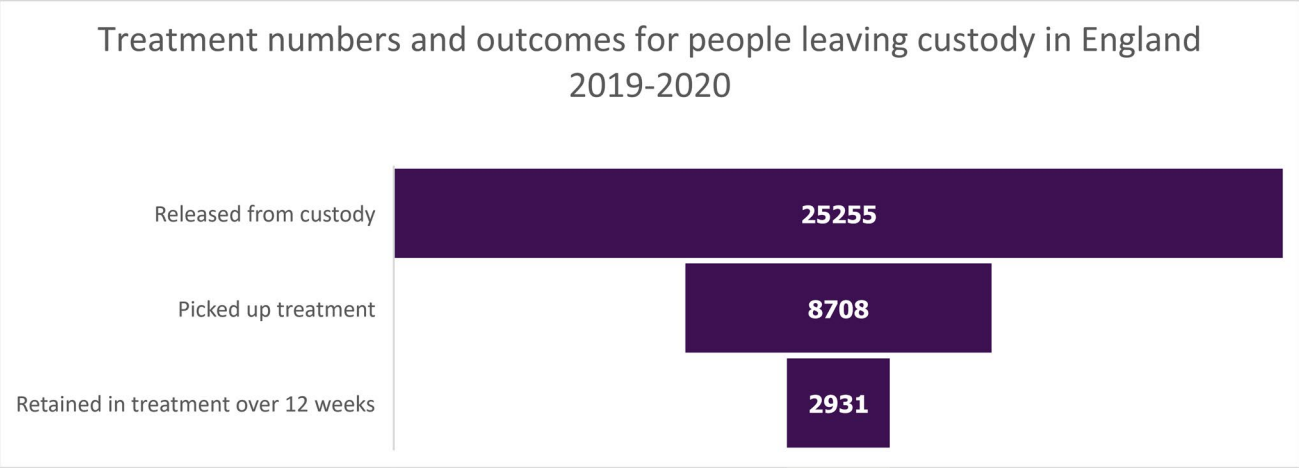

Figure 18: pick up and retention for 12 weeks in treatment for people leaving custody in England 2019/2020

We considered what had happened to these individuals. Of the 34 per cent who were picked up in treatment after release from prison, over four in 10 were still engaged 12 weeks later, which should be seen as a positive outcome and shows ongoing engagement. However, one-quarter left treatment and went into custody, with a further 24 per cent not completing treatment for another reason.

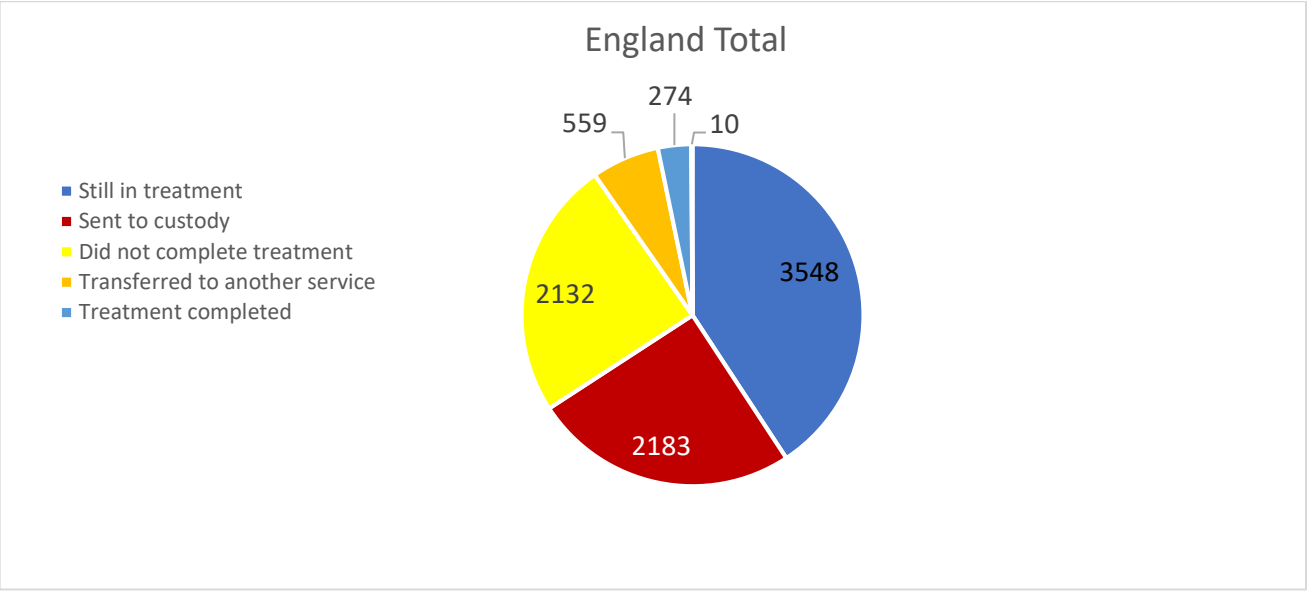

Figure 19: Treatment numbers and outcomes for people leaving custody in England, 2019/2020

Figures from PHE shown in Figure 20 below demonstrate the fallout rate of people who left prison drug treatment and failed to get into community services in the fieldwork sites we visited in England. Of 26 people who were released from prison in our six fieldwork areas in the 12 months to March 2020 who had been assessed as needing follow-up drug treatment in the community, only 10 (38 per cent) were supported sufficiently to access these services. There are a range of reasons for this, including stigma, disenchantment and lack of motivational work to support them. The reduction in the level and type of community services may also have contributed. The figures are collected differently in Wales and so only those for engagement in community treatment are available, and are shown in Figure 21 below.

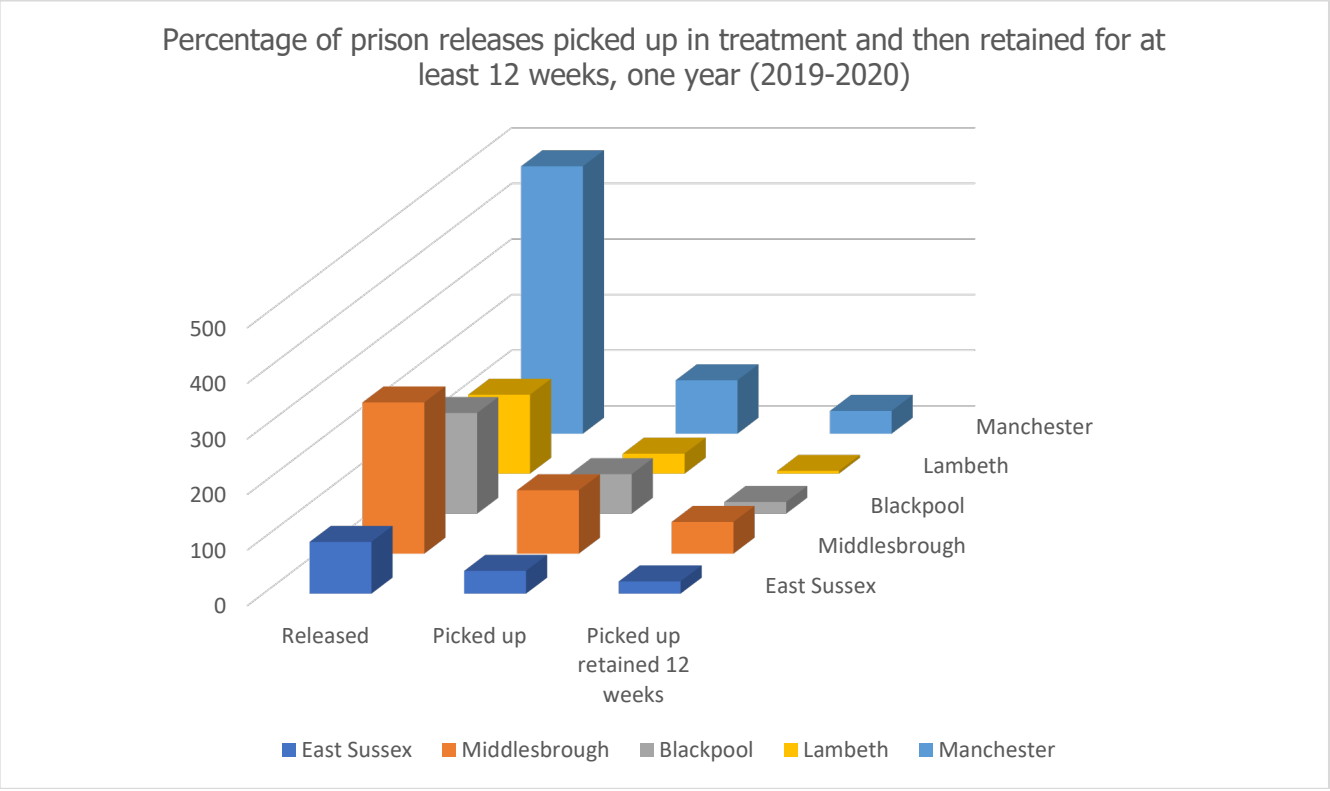

Figure 20: Percentage of prison releases picked up treatment and then retained for at least 12 weeks, one year (2019/2020)

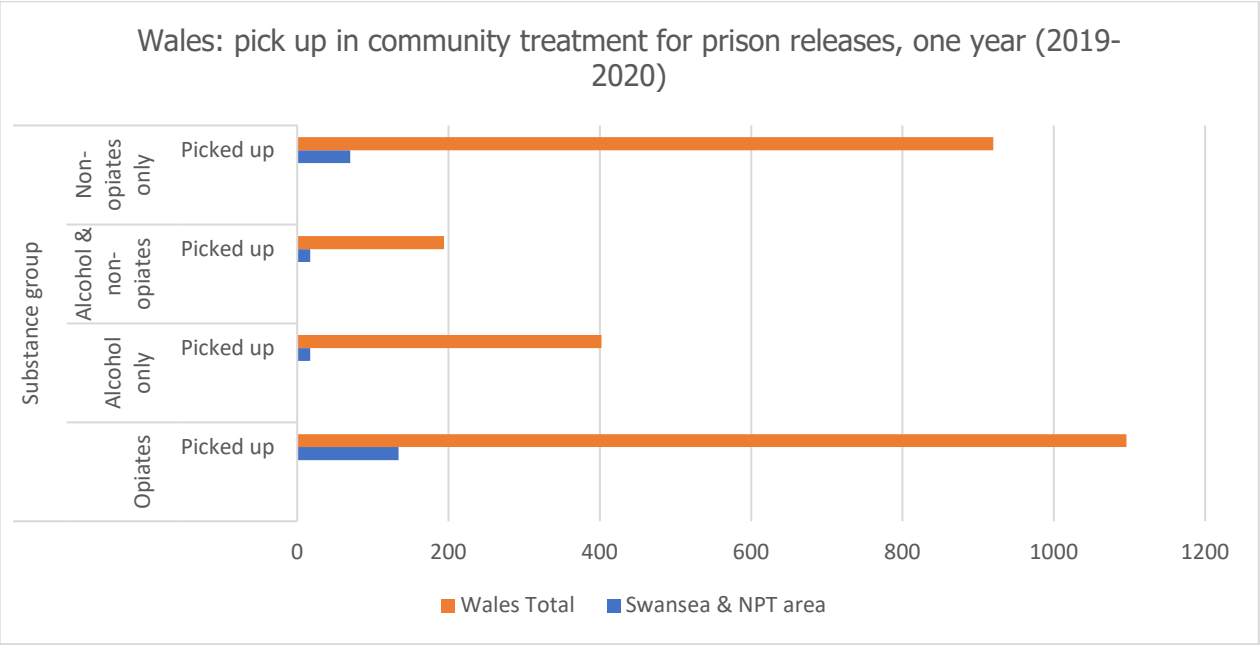

Figure 21: Wales: pick up in community treatment for prison releases, one year (2019/2020)

Note: England and Wales figures are calculated differently.

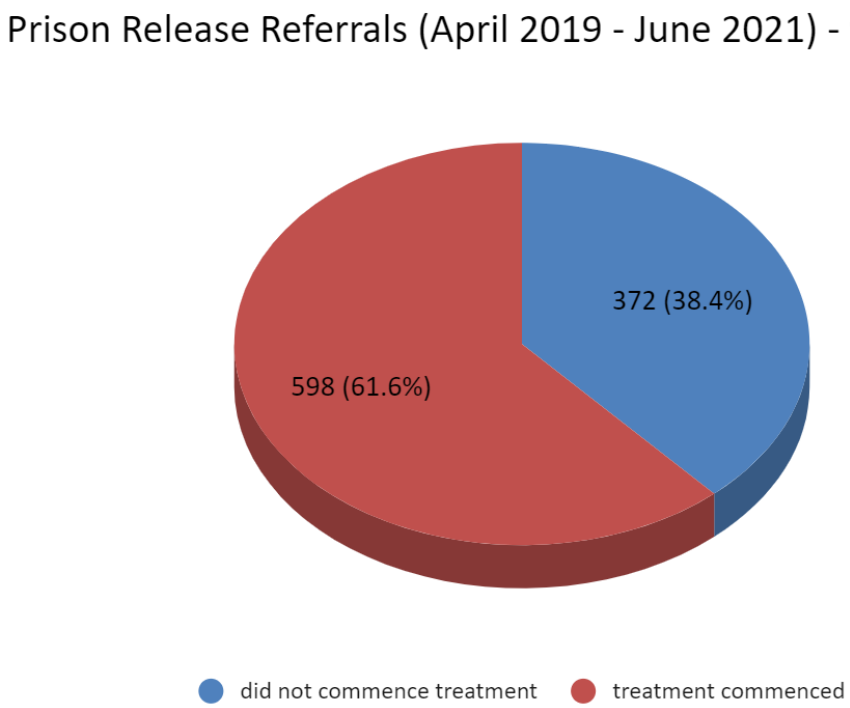

Figure 21: Prison referrals for South Wales criminal justice substance misuse contract[64]

The main difference between the Welsh and the English data is that the Welsh data does not record all arrivals in prison who have a drug treatment need. Therefore, it is not possible to show a measurement of the success of engagement of the broader group after release. Welsh data is gathered by community teams on cases for whom a referral has been received.

[64] Data provided by HMPPS, unpublished.

Even though our inspection sample was small, we found that some people had no prescription for opiate-substitution medication arranged on their release from custody. As shown in the example below, this immediately put them in a riskier position for both their health and reoffending.

Poor practice example

One woman left prison with no opiate substitution prescription arranged and slept in a public toilet on her first night back in the community. She had multiple and complex needs. Although services did come together to offer her medical help and community support, her licence was ultimately revoked, and she was returned to custody.

More could also be done to join up recovery work between prisons and the community. Many prisoners get involved in peer-led, mutual aid such as Alcoholics Anonymous[65] or SMART recovery[66] while they are serving their sentences. Some prisons have set up incentivised drug-free living[67] arrangements for prisoners in separate wings to encourage recovery and improve outcomes. There is a clear need to build on the progress that people make in custody. To protect and cement the recovery capital that people have built up in prison, resettlement planning should ensure that people are picked up by recovery services on release.

'While the science is still emerging, the body of evidence would suggest that by copying others in recovery and abiding by their rules, new identities emerge that are linked to social groups and networks, and that promote changes in the core personal resources needed (self-esteem, self-efficacy, resilience, coping skills and communication skills) to sustain a recovery journey.' (Best, 2019).

The prison leavers project, led by the Ministry of Justice, works cross-governmentally with individuals and stakeholders to explore ways to improve social inclusion of people leaving prison and reduce reoffending. The project is establishing teams consisting of public and third sector staff to co-design and test innovative pilots. The teams will focus on four key areas of challenge for prison leavers: health and wellbeing; the day of release from prison; community and relationships; and employability and skills.

The Ministry of Justice is launching a grant-funding scheme to support the development of pilots that aim to improve the outcomes of prison leavers. The first round of the competition went live in February 2021 and the second round was due to launch in summer 2021. Pilot schemes should be in the development stage from May 2021.

NHS England has recently published a new service specification to improve mental health in prisons. This places a responsibility on the prison mental health provider to undertake routine follow-up to assess whether people who have received mental healthcare in prison continue to receive care on release. However, this is not a service, and is just good practice. In Wales, the *Partnership Agreement for Prison Health in Wales* [68] has four priorities. These include the development of a new substance misuse treatment framework and new standards for mental health services in prisons. It is intended that both will include a focus on transition from prison to the community.

Typically, the planning for support for a prisoner with mental health issues as they move into the community will involve a minimum of five different organisations: the prison mental healthcare provider; the Offender Management Unit (OMU); probation; the community mental health provider, which is often different to that in prison; and the general practitioner. Many will also receive

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[65] Alcoholics Anonymous: www.alcoholics-anonymous.org.uk

[66] SMART Recovery: https://smartrecovery.org.uk

[67] HMPPS. (2019). *Prison Drugs Strategy*. Available at: www.gov.uk/government/publications/national-prison-drugs-strategy.

[68] Welsh Government. (2019). *Partnership Agreement for Prison Health in Wales*. Available at: https://gov.wales/partnership-agreement-prison-health-wales.

substance misuse and housing support. However, the volume of organisations responsible for planning support through the gate creates barriers to coordinating care effectively. Each handover is an opportunity for information to be lost and trust to break down between prisoner and provider, and to create a delay in care planning.[69]

Poor practice example

Hamza completed a methadone programme in custody and was believed to be drug-free for a considerable period pre-release. However, he had been through multiple episodes of drug treatment previously. The release plan included an objective to maintain abstinence and, while there was no involvement of drug services, a referral would be made should this be required. The probation practitioner assumed that drugs were no longer an issue. As a result, there were no plans to manage potential risks. No social care checks were completed prior to release on temporary licence or subsequently. He was recalled due to poor behaviour, but no additional licence conditions were then put in place. The probation practitioner failed to consider the wider context of his extensive history of drug use, relapse, county lines offending, and the risks posed to himself and others. The officer had not read the pre-sentence report or other key documents in the case. Any potential experience of trauma and cultural issues had yet to be explored.

5.5 Conclusions and implications

There are significant complexities in planning for successful releases from prison. Health and justice services tend to work in isolation and the agencies do not share enough information. Too many people leave prison without all the relevant support in place, and we found instances where people did not have an opiate-substitution medication prescription, leaving them in real danger of illicit drug use and at an increased risk of overdose. Short sentences and the sometimes-revolving door between prison and the community made this situation more difficult.

Licence conditions to manage people after their release were not applied consistently. We found some cases where licence conditions should have been applied and others where the requirement for treatment was not proportionate or appropriate. More guidance is needed to reset practice.

Recovery work also needs to be supported more consistently. Where people make progress in their recovery from addiction while in prison, this needs to be protected and built upon in the community.

[69] NHS. Reconnect – *Care After Custody*. Available at: www.england.nhs.uk/ltphimenu/wider-social-impact/reconnect-care-after-custody.

6. Reducing harm from drugs

This chapter explores the catastrophic harms that people suffer from drug use. It looks at the personal harms that people suffer from taking drugs and the vulnerabilities that many of them endure, and how well practitioners and systems are working currently to mitigate these harms. We consider whether drug-related deaths are reviewed effectively, and where dissemination of learning and good practice can be strengthened. We discuss overdose and the need to rediscover this vital work in probation practice. We consider the role of medicines to reverse overdose and how far these have been deployed. We review a programme in the North East that prescribed medical-grade heroin to people with entrenched opiate addictions and discuss the reductions in harm and cost achieved by the scheme. People must be kept alive and safe while they receive the help they need to turn away from crime and recover from addiction problems. We examine practice in safeguarding adults, and highlight the role of organised crime and the vulnerabilities people can experience when caught up in it.

6.1 Drug-related deaths

Sadly, 1,002 people died, of all causes, under probation supervision in the community in England and Wales in 2019/2020 including 458 who died while under post-release supervision.

Over the past two years, 32-35 per cent of post-release deaths were self-inflicted (including drug-related deaths), and 9 to 11 per cent occurred in the first two weeks after release. Opiate users are most at risk of drug-related death. While they are in custody, drug users' restricted access to illicit substances can reduce physical tolerance, leading to greater risk of accidental death if they relapse back in the community.[70] The risk is especially high, and the leading cause of death, in the first few days and weeks after release, and then it gradually drops off over time.[71][72]

However, up until 2019, it was not possible to get a clear view of how many people on probation suffered a drug-related death because probation recording systems were not detailed enough to record this. Even now, following improvements, it is still not entirely clear, as accidental and other deaths are recorded in different subcategories.

The most recent analysis from the Office for National Statistics[73] shows that in the population as a whole in 2020 there were 4,561 deaths from drug-related poisoning in England and Wales. Rates of drug-related poisoning were 60.9 per cent higher in 2020 than they were in 2010. The rate has increased every year since 2012. The 2020 figure is the highest number recorded since records began in 1993 (2,178), with numbers more than doubling since this time.

	The rate of female drug-related deaths was rising
	40- to 49-year-olds were most at risk
	Rates of drug-misuse death showed a north–south difference, with the North East, North West and Yorkshire and Humber regions having the highest rates and London the lowest

[70] Advisory Council on the Misuse of Drugs (ACMD) (2019). *Custody-Community Transitions*.

[71] Graham, L., Fischbacher, C. M., Stockton, D., Fraser, A., Fleming, M., & Greig, K. (2015). *Understanding extreme mortality among prisoners: a national cohort study in Scotland using data.*

[72] Merrall, E. L. C., Kariminia, A. Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J., & Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction, 105,* 1545–1554.

[73] Deaths related to drug poisoning in England and Wales - Office for National Statistics (ons.gov.uk)

	Opiates were involved in just under half (49.6 per cent) of drug poisonings registered in 2020. Trends over time tend to resemble those of all drug poisonings. Heroin and morphine were the most frequently mentioned opiates, with 1,337 drug-poisoning deaths featuring one of these substances in 2020
	In 2020, registered drug-poisoning deaths involving cocaine rose for the ninth consecutive year to 777 fatalities, more than double the 320 deaths in 2015 and over six times higher than the 112 deaths in 2011.

Providers delivering drug-misuse services regulated by the CQC in England are required to notify it of any deaths of people who use these services and must provide this information without delay. All the drug-misuse service providers we reviewed had appropriate internal processes and systems for responding to deaths of service users. This included reporting, reviewing information and engaging in learning. Some services considered this as part of a wider harm-reduction strategy and approach.

In Swansea Bay, the APB has convened a Harm Reduction Group to raise awareness of harm reduction procedures using multi-agency working practices, sharing good practice and problem-solving. It provides a forum for discussion and agreeing actions relating to harm reduction within the area. It aims to develop policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs and alcohol. Crucially, it oversees the Non-Fatal and Fatal Overdose Review Panel, in line with the Welsh Government guidance for carrying out such reviews. The group links with the National Implementation Board for Drug Poisoning Prevention.

In Wales, staff told us there was no routine dissemination of learning across agencies but there is an expectation that this will be done locally. We were pleased to hear that there is a requirement for all non-fatal overdoses to be reported daily and reviewed, with a target to contact each individual within 72 hours. Reviewing work has established that sex workers and people with mental health vulnerabilities are higher risk groups.

Despite some better work in Wales, in general, systems for reviewing drug-related deaths are weak in probation services, and process-focused. We saw too little learning from incidents shared across local agencies. Death-under-supervision processes for the probation service are being overhauled and a new instruction is due to be issued in 2021. This is much needed, as current systems do not consider near-misses or draw sufficiently on knowledge and information from prisons or partnerships.

Drug and probation services almost always conducted reviews of drug-related deaths in isolation from each other, and we saw virtually no sharing of learning or good practice across agencies. All the agencies complied with internal review systems but were process focused. In the year prior to fieldwork (January 2020 to January 2021), five people on probation died in Blackpool alone, in part because of drugs. Although these were all untimely deaths, we saw no real analysis of why this was happening. Unfortunately, a good, local initiative to review drug-related deaths via a multi-agency panel was suspended from February to July 2020 and restarted in August 2020 due to Covid-19.

In Durham Tees Valley, four local authorities jointly funded a post to reduce drug-related deaths. However, the focus so far had been on bringing agencies together, rather than on implementing learning or sharing good practice. There are good opportunities to work together nationally through Operation ADDER (see section 2.2), and local areas will need to drive this work forward.

The Prisons and Probation Ombudsman has recently been mandated to review all deaths that occur within seven days of release from custody and this will help identify where practice can be improved.

6.2 Overdose prevention

Few probation practitioners were confident in giving overdose-prevention advice. There is a growing awareness among probation staff of the use of naloxone, a drug to manage substance misuse overdose, as a preventive measure. Naloxone is a fast-acting antagonist drug which blocks the

effects of opioids. It is given nasally or by injection and can be used by any trained person in an emergency to reverse respiratory problems caused by overdose. Training is quick, easy and accessible. It can prevent death.

All the drug services we visited had strategies to distribute naloxone. At the time of the inspection, none of the approved premises had facilities on site yet, although many staff were trained to administer it. Managers in Wales and Middlesbrough told us that staff had been trained but there were technical problems getting the medicines available at local premises. Local commissioners were very keen to be as creative as possible, with a range of measures to reduce drug-related harms. One told us of their aspiration to have "naloxone flowing down the streets".

There is a national plan to increase the availability of naloxone, run by the NPS in partnership with local drug agencies. The NPS had advised us that it had been working to a June date this year, to equip 85 approved premises with naloxone facilities, under its commitment to save lives. By July 2021, naloxone was available in approximately 60 approved premises and we are pleased that it is already being administered by staff where needed. The programme is now working towards implementation of naloxone in 85 sites by the end of August 2021, with the remaining approved premises subject to further discussions with local health partners.

A few cases we inspected included clients prescribed long-acting buprenorphine (LAB, a slow-release opiate substitution given by depot injection and lasting up to one month). There was a positive response to this treatment; however, it was a small sample and the LAB treatment was given over a short period. We looked at cases in London and Swansea Bay where people were offered LAB treatment and more than one person told us how life-changing this had been for them. The initial findings appear promising and worthy of further attention and analysis.

Clearly, there are serious clinical considerations to be thought through prior to prescribing LAB. However, in a recent peer-led report examining the impact of Covid-19 on drug and alcohol service users in South Wales,[74] professionals were very positive about the benefits it had offered to many local people and had moved 22 per cent of patients on to this therapy. Many people spoke of the benefits they saw in having more control over decisions about their medicines and treatment. LAB is awaiting a full UK evaluation, but widely regarded as an important new therapy.

"The first dose of long-acting injectable buprenorphine was administered by our service in March 2020. To date, this has been the treatment of choice for more than 70 patients (about 15 per cent of our caseload). The expansion in our numbers has been driven by patient choice. In the eight months since that first patient, more than 85 per cent of people initiated on long-acting injectable buprenorphine have been retained in treatment. This is a clear indication that we are offering something that is valued by our patients." – Danny Mogford, Consultant Psychiatrist, NHS Lothian.[75]

6.3 Heroin-assisted treatment

Up to 10 per cent of people who are heroin-dependent fail to benefit from established conventional treatment, but an emerging evidence base has shown the effectiveness of maintenance treatment with directly supervised medical heroin as a second-line treatment for chronic heroin addiction (Strang et al., 2010; Sneader, 1998).

Heroin-assisted treatment (HAT) is the practice of prescribing pharmaceutical-grade diamorphine, which is then self-administered via injection under the supervision of clinical staff. The model was

[74] Kaleidoscope Project. (2020). *Peer-led COVID-19 Impact Survey. A review of the impact of COVID-19 on drug and alcohol users in Wales.* Available at: https://barod.cymru/lessons-from-covid-19/.

[75] Scottish Drug Deaths Taskforce. (2020). *Long-acting Injectable Buprenorphine: West Lothian's Experience*. Available at: https://drugdeathstaskforce.scot/our-work/optimising-the-use-of-medication-assisted-treatment/mat-quality-improvement-initiative-blogs/long-acting-injectable-buprenorphine/.

developed in Switzerland and was used in randomised injectable opiate treatment trials (RIOTTs) in the UK (Strang et al., 2010).

Supervised injection clinics were established in England after publication of the UK government's 2002 Drug Strategy, which stated that: 'the administration of prescribed heroin for those with a clinical need will take place in safe, medically supervised areas with clean needles. Strict and verifiable measures will be in place to ensure there is no risk of seepage into the wider community' (Home Office, 2002). In the 2008 Drug Strategy, 'rolling out the prescription of injectable heroin and methadone to clients who do not respond to other forms of treatment' was detailed as being subject to the results of the RIOTT (Home Office, 2008).[76]

The authors concluded that in the 15 years prior to the study in 2010, six randomised trials had all reported benefits from treatment, with injectable heroin compared with oral methadone. As such, supervised injectable heroin should now be provided, with close monitoring, for carefully selected chronic heroin addicts in the UK.

In Middlesbrough, we inspected a HAT programme that was showing very promising outcomes, working with a small number of people who had between them committed over 500 crimes and cost victims and the public purse the equivalent of over £2 million.

Participants attend a specialist clinic twice a day and are assessed by a medical professional to determine the dose of diamorphine to be prescribed. Once their drug use is under control, they see specialists from other agencies to help them rebuild their lives and integrate into society. In the treatment room, individuals self-administer diamorphine under the supervision of medical staff to ensure there is no adverse reaction.

The scheme launched in October 2019 and is part-funded by Cleveland's Police and Crime Commissioner using money sequestered under the *Proceeds of Crime Act*. The clinical team is based at the Foundations Medical Practice. Funding for the second year has also been provided by Durham Tees Valley CRC and enhances existing staff resource provided by South Tees Public Health. The pilot, which is licensed by the Home Office, aims to:

- reduce the number of street deaths caused by heroin addiction
- promote independence, long-term recovery and desistance from offending behaviour
- provide respite for local residents and businesses, so often the victims of crime, to fund addiction
- remove the health risks associated with street heroin and drug litter
- free up the substantial public resources, including health and police, currently dealing with the problem
- cut off the funding stream to drugs gangs.

Teesside University evaluated the first year of the programme. The outcomes for the 14 people accepted on the scheme were that:

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[76] Strang et al., (2010). 'Supervised injectable heroin or injectable methadone versus oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial', *The Lancet*, 375(9729), pp. 1885-1895. A randomised control trial, it looked at chronic heroin addicts (*n*=127) who were receiving conventional oral treatment but continued to inject street heroin regularly. Patients were assigned to receive supervised injectable methadone (*n*=42), supervised injectable heroin (*n*=43) or optimised oral methadone (*n*=42). Treatment was provided for 26 weeks in three National Health Service-supervised injecting clinics in England (London, Brighton and Darlington).

The report found that, at 26 weeks, 80 per cent of patients remained in assigned treatment. Those on supervised injectable heroin had the highest retention rates (88 per cent), with 81 per cent of those on supervised injectable methadone and 69 per cent on optimised oral methadone remaining in the treatment at 26 weeks. Proportions of patients achieving 50 per cent or more negative samples for street heroin were highest in the injectable heroin group (66 per cent), followed by injectable methadone (30 per cent) and oral methadone (19 per cent).

- seven continued to receive treatment
- one left treatment voluntarily
- in two cases, treatment had to be halted due to ongoing medical risk
- in two cases, treatment was paused due to other medical issues
- two left the programme after committing crime.

Self-declared data suggested that none of the participants were now sleeping rough, their use of other illicit substances had declined markedly, and their mental wellbeing was improving.

> *"In the past year, 14 of the most 'at risk' individuals in Middlesbrough, for whom all other treatment has failed and who are causing most concern to criminal justice, health and social care services, have been accepted onto the pilot. Some of them had been using street heroin for over 20 years prior to joining.*

> *"Analysis of six participants, who have spent at least 30 weeks on the scheme, revealed that prior to the pilot they had committed 541 detected crimes, with an estimated cost to victims and the public purse of £2.1m. Since starting treatment their combined crime total fell to three lower level offences.*

> *"In all six cases the individuals have either completed probation or shown improved compliance with their community order. The six participants recorded a 98 per cent attendance rate at the twice-daily treatment sessions which continued throughout Covid and lockdown."* – Office of the Police and Crime Commissioner, Cleveland.[77]

6.4 Safeguarding adults

Far too few people received enough focus on their safety and wellbeing, with only 34 individuals in our review getting the necessary assessment of these needs. Vulnerabilities, complexity of need and social isolation are often amplified for drug users. There were no interventions to support the safety and wellbeing of these people, despite the high needs in this group. Sadly, 38 people whose cases we reviewed received inadequate intervention to safeguard their wellbeing.

Poor practice example

Will, a 35-year-old male, received a three-year custodial sentence for a dwelling-house burglary. He was released on licence and recalled to prison on two occasions. No licence conditions to address his drug misuse were requested by his probation practitioner. Will had committed 90 offences since he was 15 years old, mainly involving dishonesty and acquisitive crime and some violence. He had a longstanding history of drug misuse, heroin, benzodiazepines and alcohol being his drugs of choice. He has also used crack cocaine and illicitly obtained prescription medication.

He has been in and out of drug treatment throughout the years. His previous injecting drug use had resulted in injury and overdose, and he had been hospitalised in the past due to alcohol and drug misuse. He had a longstanding pattern of progress followed by relapse. Case records were very unclear about his drug misuse. The local drug service held information, not shared with the probation practitioner, about Will's past injecting use, which had resulting in injury, overdose and recurring problems with his mental health. The lack of information-sharing and paucity of assessment contributed to unmanaged risks to Will's personal safety.

[77] Middlesbrough's Heroin Assisted Treatment programme – one year on - Cleveland Police and Crime Commissioner (pcc.police.uk)

We saw examples of people with severe mental health difficulties and significant physical health problems sleeping rough, despite proactive assistance. Rates of disability are higher in this group of individuals than in the general probation caseload, and 41 people had a disability, with 36 people having a mental illness. We were staggered by the complex needs in this group of people on probation, as highlighted in the following case example.

Case example

Ellie had been diagnosed with emotionally unstable personality disorder, depression and anxiety. She can be aggressive and verbally abusive when challenged. She has a history of street begging and was managed under a community order with a DRR and 50 RAR days for breaching her previous criminal behaviour orders, linked to begging and drug addiction. She has a history of self-harm by biting, cutting and hitting herself and was detained under the Mental Health Act twice. She has a daughter who was removed from her care, and she does not see her. She struggles with self-care and maintaining a tenancy. Ellie has a mixed heritage, a history of being domestically abused and has suffered mental health breakdowns. She speaks of abuse from her father in childhood and having difficulties with her cultural identity.

After a short spell in custody, she was released without a prescription for opiate substitution medication and she slept her first night out in a public toilet.

Some of the people on probation we interviewed were more positive:

> *"There was a lot of planning round keeping myself safe from other drug users and not wanting to be round them. Both the probation service and the drug and alcohol services has been a big help and have supported me big time round this and have been a big help in getting me to where I am today, drug free and not committing crime anymore."*

Drug misuse providers had some contact with other care services, and made referrals to the local mental health team, GP, social services and other key professionals as needed. However, there was a lack of understanding and activity in some cases to manage adults at risk, and not enough safeguarding adult referrals were made to social services for drug users experiencing high levels of vulnerability.

Poor practice example

Kelly is very chaotic and has complex needs. She presents real risks to the public. However, there was no clear approach to managing these multiple concerns. Over the course of supervision, Kelly was seriously assaulted on three occasions. She was stabbed in the arm, severing an artery and requiring 36 stitches; hit around the head with a metal pole, resulting in a suspected bleed on the brain; and slashed across the forehead. She was also 'cuckooed'[78] repeatedly, with an individual at her address in possession of a machete.

None of the agencies involved with Kelly made a referral for adult safeguarding.

Kelly was also arrested for many further offences against members of the public and those known to her, including several serious assaults, and has now been convicted of robbery committed against a vulnerable amputee.

In East Sussex, we saw good learning from a serious case review,[79] published in December 2020. The learning from the tragic death of a woman under probation supervision highlights some very

[78] In 'cuckooing', criminals take over a person's accommodation for criminal purposes and exploit their vulnerabilities.

[79] East Sussex Safeguarding Adults Board. (2020). *Adult C SAR.* Available at: https://www.eastsussexsab.org.uk/documents/adult-c-sar-published-december-2020-2/

important issues. She had multiple and complex needs, including domestic abuse and drug misuse, was nearing the end of her life and was in treatment when she received a short-term prison sentence. As there were no women's prisons in the local area, she went into HMP Bronzefield, where her drug treatment ended. She was then released from custody with no prescription and endured a forced detoxification. One of the four findings from the review centred on women who are imprisoned. Part of the action plan was for the local drugs service, NPS and the CRC to tighten their working arrangements, and a service level agreement has been developed.

The below practice example illustrates the level of complexity in some of the cases inspected and the benefits of positive engagement with individuals and local agencies.

Good practice example

Sammy is a 26-year-old man with complex needs, sentenced to a DRR for non-dwelling burglary, with court reviews. A restraining order was made for harassment of his parents. He is managed through IOM.

Sammy began to experiment with illicit substances at the age of 13, using cannabis and prescription medication. By the age of 15, he was regularly using cocaine, M-Cat and heroin. He became addicted to Subutex (buprenorphine) aged 17, using this drug to help him reduce his heroin misuse. He completed a methadone programme in custody but relapsed on release and used crack cocaine. He is diagnosed as having drug-induced psychosis and he offends when his emotional wellbeing and drug use worsen.

He has been in intensive care following drug overdoses at least four times in the past two years. Sammy is a poly-drug user who has been offered naloxone and harm reduction because of his injecting drug use. He is described as misusing 'anything he can get his hands on'. He features on the local 'misadventure' list, with the drug agency trying to support him to reduce his drug misuse and risks to himself.

Sammy has significant mental health issues and self-harms frequently. He has been hospitalised during the period of supervision. His probation practitioner showed a caring approach, ensuring that the community psychiatric nurse and other professionals responded to his needs. She liaised closely with his family, who provide him with significant support, and this is balanced by the protections offered by the restraining order. She has used her strong relationship with Sammy to maintain telephone and doorstep contact through the pandemic. Although Sammy was recalled to custody, good planning took place and he was released to specialist mental health supported accommodation.

6.5 Modern slavery and county lines

Many of the people whose cases we reviewed were extremely vulnerable. Several had been subject to cuckooing, a practice where someone's vulnerabilities are exploited and their accommodation is taken over for criminal purposes, often the sale of drugs. Three of the individuals whose cases we looked at had been involved with county lines.

We were staggered by the level of risk of exploitation, violence and abuse that people with drug problems faced. Many are victims of violence themselves. This, in turn, can often make them riskier towards others and their behaviour more chaotic. It is crucial that probation services look at risks in the round and ensure that people are not stigmatised and side-lined when it to comes to their protection.

6.6 Conclusions and implications

The UK government has recognised that too many people are dying prematurely as a result of their drug problems. The additional funds that were allocated in 2020 to tackle drug-related deaths

underline the commitment to improving this situation. Currently, learning from drug-related deaths is not effectively shared. The NPS's work to improve the reviewing system has not yet concluded and it is vital that this brings bold changes to the current systems, which are weak and process focused.

More broadly, harm reduction and overdose prevention work are not being delivered to people with drug problems effectively and consistently across the system. Leaders should ensure that all frontline practitioners understand and take steps to recognise risks to drug users' health and wellbeing and be proactive, intervening and advising people who are at risk. Similarly, all practitioners and managers should understand and take steps to safeguard adults at risk.

Opiate addiction causes huge amounts of offending and requires bold programmes to tackle the harms it causes. The evidence base for injectable heroin schemes has been established. There is promising work in Middlesbrough, and investment in heroin-assisted treatment is a key tool in the fight to reduce crime and the significant risks that people experience.

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Annexe 1: Glossary

Accredited programme	A programme of work delivered to offenders in groups or individually through a requirement in a community order or a suspended sentence order, or as part of a custodial sentence or a condition in a prison licence. Accredited programmes are accredited by the Correctional Services Accredited Panel as being effective in reducing the likelihood of reoffending
Alcohol treatment requirement (ATR)	A requirement that a court may attach to a community order or a suspended sentence order aimed at tackling alcohol abuse
Allocation	The process by which a decision is made about whether an offender will be supervised by the NPS or a CRC
Building Better Relationships (BBR)	BBR is a nationally accredited groupwork programme designed to reduce reoffending by adult male perpetrators of intimate partner violence
Child protection	Work to make sure that all reasonable action has been taken to keep to a minimum the risk of a child coming to harm
CRC	Community Rehabilitation Company
Drug rehabilitation requirement (DRR)	A requirement that a court may attach to a community order or a suspended sentence order aimed at tackling drug misuse
HMPPS	Her Majesty's Prison and Probation Service: the single agency responsible for both prisons and probation services. See note below on NOMS.
Integrated Offender Management (IOM)	Integrated Offender Management brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together
LDU	Local Delivery Unit
Mental health treatment requirement	A requirement that a court may attach to a community order or a suspended sentence order aimed at supporting mental health problems
MoJ	Ministry of Justice
nDelius	National Delius: the approved case management system used by the NPS and CRCs in England and Wales
NOMS	National Offender Management Service: until April 2017, the single agency responsible for both prisons and probation services, now known as Her Majesty's Prison and Probation Service (HMPPS).
NPS	National Probation Service: a single national service which came into being in June 2014. Its role is to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA

OASys	Offender assessment system currently used in England and Wales by the NPS and CRCs to measure the risks and needs of offenders under supervision
Out-of-court disposals	Out-of-court disposal: the resolution of a normally low-level offence, where it is not in the public interest to prosecute, through a community resolution, or conditional caution.
Partners	Partners include statutory and non-statutory organisations, working with the participant/offender through a partnership agreement with the NPS or CRC
Providers	Providers deliver a service or input commissioned by NPS or CRC, local authority or police and crime commissioner
PSR	Pre-sentence report. This refers to any report prepared for a court, whether delivered orally or in a written format
Rehabilitation activity requirement (RAR)	From February 2015, when the Offender Rehabilitation Act was implemented, courts can specify a number of RAR days within an order; it is for probation services to decide on the precise work to be done during the RAR days awarded

Annexe 2: Methodology

Fieldwork

The fieldwork was completed between January and March 2021. Due to the Covid-19 pandemic, the inspection was done remotely using video conferencing technology such as MS Teams. The below areas were chosen for the inspection and included five separate CRC companies:

Area	NPS region	CRC
Middlesbrough	North East	Durham Tees Valley
Manchester City North, Central and South	Greater Manchester	Cheshire and Greater Manchester
Blackpool	North West	Cumbria and Lancashire
Swansea	Wales	-
Lambeth	London	London
East Sussex	Kent Surrey Sussex	Kent Surrey Sussex

Quantitative methods

We conducted three electronic surveys. The survey of magistrates received 449 responses, that of probation providers had 125 respondents and the survey of drug service commissioners garnered 15 responses.

Data development work was carried out to support this inspection with:

- Public Health England (PHE)
- NHS Wales Informatics Service
- HMPPS.

Qualitative methods

We reviewed comprehensive information in advance from each area and examined 60 cases, including people sentenced to drug rehabilitation requirements, or under licence condition for drug treatment and/or testing, and/or those with high drug needs determined by their probation assessments. Cases were evenly split between each area but included more CRC cases in the sample to ensure drug rehabilitation requirement cases were inspected. All cases had community or licence supervision that had commenced 12 months previously. We interviewed 52 probation practitioners whose cases these were, complemented by focus groups with probation practitioners in each area. Senior managers from these local delivery units were interviewed, along with lead managers for drug misuse and local partners, including the Police and Crime Commissioner, Community Safety Partnership, Safeguarding Adults Board and a local judge from each area.

In the English fieldwork sites, the Care Quality Commission (CQC) interviewed a range of staff, who included commissioners, registered managers, team leads, doctors, psychiatrists, prison link workers and practitioners. Inspectors explored the commissioning arrangements between community agencies and the contracted providers. We reviewed a range of evidence from providers showing leadership, governance, partnership arrangements and key practices within services. We sampled patient referrals, risk assessments, care plans and reviewed the treatment for case studies in each area. Out of the 50 English case studies, 28 were known to drug misuse services and 22 were not known.

In the Swansea Bay area, the Healthcare Inspectorate Wales (HIW) applied the same methodology and found that eight out of the 10 case studies were known to the local service, Dyfodol.

Covid-19 impacted on interventions and criminal justice engagement. We saw all services respond well to the pandemic and adapt service models to suit the needs of local people. This included telephone appointments, doorstep visits and limited online group work. Providers continued to cover all clinical reviews needed and engaged patients in new treatment plans.

Interviews were also conducted with:

- the NPS regional probation director with functional responsibility for health, including drugs
- HMPPS drug policy lead and policy officers
- a senior manager, HMPPS health and social care partnerships team
- a senior policy manager responsible for substance misuse policy, Welsh Government
- the substance misuse lead, Welsh Government.

Engagement with people on probation

We worked with Choice Support, who co-produced the user insight questions. Choice Support secured 12 in-depth telephone interviews with people on probation from these areas, which represented 20 per cent of the case sample. Further work was undertaken in Lambeth to gather more views from people who have used local probation and drug services.

Consultation with an expert reference group

An expert reference group contributed to this report by advising on strategic, technical and operational issues associated with the subject and service under inspection, representing the views of key stakeholders in the areas under scrutiny, comment on emerging findings and final recommendations, and facilitating direct links with organisations or groups to accept ownership of recommended action and help drive implementation.

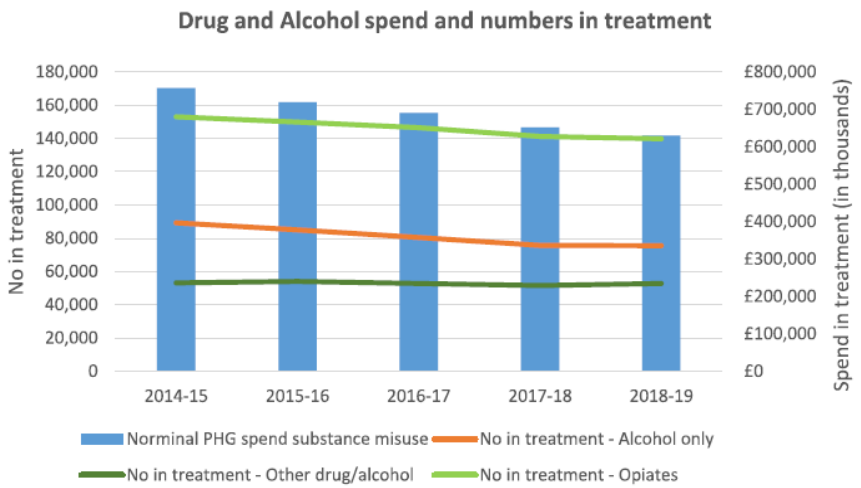
Group membership included:

- Professor David Best, Professor of Criminology, University of Derby
- Martin Blakebrough, Chief Executive, Kaleidoscope
- Samantha Cole, Expert by experience
- Sunny Dhadley FRSA, Independent Consultant & Speaker
- Mignon French JP, Programme Manager, Community Sentence Treatment Requirements (CSTR) on behalf of: MOJ, DH, PHE and NHS England
- Danny Hames, Chair of the NHS Substance Misuse Providers Alliance and Head of Service for Inclusion part of the Midlands Partnership NHS Foundation Trust
- Paula Harriot, Head of Prisoner engagement, Prison Reform Trust
- Ben Hughes, Head of Wellbeing and Public Health: Safer Essex, Health and Justice, Risk Behaviours, Essex County Council
- Steve Moffatt, Senior Policy Manager, MEAM
- Dr Coral Sirdifield, Research Fellow, University of Lincoln
- Oliver Standing, Director, Collective Voice
- Mike Trace, CEO Forward Trust
- Russell Webster, Independent consultant
- Zahra Wynne, Health and Justice Policy and Development Officer, Clinks

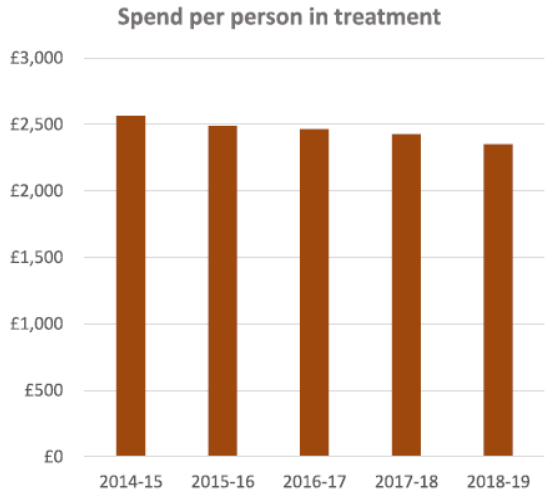
Annexe 3: Drug treatment budgets and treatment places

There has been a marked decline in the funding for community drug treatment, as detailed in the following figures.

Drug Treatment – funding, cost effectiveness and unmet need

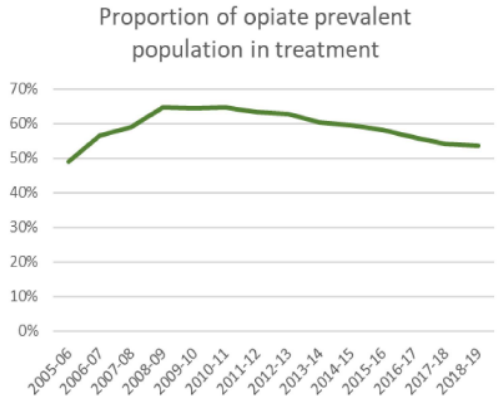


- The overall numbers in treatment have fallen at a similar rate as funding with the largest decreases seen in opiate users (and those in treatment for alcohol only)
- As both funding and numbers in treatment have fallen the cost per person has remained relatively stable over time



- Overall funding for treatment has fallen by 17% (it is not possible to disaggregate accurately between alcohol and drug treatment spend due to lack of robustness in reported expenditure data)
- Many local authorities will have reduced drug and alcohol expenditure by far larger amounts, with residential services being particularly hard hit
- Some areas are already 'rationing' treatment by setting higher thresholds for being able to access structured care
- With drug users who would have received treatment previously being diverted into less intensive and potentially less evidence based interventions
- Likely many areas are now offering the bare minimum service with large increases in worker caseloads an inevitability

- With the prevalence of opiate and crack use increasing and number of opiate users in treatment falling, the levels of unmet need (those that need treatment not getting it) has increased



Source: i) local authority expenditure ii) Unpublished NDTMS Analysis, PHE, 2020

Annexe 4: Adult drug treatment numbers and substance use for people on probation, including licensees[80]

People in drug treatment: A 15-year analysis for whole population (England)[81]

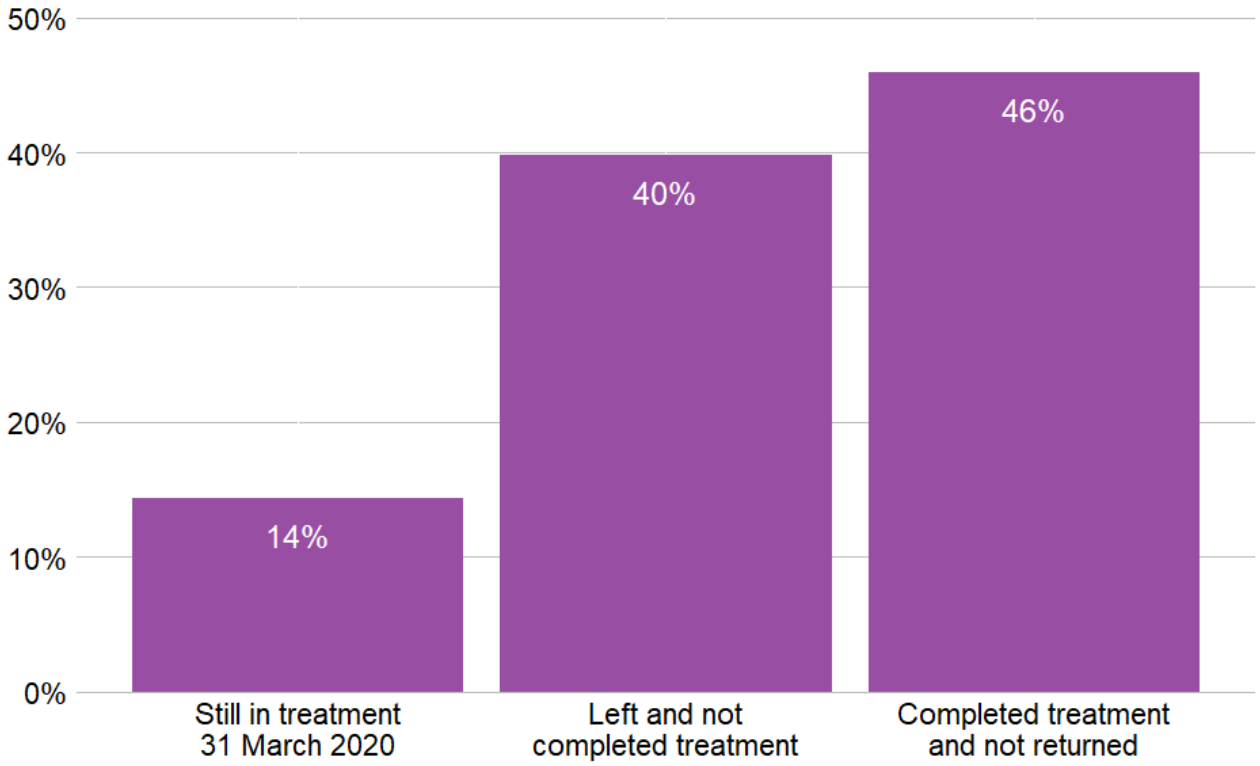


Figure 22: Last status of all people in treatment between 2005 to 2006 and 2019 to 2020

How many people are referred for treatment and what are the outcomes?

In the 15 years of treatment data starting from 2005 to 2006, a total of 1,011,762 different people have been in contact with drug and alcohol treatment services. By 31 March 2020:

- 144,805 (14 per cent) were still engaged in treatment
- 402,518 (40 per cent) had left before they completed their treatment and had not returned
- 464,439 (46 per cent) had completed their treatment and not returned.

[80] Public Health England. (2021). *Adult substance misuse treatment statistics 2019 to 2020*. Available at: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020/adult-substance-misuse-treatment-statistics-2019-to-2020-report#meeting-the-needs-of-people-who-are-dependent-on-alcohol-and-drugs.

[81] Public Health England. (2021). *Adult substance misuse treatment statistics 2019 to 2020*. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020/adult-substance-misuse-treatment-statistics-2019-to-2020-report#treatment-outcomes.

Treatment journeys

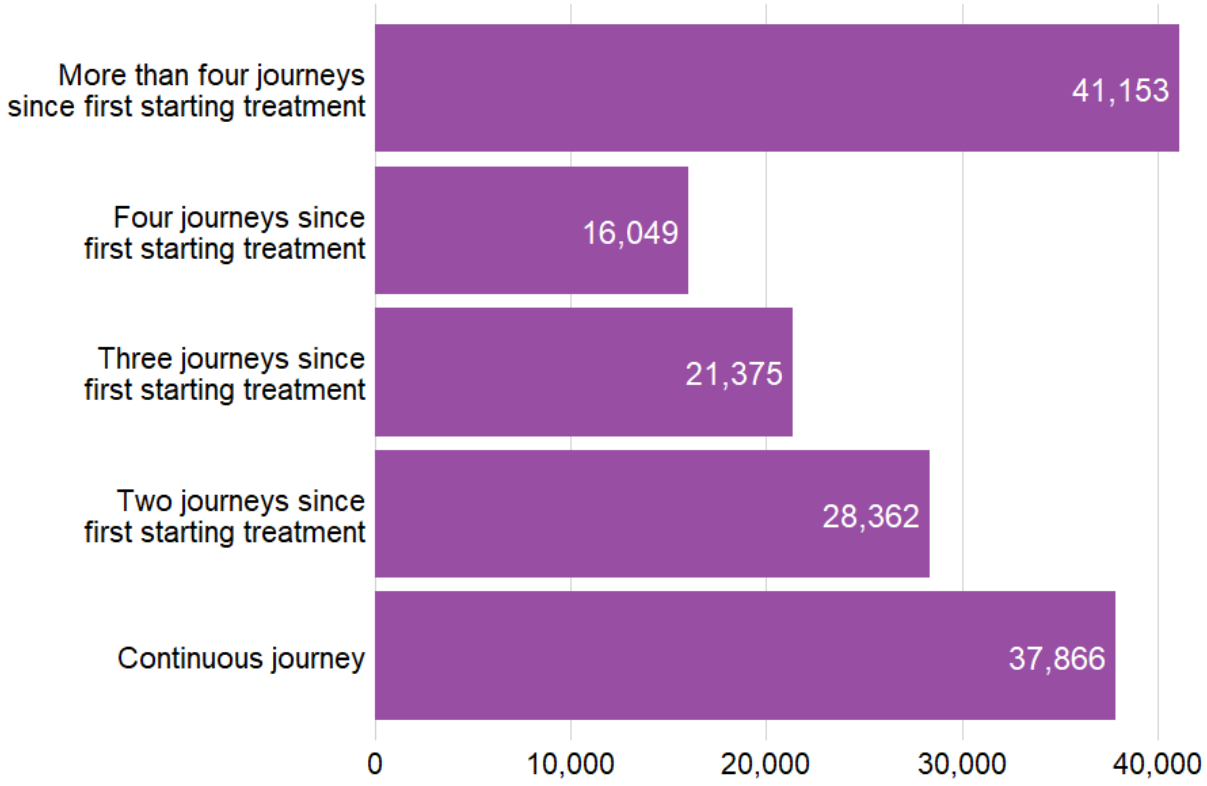


Figure 23: Number of previous journeys for people still in treatment at the end of 2019 to 2020

Of the people still in treatment in England at the end of March 2020, 40 per cent have had four or more treatment journeys and over a quarter (26 per cent) have been in treatment continuously. This underlines the fact that drug addiction is a chronic and recurring condition and it usually takes repeated attempts to recover. It occurs within and is determined by the social context people live in.

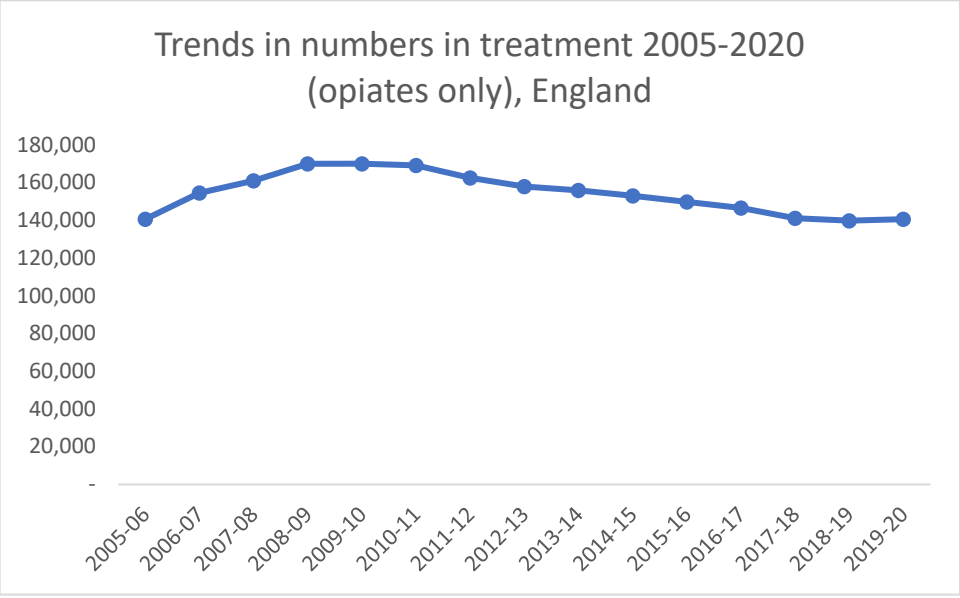


Figure 24: Trends in numbers in treatment 2005-2020 (opiates only), England

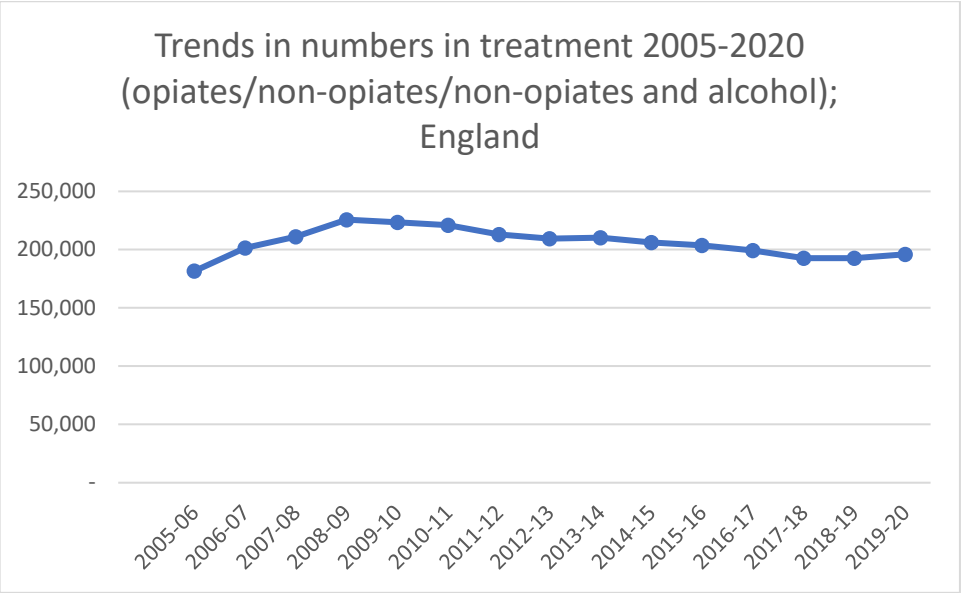


Figure 25: Trends in numbers of all drug treatment England, 2005-2020, whole population

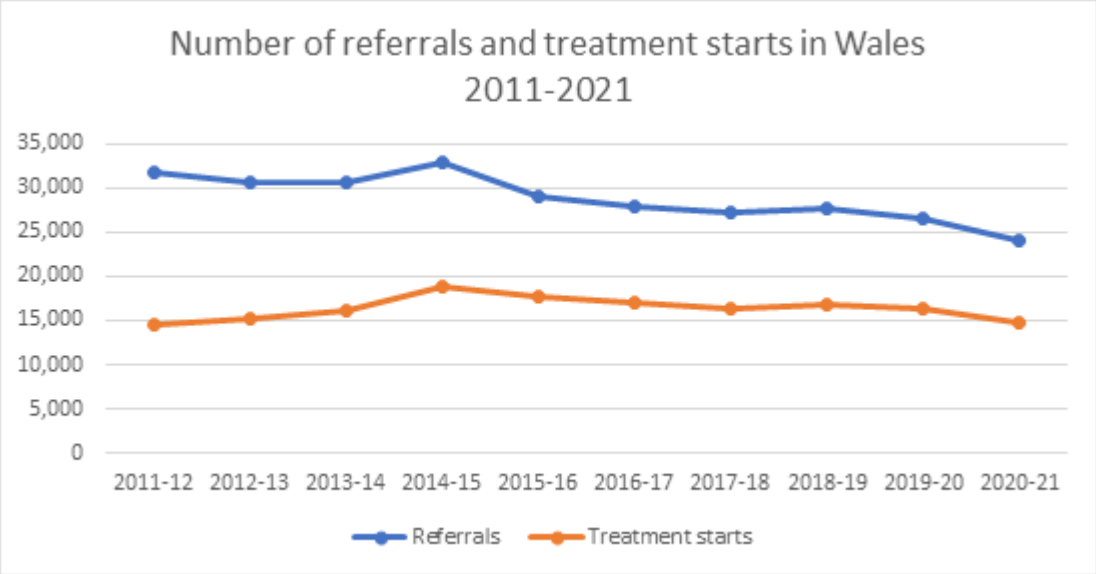


Figure 26: Trends in numbers of all drug treatment Wales, 2011-2015, whole population

Unlike the data for drug treatment in custodial settings,[82] there is no equivalent data set published for people on probation and on licence in the community. For the purposes of this inspection, we have worked with PHE to present information on the referrals into community drug treatment from probation referrers and other sources. Referrals from probation are low. This can be partially accounted for by referrals from other sources, such as prison, general practitioners and self-referrals. However, it is clear that too few people are referred from probation into structured drug treatment.

Reported here are a sample of cases using a starting cohort (1,149 probation referrals with opiate issues newly starting treatment in 2019/2020) plotted back to 2009/2010.

[82] Public Health England. (2020). *Official Statistics Alcohol and drug treatment in secure settings 2018 to 2019 report*.

The reasons people exit from treatment are shown, comparing people who exited from treatment in the period who were referred from a probation source. It is limited to people with opiate problems but looks at adjunctive use of other substances to alcohol and non-opiates.

For context, the numbers are included of all new referrals to treatment for opiates or all opiate clients exiting from treatment. They are provided, more generally, at https://www.ndtms.net/ViewIt/Adult.

The absolute number of referrals reduced since 2009/2010 (from just under 4,000 to only just over 1,000) but the percentage completion rate for these referrals has also dropped (from a peak of 29 per cent in 2011/2012 to 16 per cent in 2019/2020.

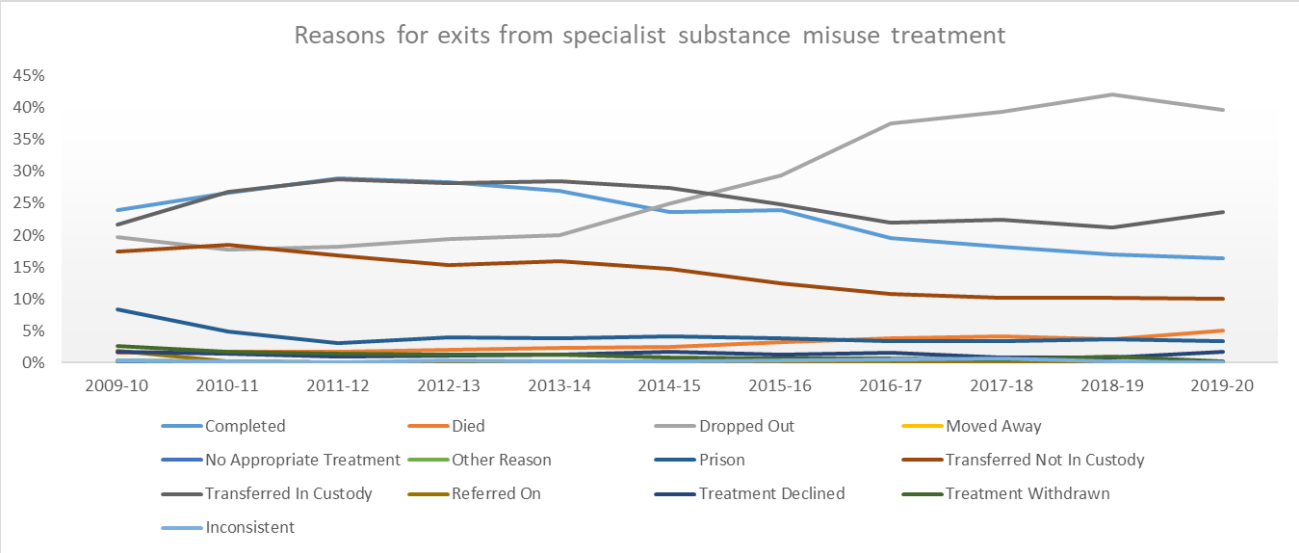


Figure 27: Reasons for exits from specialist substance misuse treatment

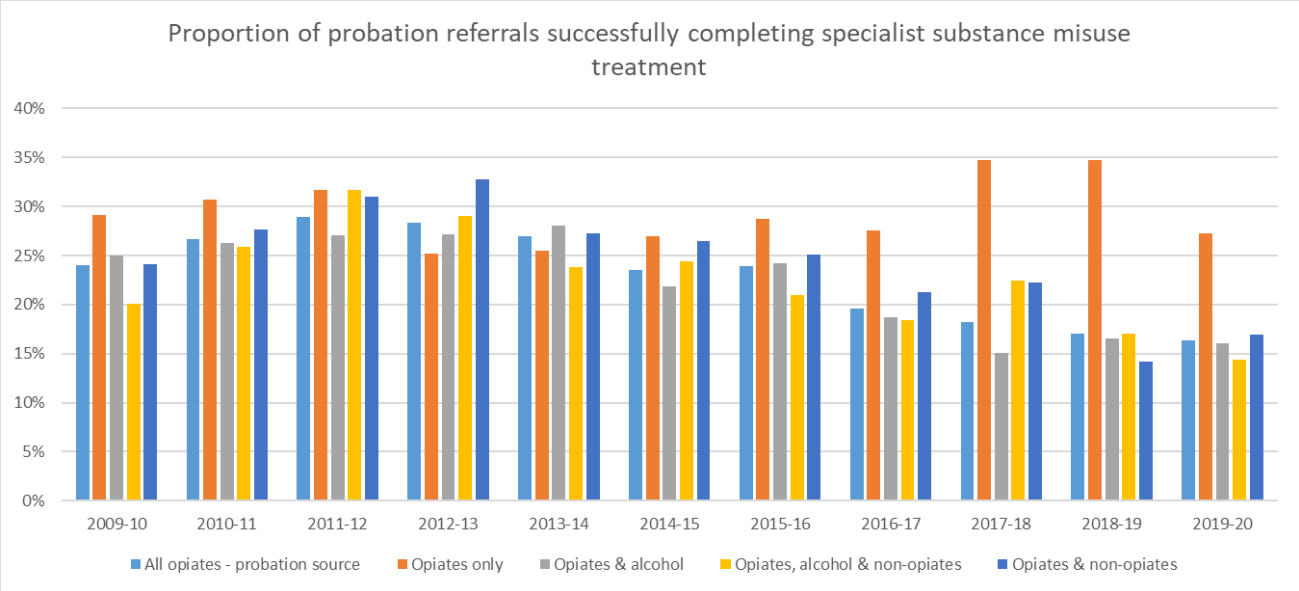


Figure 28: Proportion of probation referrals successfully completing specialist substance misuse treatment