

Justice Committee

Oral evidence: [Rehabilitation and resettlement: ending the cycle of reoffending](#), HC 469

Tuesday 10 June 2025

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[Watch the meeting](#)

Members present: Andy Slaughter (Chair); Josh Babarinde; Matt Bishop; Pam Cox; Linsey Farnsworth; Sir Ashley Fox; Warinder Juss; Tessa Munt; Sarah Russell.

Questions 241 - 297

Witnesses

[I](#): Kate Davies, Director of Health and Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England; Dr Russell Green, Medical Director for Health in Justice, Practice Plus Group.

[II](#): Dr Will Haydock, Executive Director of Policy and External Affairs, Collective Voice; Mike Trace, CEO, The Forward Trust.

Written evidence from witnesses:

Collective Voice [[RAR0067](#)]

Examination of witnesses

Witnesses: Kate Davies and Dr Russell Green.

Q241 **Chair:** Good afternoon, and welcome to this afternoon's session of the Justice Committee at which we will be continuing our inquiry into health and wellbeing services in prisons and the community as part of the rehabilitation inquiry. The first thing we have to deal with is declarations of interest. I will then ask our first panel of witnesses to introduce themselves and shortly we will suspend for a vote on the floor of the House of Commons. So can we do declarations of interest, starting with Sir Ashley Fox?

Sir Ashley Fox: Thank you. My interests are as declared on the register.

Linsey Farnsworth: I am the Member of Parliament for Amber Valley, formerly a solicitor in the Crown Prosecution Service and my interests are as declared on the register.

Chair: I am the Chair of the Committee. I am a non-practising barrister, a member of the GMB and Unite Trade Unions and a patron of two justice-related charities: Hammersmith and Fulham Law Centre and the Upper Room.

Josh Baberinde: I am the Member of Parliament for Eastbourne, and my interests are as declared on the register.

Tessa Munt: I am the Member of Parliament for Wells and Mendip Hills, and my interests are as declared. I am also a director of WhistleblowersUK, which is a not-for-profit organisation.

Matt Bishop: I am the Member of Parliament for Forest of Dean. My interests are as declared. I am a former police officer.

Warinder Juss: I am the Member of Parliament for Wolverhampton West. I am a solicitor but not practising at the moment. I am a member of the Central Executive Council of the GMB trade union and a member of various APPGs.

Pam Cox: I am the MP for Colchester, and my interests are declared on the register.

Mrs Russell: I am a solicitor although not currently practising. My interests are declared on the register. I am a member of various trade unions and chair of the all-party parliamentary group on family friendly and flexible work.

Q242 **Chair:** Thank you very much. Now, Dr Green and Ms Davies, would you like to introduce yourselves briefly?

Dr Green: I am the medical director for Practice Plus Group. I am also a consultant psychiatrist, and I have worked within prisons for around 12 years.



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Kate Davies: Good afternoon everybody. I am the national director for health and justice commissioning in NHS England, and I have portfolios for armed forces sexual assault and migration.

Chair: Thank you very much. The first questions, on commissioning, will come from Pam Cox.

Q243 **Pam Cox:** Thank you, and good afternoon. Could you explain to us how prison healthcare is commissioned?

Kate Davies: I will go first, as the SRO for health and justice commissioning. Since the Health and Social Care Act 2012, there has been the legislation and the requirement to commission equivalent healthcare services in adult prisons, immigration removal centres, and children's secure. That has enabled NHS England and the broader pathway of patients going in and out of adult prisons or police custody to be looked at as part of health inequalities, quality standards, as well as the requirements that are needed through commissioning.

The model over the last 10 or 12 years, which I have had the joy and very humble delight to have been part of leading for that period of time, has changed depending on changes in the NHS, which of course is very pertinent at the moment. We currently commission health and justice by seven regional commissioning teams. The budget is £1.22 billion. Healthcare within our adult estate, children's secure and ILCs is commissioned through those seven regions and worked as part of a direct commissioning requirement with our providers, clinicians and lived experience. I should say that since the Health and Social Care Act 2022, that has been continued as a direct commissioning area in order to support and maintain that level of prioritisation as part of the funding flows, particularly with things like prison expansion and the growth that we have wanted to particularly support in needs assessment of mental health, neurodiversity and substance misuse.

One of the things that has also been key in that commissioning element is working with a long-term plan, and obviously now the 10-year plan, to make quite sure that, with integrated care boards, we can support that whole flow of patient need in and out of custody. Our biggest area of development since 2019 has been actually commissioning more services as part of that pathway of care into custody and out of custody in the commissioning model.

Q244 **Pam Cox:** How much of the commissioning process is in the public realm, and how much of it is deemed commercially sensitive and therefore unable to be in the public realm?

Kate Davies: Like all NHS commissioning, there is an element that obviously should be in the public realm. Part of that is also part of the terms and conditions that we do for audited requirements and audited budgets when we are looking at finance. Actually, the best way to commission—we looked at this with a quite unique patient group that has



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people's assumptions and personal opinions on it—is by being really open and looking at the consultation, particularly with lived experience and families as part of clinical standards. The transparency and openness have helped those areas that have been more misunderstood or not seen as important as other areas, such as elective care or primary care. So there is an element that has to be transparent within the public realm, but there are obviously other elements that we work to within the standards and requirements within the NHS.

Q245 Pam Cox: So some of it is commercially sensitive and not in the public realm?

Kate Davie: Yes, some is commercially sensitive, or—as it is in this Committee—a declaration of interest is absolutely key.

Q246 Pam Cox: Thank you very much. Dr Green, could you give us an overview of how Practice Plus Group delivers as a healthcare provider in prisons?

Dr Green: Yes. We operate across around 60 prisons. There is a mixed model which affects how the services are commissioned. For most of those prisons we would be the prime provider and lead on the delivery of healthcare. It may be the case that we internally deliver all aspects of that; it could be that we deliver the primary care, mental health, and the substance misuse; or it may be that we have subcontracted partners that we work with, which could be an NHS trust or a charity. In other parts of the country, the commissioning is separated: primary care is one lot or contract and mental health is another. In that situation, it could be that we are delivering primary care and substance misuse and a separate entity—an NHS trust—is delivering the mental health. So that is how it is done from a commissioning point of view.

From a practical point of view, my passion for working in prisons is because it is unique. We deliver the whole range of healthcare, so it is a really great opportunity to work together with all those partners. One of my big frustrations working in the community is getting hold of the GP, or the substance misuse workers. The way it is commissioned and the environment allow whoever is providing it to deliver the care in an integrated way.

Q247 Pam Cox: Do you set your own KPIs for service level agreements or are they set externally?

Dr Green: They are managed by NHS England. We have we have regular monitoring meetings with NHS England in order to do that.

Kate Davies: There are national service specifications that are set as part of national standards. We have 19 different national service specifications, from primary care to substance abuse, mental health, pre and postnatal and the work we do with public health and what that means to do with physical health care and that whole flow. Obviously, the



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national clinical standards are really important, regardless of who the provider is, as part of those NHS requirements and contracts.

As Dr Russell has said, we have 10 lead providers across our 114 adult prisons. In substance misuse terms, because I know that is something that this evidence session is very keen to look at, there are 17 different providers working across those prisons. It is not necessarily about the number; what we want is quality and consistency around those service specifications. Our biggest challenge is working under a national partnership agreement with the MOJ and HMPPS, the Department of Health and Social Care and UK HSA, and working within the culture and the requirements of the particular prison system. I have worked in and out of substance misuse, criminal justice or health for 40 years, and I do not think I have ever worked in a time that is so pressured and difficult as part of the enablement within the prison environment, particularly for health and wellbeing services.

Q248 Pam Cox: So you are using KPIs to measure effectiveness. If we home in on drug treatments and the effectiveness of your work in that sphere, how would you comment on that?

Dr Green: There are, I suppose, two kinds of measures. One is an activity measure: are we seeing people, are we engaging people in the various treatments that we would want to? From a clinical point of view, measuring the outcomes for people's lives is quite challenging, because what we want to see is people stabilised in our prison settings and engaged with the various treatments, then moving out of prison to live either drug-free lives or lives that have supportive medication and various things. I am not aware of long-term measures that do that. From memory, most of the KPIs are more around the engagement with the services and those kind of things and making sure that we transition people into services in the community.

Q249 Pam Cox: Is that engagement good, bad or indifferent?

Dr Green: Generally, good. As Ms Davies said, one of the biggest challenges we face is as simple as finding space and opportunity to get people to psychosocial groups or other things. It is a real challenge in prisons at the moment. Across healthcare, not just in substance misuse, we have people, in effect, having to deliver healthcare in corridors or people having to find a room akin to a cupboard with a broken chair. It is not everywhere, but it is unbelievably challenging simply logistically to do that, and obviously the prisons are under pressure, so things get cancelled. We try to prioritise that as we can, but I would agree that, again less experience, over the last decade it is harder to deliver the care, and it is really frustrating, because sometimes we have stuff that we could do but you literally cannot find a room or offices to support it.

Q250 Chair: I have a few questions about substance misuse services and mental health services. What impact does having a high proportion of prisoners with identified drug needs have on the ability to provide drug



treatment services and access recovery support effectively? What steps are being taken to address this? I am thinking about things like overdoses, the effect on staff of having to deal with prisoners in crisis, as against being able to pursue drug treatment programmes.

Dr Green: The issue you raise is really important. The impact we have seen of new substances coming into prison has definitely increased the number of overdoses we have to work with. It obviously has an impact on the person who that happens to, but again at a practical level, it knocks off the whole of the healthcare delivery. That person now cannot access the group they were going to, and there is the wider healthcare impact, where staff attending that means the same person who has the drug problem is not getting their diabetic care and things like that. The planned care tends to get knocked off by these emergencies. You can have two happening at the same time or multiple times during a day. So acute episodes definitely make it harder to deliver the planned care.

At a systems level, people being intoxicated and having overdoses significantly limits their ability to engage with those processes as well. We have gradually seen that get worse; the nature of the substances and their availability have made that increasingly difficult. It impacts substance misuse services and the whole of mental healthcare, because dealing with mental health crises as a consequence of that substance misuse is, again, a real problem in the services.

Kate Davies: As you were saying, there is an issue about the reality of delivering healthcare services and substance misuse services in an adult prison where the needs assessment can absolutely evidence that anything from 40% to 80% of the men and women within an establishment have a history of substance misuse and mental health issues, or have been introduced to it because of their stay in prison, sadly.

We have really strong evidence through our prison pressure reporting requirement—the KPIs and the enablement factor—that 40% of our establishments find it difficult at the moment to have regular appointments and see people in the way that they would like to, because of the churn and the amount of code blues, or some of the practical issues within the environment.

Having said that, I know that the following panel represents a number of the services around substance misuse and of course many more from mental health and physical healthcare, and it is important to say that we have amazing staff and services working in very difficult times in very different environments where their priorities are to run services seven days a week for mental health and substance misuse and for whoever comes through the door, which is why we commission them in the way that we do. People are assessed on the first day and then there is a requirement in the KPIs to reassess on the seventh day. That is the window of opportunity to actually look at where there may be issues around risk, health, suicide, overdose, and long-term conditions. We need



more time and more infrastructure for that element in a changing environment, and it is why we are very keen to support our providers and our lived experience men and women to really be part of codesigning and producing that as we go forward.

I am very pleased be able to tell the Committee that we have reconfigured some funding, as part of the Dame Carol Black review, and there will be an additional £7 million from existing funds targeted just at your question, Chair, so around how we ensure that things such as long-acting buprenorphine are rolled out across the whole estate, and how we can get more impact on peer support, which we see as giving real added value and so do service users and particularly our charitable sector. As Dr Russell said, how do we get more targeted on synthetic opioids and cannabinoids, which is a horrible game changer within the prison environment at the moment? We're also looking to what that really means about more integrated work, with things like integrated drug-free living wings and the rest of the healthcare environment, because we have to deal with all those issues.

Chair: Thank you very much. I have a few more questions, but the bell is ringing and distracting us. I will suspend the Committee for 15 minutes.

Sitting suspended for a Division in the House.

On resuming--

Q251 **Chair:** After the vote of the Commons, we resume this afternoon's session of the Justice Committee. I was asking some questions to our first panel of witnesses, which I will continue with. We have heard a bit about the incentivised substance-free living units, and indeed we visited one or two of them. They are a good idea in principle, but they often do not work as intended, do not necessarily have the resources they want and may not be drug-free. How is NHS England working with prison governors to ensure these wings are effective and meet their objectives?

Kate Davies: One of the areas that is absolutely a priority for any substance misuse service within prisons is to maintain a full level of ambition on recovery, particularly around drug-free lifestyles. Lots of evidence over the years demonstrates that independent drug-free living wings—under previous Governments, this initiative was called drug recovery wings—to support the reality of prison, which is that unfortunately getting drugs into a prison is a global industry. These wings are a really essential requirement to support psychosocial interventions and this model of recovery. It is really important that it is done as part of a full requirement of services, such opiate substitute prescribing and long-acting buprenorphine, and harm reduction, because many men and women, unfortunately, do not necessarily come in with that ability to move straight into an independent drug-free living wing.

We have seen the growth of independent drug-free living wings in the last two years. That is a really good development. I have worked very



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closely with our partners in the prison service, the MOJ, the Department of Health and Social Care, and particularly our service providers to broker that development. The issue is that it is an element that is commissioned in service through offender services, and ultimately we are all here to support reduction of reoffending. That is one of our biggest goals, as well as keeping people alive and well. That is where independent drug-free living wings are really important.

I have been in and out of a lot of prisons all my life, and recently I have seen these wings working really well in some establishments. Then I've seen them fade a little because the pressure of a prison will mean that that environment, which is quite precious, looking after maybe between 40 and 100 inmates, is then seen as a prioritisation for another part of the need in the prison. I know that has certainly happened in a couple of places over the last couple of years. I have also seen them where they have grown. I was in HMP New Hall only two weeks ago where within that women's establishment, I saw a really good development of the independent drug-free lifestyles and the integration with physical healthcare and other elements.

Back to what I was just saying before the break, Chair, what we need to do is target more integrated work between generic healthcare needs and wellbeing and independent or recovery wings. HMP Hull is a very chaotic reception prison mainly. It has a very good recovery wing. CGL, one of our biggest charitable providers, along with The Forward Trust and many others, does great work in bringing that element into the prison, which then actually changes the culture around recovery, drug-free lifestyles and people having that ambition. They may not always hit it, but they need to have it.

We also need to make quite sure that we look after people who are very chaotic when they first come in—they are maybe using a concoction of drugs and are very poorly—to get them stable. Those elements and balance are what we all aspire to.

Thank you for the question. I agree that the growth is important, but the culture of actually maintaining that provision is something that we are still struggling to deliver in some areas. I am sure Dr Russell, as one of our providers, will say more about what is on the ground.

Dr Green: You mentioned the challenges that these units face. When they work well, they are a great part of the spectrum of interventions that we can offer people. The reality is, unless everyone within that prison buys into it—that is, health in its widest sense—and the prison sees the value, as Ms Davies said, my experience is you see this drift. Everyone starts with great ambition, but because it is in the operational capacity of the prison, the moment someone says, "Oh, we're going to have to move this person who isn't really appropriate, but we just need to move them," it breaks that wall. It happens once, then there is a crisis at the weekend and some people move and very quickly—



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Q252 **Chair:** Does that happen a lot? That is really a breach of the whole principle, is it not?

Dr Green: Sadly, it is a consistent thing we see across this kind of unit, the drug-free living; we sometimes see it with our in-patient health units. The pressures on the prison are just so great, and these beds are within the operational capacity of the prison. I understand the pressure they are under, but yes, you are right, it breaks what the ethos is. Once that is lost, it is quite hard to get it back. To echo what was said, where that is done and we can protect them, they can be really effective as part of a whole-system offer to people. There is no magic bullet of one thing that solves everything, but they can certainly be very helpful.

Q253 **Chair:** I have a couple of questions on mental health services. When 48% of men and 70% of women in prison have a mental health difficulty, are there the services available to support such a large cohort? Are people with severe mental health needs able to access the right support in prisons, or should some, in fact, be in secure hospitals?

Kate Davies: Some of our biggest feedback from our service users, prisoners and governors is that people want and need to access more mental health support. People's mental health often deteriorates when they are in prison, so it is really important. By mental health, we mean both primary mental health services and secondary mental health services, and as you say, acute support for anxiety to depression and psychosis. The initial element is to make quite sure that we have service specifications and KPIs that make sure that all our services are doing that initial assessment of people's risk and people's need.

Sometimes, the first time people talk about their mental health it with the prison healthcare services. It might be related to bereavement, or sexual abuse, or other elements of trauma within their lives. Ultimately, the other element of what we would like to see more of is that trauma-informed way of working across all establishments in order for mental health to be prioritised.

We have commissioned a very good offender personality programme for the more acute and higher-risk offenders. As part of the need assessment in mental health, we have been trying to fill the gap between early indications of mental health and indications of depression and anxiety, not so much necessarily the pipelines around more acute, but where people become more unwell and where that mental health assessment—either at court and they are then remanded, or when they are in custody—establishes more needs that may well be better supported by the appropriate medication or the appropriate interventions around mental health needs or requirements.

To the last part of your question, one of our biggest challenges is that we developed a policy just before covid—everything is just before or after covid—on establishing new targets of 28 days for people's mental health assessment, to get them in the right place at the right time. That could



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mean either a low, medium, or high secure placement in order to either stabilise or to serve much more of their sentence, or even their remand, in that time. I am disappointed to say that we do not meet that target with every single person we assess and support and what that means for continuity of care when people are released, but it is one of our biggest priorities, and we are now up to an average of anything between 47% and 63% of hitting that target on getting people in the right place at the right time.

It is an element where there are lots of sections that have to come together, and particularly for our forensic or our colleagues in lower, medium and high secure, men and women who are in prison are not always the priority. I really welcome the new Mental Health Bill that is going through Parliament at the moment, which has a particular recommendation on prison not being used as a place of safety. It is absolutely crucial, alongside the independent sentencing review, that this is an area where we get people in the right place at the right time as early as possible as part of their earlier stages in remand.

Q254 Chair: Did you want to add anything, Dr Green? I noted that you said to a predecessor Committee of ours in a previous inquiry that prison itself could be a cause of developing mental health difficulties. I do not know whether you have changed your mind on that. Do you think the situation is better or worse?

Dr Green: The reality is that the risk factors for ending up in prison are very similar to the risk factors for having poor mental health. The reality, and my experience, is that almost everyone who comes into prison has a degree of need for help with their mental health. Separating the population in prison into the mentally well and the mentally unwell is probably unhelpful. Most people who come into prison would benefit from some input, even if that is fairly low level or about building up their resilience.

From my point of view, what we need is a system that can offer psychological support and mental health to everyone, then in effect we increase the intervention people need as the severity gets worse. I have worked in the community with the NHS and in prisons, and I would say in many ways that the mental health services in prison are more responsive. You see a mental health professional within 24 to 48 hours if it is urgent, and five days if it is more routine. Actually, the access to mental health in many ways is better, but the demand is so high.

Of course we could always have more resource, but addressing people's mental health is much wider than having more psychiatrists and nurses. I suppose this is my point. The environment of the prison matters. Some of the best therapeutic results I have had were from engaging someone in work in prison or managing to get them well enough to engage in education. With both mental health and substance misuse, while as a professional I believe it is really important we do what we do, there are much wider things—same as in all our lives—that support us in living



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better. We need to approach the people who end up in prison in that widest sense, in supporting their psychological wellbeing.

Importantly, from the point of view of people who are acutely unwell, it is not okay that people are waiting 28 days to access treatment for psychosis. We know the longer you leave someone untreated, the harder it is to get them better, and the outcomes are worse. It is one of the areas where there is the biggest inequity between someone in prison and someone in the community. A person with the same level of illness in the community would be accessing a bed—sadly, perhaps detained under the Mental Health Act 1983—in a matter of hours or a day; in prison, that routinely takes a number of weeks, and sadly sometimes months. That is terrible for the person, and it puts the healthcare and the prison under real pressure. I have always been impressed by how the prison has worked with people in this situation, but a lot of resource has to go to try to support that person when everyone—all the professionals involved—recognise they need a medium or high secure bed and all the resources that go with that. That is certainly an area I would hope we could improve on in the future.

Q255 Warinder Juss: Can I just ask a quick question about substance misuse services? I visited Featherstone prison near Wolverhampton, and I was quite pleased to see that there a group of prisoners who at one point had been addicted to drugs but had been able to make a recovery, and they were helping other prisoners to make that recovery. Is that kind of model prevalent in other prisons and how effective do you see it?

Dr Green: Peer support is crucial. In the nicest possible way, someone will look at me and say, “What do you know about it, Dr Green?” Having people who have walked that path and actually changed things is crucial. It is what every service does or wants to do. It can be more challenging in, say, remand prisons where people are moving around, and sometimes there are challenges in employing people who have previously been in prison, but I am sure anyone you speak to in substance misuse services will say peer involvement is crucial to the delivery of those services.

Kate Davies: This is actually one area where we do this well. It is about having peer support and lived experience as part of how we design and support those services and change them. We get a lot of challenges, quite rightly. I was with a group of women in a prison last week who were quite rightly giving me very good advice about what that meant in mental health terms, particularly around women’s hub services that we are also commissioning in every women’s establishment.

Our liaison and diversion services in court and police custody have a requirement within their service level agreement to have so many men and women who are part of peer support employment and volunteering. Our prison leaver service RECONNECT, which is one of our newest services, is designed on a peer support as well as a clinical model. That is because of the evidence that shows us that that is absolutely essential going forward.



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Q256 Tessa Munt: My question is to you, Kate. Bearing in mind what we have just heard from your colleague, in your written evidence you said that services are commissioned by the principle of equivalence. Does this happen in practice?

Kate Davies: Well, the principle of equivalence was in the legislation that came down from the Andrew Lansley review, and I welcome that as part of the prioritisation of the pathway of patients within the criminal justice system. Is it happening in practice? Ultimately, in some areas, probably more so in the way that we are looking at things like hepatitis and BBVs. People may have a cancer diagnosis for the first time in a prison, because cervical screening or bowel scope screening, where maybe they have not accessed it before because of their lifestyles.

Where we are up against challenges—I know other colleagues and I have been in these Committees before when this question has been asked—is a matter of equity rather than equivalence. If we have a higher level of people with substance misuse, mental health, or poor physical health, how do we get to that equivalence point? We have a different starting point to get to equivalence. It is a very laudable and very appropriate element for us all to drive to, and to very clearly say that these are patients who require those healthcare services—that is part of the legislation going forward in changes within the NHS—but the previous question is a really good example of how we still have elements of need around substance misuse, mental health, and poor healthcare of physical health in which we are having to start, where equivalence is a different place.

At the moment, we are seeing a rise in natural cause deaths within our prisons—in other words, people who have died of strokes, pneumonia, or a reason in the community. The mortality rate is also a lot higher for people in prisons; they die a lot younger. There are elements of equivalence that are always going to be a challenge because people are quite poorly when you start with some pathways of care.

Q257 Tessa Munt: Is the take-up of the screening that you are doing good?

Kate Davies: Our take-up of screening has been very good, but it dropped off a little as part of covid, which it did in the community as well. We are driving very hard at the moment to improve things like the flu jab uptake, bowel scope screening, and particularly AAA, BBVs and HIV. I am very proud to say that the hep C programme and the treatment programme started with the prison patient group, and particularly the drug and alcohol patient group.

We often hear that we can get to people because we have them in an environment. Part of the early screening is to ask those questions very clearly. When was the last time you had a cervical screening? What does that mean around contraception? What does that mean around bowel scope? But we have to do bowel scope screening in a very different way from the community. We cannot have something that comes through the



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letterbox. We have to look at different systems and different elements to do that.

I also need to be very clear that we have such high levels of churn of people coming in late at night that it is actually quite difficult sometimes to do that level of screening at the time we would like to. We have to go backwards a few days later.

Q258 Linsey Farnsworth: Obviously, you are talking about screening and opportunities for good practice in screening, but can I ask about when somebody needs treatment outside the prison estate? We were informed of a lady who was supposed to be going into hospital for an investigation for cancer, and she was not able to go. First, the preparation medication that she needed to take in advance of that appointment was not available to her in prison. Secondly, on the day, she was not able to be taken for that screening test in hospital because there were no staff. Is lack of staffing resource something that you recognise as an inhibitor to those sorts of treatments and appointments that need to take place off the prison estate, and if so, what can be done to mitigate that?

Kate Davies: It is a really key question. One of the issues of the partnership agreement with the Prison Service and the Ministry of Justice is around escorts and bed watches and making quite sure that—as I often say to my providers and clinicians—the clinical assessment of someone's health and risk trumps a regime decision on whether there are members of staff to escort that person. If someone is very poorly, high risk, has broken a bone, or has a cancer diagnosis, it is really important that they hit the same waiting targets of assessment in cancer as someone in the community. That goes back to the equivalence question.

Ultimately, we are finding it more difficult to get the numbers of people who may need to be escorted to a specialist appointment. It could be a planned appointment, or it could be a high-risk appointment because of somebody falling down some stairs and breaking a bone, for example. We have a daily negotiation with our providers and our partners in the prison system on how we have so many people who are escorted out to an acute trust or to a planned appointment.

What we try to do is make quite sure that we do as much in the prison as we can. That is why it is a whole healthcare need and requirement. Technology and information in this age are really important to do that, but ultimately there are times where an acute trust or a hospital specialised department is the only choice. That negotiation prison by prison is something that our healthcare providers probably spend most of their time doing. The expense of it is something that we pay—as in, the NHS also pays—to the Prison Service in order to get the time of our prison staff, who quite rightly have to escort somebody as part of health and security.

Q259 Tessa Munt: Do you hold the data, or does somebody hold the data? Who holds the data relating to the occasions on which a prisoner is



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unable to access healthcare services and the reasons for that? There is another part to that which I would like to understand: how often do prisoners ask for a second opinion and how often is that available to them? I mean completely separate, not going from one doctor to another within the prison, but actually getting a proper second opinion. How often do they access a consultant, as opposed to a doctor, or a nurse, or a healthcare assistant? How far does that go?

Kate Davies: I will let my medical colleague help with that answer. If I just talk about the data element, all our providers have a requirement to fill out not only KPIs, but an electronic patient digital system. I am very pleased to say that we have commissioned this in the last eight years as part of equivalence of electronic patient records and requirements for patients within the NHS. Within that also are things like DNA—did not attend—rates and then ultimately the reasons why not. We find a much too high level of DNA rates, maybe to do with churn, or lockdown in a prison, or other appointments or priorities.

Q260 **Tessa Munt:** Is that record shared with the prisoner?

Kate Davies: Yes. We know in the last year, for example, we had 160,000 individual appointments that were on the DNA element for various different reasons. We have 84,000 prisoners at any one time—more than that: in the prison system it is about 87,000 at the moment. These are individual appointments for people being seen on a daily basis as well as a weekly basis, not necessarily numbers of people.

It is really important to say that in the same way that our prison colleagues are as exercised as I am in getting that improvement on escorts, this is an element that is probably one of our biggest risk areas at the moment. This then leads you on to a second question. Of course, all patients should be required to have that as part of their need and requirement. Do all patients get that when we are also wanting to support the initial assessment? I hope so, but the initial assessment is absolutely key.

Dr Green: There are a number of challenges in people accessing appointments. For the external ones, we try to work really closely with the prisons. They usually can facilitate a certain number a day, just because of their staffing. This comes back to the original point, but ideally, if something acute happens, for example, someone taking an overdose, ambulances arrive which uses up some of that resource. We will try to work with prisons so that there is clinical input into the decision-making about who goes, so we can say, "No, that appointment is more important than this appointment." It works better and worse in different prisons, but it happens.

There are also problems with facilitating appointments within the prison. That could be seeing the GP, seeing myself as a consultant psychiatrist. Again, sometimes the did not attends are actually people not able to



access the appointment because the prison has not been able to facilitate that.

Regarding people accessing second opinions, many of those specialist appointments will be external with an NHS trusts so they would access it through that. We certainly have people who disagree with what the doctors say. If I am open, they are usually disagreements around pain medication or mental health medication. Understandably, people feel that medication is really important for them, but it may be that the doctor says, "Well actually, combining something like pregabalin with your methadone is not safe and not recommended." It is actually quite rare that we reach the point of breakdown; we try to negotiate with people to help them understand. If I am honest, that is often around pain medication, and helping people understand that opiate pain relief is not helpful in the long term. That is probably the commonest area that happens.

We have had people access second opinions. It is very tricky to facilitate. It is not that we do not want to do it. As you say, we sometimes ask a doctor from another site to come and do that, but I appreciate that does not always feel independent for the person. It is difficult to get a totally separate view, but it has happened.

Q261 Tessa Munt: I would be quite interested if there is some data available. I have had experience of, in both cases, young people who died in their mid-20s. One young man had done a huge amount of research with the help of his prison officers, and he told them what he had, and he was right, but he could not get to a doctor or a consultant, and he could not access the appropriate equipment that would have perhaps helped him live a little longer.

Dr Green: Just to your point about accessing doctors. There are GP doctors—

Tessa Munt: I am talking about a consultant, in reality.

Dr Green: Okay, so that would be external, yes.

Tessa Munt: There was a prison doctor, sure enough, but he could not get what he knew he needed. He was a very bright young man. It did not do him any good being bright because he just could not get the healthcare he needed. That is something that makes me burn because it was a waste of a life. I would be interested if you were able to share with the Chair what data you have and what your providers have. That would be helpful, thank you.

My last question really is about promoting rehabilitation. That is stipulated in national service specifications for healthcare. Is this happening in practice?

Kate Davies: One of the things that is absolutely core about any good health and wellbeing service, whether it is in the community or in prisons,



is if you get good health and what one of my public health colleagues called, “community dividend” around people’s rehabilitation, then you are going to get better outcomes around offending behaviour. Of course, we have all levels of men and women locked up in our adult prisons and our children and young people’s prisons. Quite rightly, some very dangerous, high-risk offenders ultimately will always need to be serving a prison sentence—our fastest-growing element is older prisoners and sex offenders—but there is never a point for whoever we are working with that it is not about the rehabilitation of their offending health, but also their health and wellbeing.

We are not the Probation Service. It is about how we do more in partnership. At the moment, I think we have too many people on short sentences and long-term remands, which means that we are silting up a little our ability to do more focused and timely work that takes time. One of my lived experience leads was quite rightly telling me in my clinical group only yesterday that it is about time. We get the waiting times: five and a half days for mental health and substance misuse, 84,000 people seen last year. But ultimately, for rehabilitation it is also about that time and that personal pathway, which I am massively passionate about, hence why I continue to want to lead this area of work around health inequalities for all people.

Ultimately, it is also about risk management and reducing the risk to society at large. That is the other reason why health and wellbeing services and rehabilitation are essential because it actually is a community dividend to civil society as well.

Dr Green: As I said, I started working in prisons around 12 years ago. The determination and enthusiasm of the health teams and the prison teams under really difficult circumstances to try to do their best to offer rehabilitation has always impressed me. Sometimes that is limited by the environments and the pressures that are on them.

Medicine in its widest sense is about helping people to live lives that are meaningful for them. That is more complex in a prison, but actually the one opportunity we have in a prison is everyone is together: the substance misuse team, the mental health team, the primary care team, and the education team. We can actually bring all that together to offer a set of support that is impossible to do in the community. Really good rehabilitation happens, but a bit like the situation with the specialist units, as the system comes under more pressure, the reality is it becomes more about containment. That makes it harder to deliver healthcare, and everything just gets harder to do.

It is really difficult to separate out either one component of health or the whole system. We are a community in the prison, working together to do that rehabilitation. You cannot have one bit that does a brilliant job and carries the rest. Going around different prisons, when it works well, it works well together in that holistic sense. If you support people’s pain



management, they have less desire to use substances; the substance misuse team can work with them, therefore they can access education and because they are not using substances; and family members can come and visit them. It is about trying to move that spiral that has landed them where they are back up, and there are always different parts to that. There is some amazing work that goes on.

Q262 **Tessa Munt:** How do you embed that in your service?

Dr Green: It is culture, if I am honest. There are the structures we have, but it is having that culture within the prison and our healthcare to recognise that actually you make those small differences. Yes, maybe you have seen the person you are seeing five times before because they keep coming out, but actually let's start again and try again. It is about having that culture of hope that you can change and you keep trying to do it even in the difficult circumstances.

Obviously, the structures and systems help, but it is about having a holistic approach where we work together. It is not about health doing one thing, the prison doing another thing, and probation doing another. It needs all that to come together. The reality is that when someone reaches prison, there is a whole story behind that, and it is rarely a good story. Part of the opportunity we have in prison is a bit of time and space to try to help people change. We are often having to work with people who, although it does not excuse why they are there, have experienced trauma, and disadvantages. We cannot turn all that around in a short period of time, but we can start that process.

Kate Davies: Continuity of care is absolutely a priority for the future, because quite often we get the feedback, "For the first time I'm on more stable medication," or, "For the first time I've got the motivation around psychosocial drug recovery," or, "Yes I have had a hep C diagnosis or even a cancer diagnosis, but I now know what that means." It is the same for mental health. Continuity of care is absolutely a priority because most of the 200,000 people who are in our adult establishments will be leaving prison at some point in time.

Chair: We are just about to go on to that topic.

Kate Davies: I will stop then, Chair.

Q263 **Mrs Russell:** You mentioned missed appointments and the number of did not attend appointments. Do you have reliable figures for how many appointments are being missed internally, how many appointments are missed externally, and how many people are potentially dying avoidably as a result of not getting timely referrals to external providers? That is my first question. My second question is about contraceptive availability within prison, particularly on release. What work happens around that, and what percentage of prisoners will be released with a contraceptive?

Kate Davies: I will go backwards, if you like, on the question. Thank you very much for the question on contraception. We commissioned a major



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review of women's healthcare within the criminal justice system, and particularly within adult prisons, about six years ago, which enabled the voice of 2,500 women who have either served or been in the criminal justice system to be absolutely the core of what those recommendations were. That was done in partnership with the Prison Service and with an independent chair. Ultimately, what has been missing has been how the Prison Service has developed its services that are to do with gender, and I say that for men as I do for women.

Q264 Mrs Russell: It was deliberately a gender-neutral question because actually men have as much responsibility for contraception and need to leave prison with it.

Kate Davies: Yes, absolutely. Ultimately, as we know, in a lot of society women and contraception is the predominant view. That is certainly what we were hearing from our women. That is where I was going with that particular feedback and why we have developed the women's hubs in our women's establishments. We have actually done that in partnership and with advice from Dame Lesley Regan, who is the women's health ambassador. She also came into a couple of women's prisons with us to focus on women's health issues, not only contraception but menopause, endometriosis, miscarriage and everything else. We have had some very sad cases where that has been very acutely appropriate for us to focus on.

As part of men's health, that is something that we require all our service providers to do as part of men's contraception for them as people who have either been part of conceiving children or maybe trying to conceive children and not being able to do that.

The whole health element to do with health and sexual health is part of the public health legal requirement for equivalence. On where we have been going and where we want to do more of that, I am very pleased to say that because of the women's review that was published two years ago, we now have targeted reviews in the service specifications within the healthcare elements and with our providers around women's services. I have seen some amazing leadership in women's prisons from governors and healthcare providers who are the reason why the culture changes and things become a real benefit.

I do not want to repeat myself, but I am very happy for us to go back and provide that information, particularly on some DNAs and some inputs around escorts and missed appointments, either externally or internally. I want to emphasise that a lot of the men and women who are coming with poor healthcare conditions—very sadly, that also may well mean early deaths or fatality—are in that condition because of poor experiences in the community. They are often coming in with no diagnosis, or not even access to a GP. We are trying to make quite sure that that is one of the outcomes of missed appointments, or elements of bringing people into the health service as a whole. Again, with continuity of care, the electronic prescribing we are now rolling out and the GP-to-GP element,



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we are trying to not have that as an ongoing cycle of missed appointments. That has to be a priority to get that right going forward.

Q265 Josh Babarinde: I would love to pick up on the points around continuity of care and in particular to explore some of the role of the RECONNECT service. For those in the Public Gallery or on the Committee who are less familiar, the RECONNECT service works with those in prison with an identified health need for up to 12 weeks before they are due to be released and as long as six months after release to help them transition into community-based services. We know that proper access to health services, especially if you have an identified health need, can support desistance from crime. Do you have data that can help us to ascertain what impact the RECONNECT service is having on reducing reoffending rates?

Kate Davies: RECONNECT has been rolled out over the last two years. It has been rolled out in 98% of adult prisons in the last year. We still have some London prisons in the male estate that are developing further. We have the RECONNECT service as a prison leaver service because, quite rightly, Justice Committees like this, lived experience and clinicians, served us a challenge a few years ago saying, "You're spending a lot of appropriate funding on healthcare elements, mental health, physical health, GPs and substance misuse, but it's the connection on release that we need to see more of." We did a lot of work on modelling what that could look like, particularly with lived experience and clinicians, and then through the long-term plan got a £20 million service programme that was then commissioned by the NHS to deliver the RECONNECT programme.

Its ethos is always around that 12 figure. It has a requirement to see people before they leave, and it has a requirement to follow up with people after they have left; it may well be about 12 hours, 12 days, 12 weeks, 12 months but it is that opportunity to tie people's health and wellbeing services and needs together as part of a pathway of support. That is where the peer model was particularly part of that service specification. Again, there are many different service providers that are now commissioning that, both in the charitable sector and in NHS trusts.

The reduction of reoffending statistics that we have are not as strong, because we have been focusing very much on the statistics that show that people then access continuity of healthcare in primary care, mental health, physical health, and substance misuse. Those are our key areas. Combined, we see around an 82% success rate on continuation once people leave prison.

People have lots of things on their mind when they walk out of the gate. Where do I get my benefits? Do I see my mum? Is my dog all right? Unfortunately, sometimes with substance misuse, where is my next hit? What we are trying to do with the RECONNECT programme is gather people into a culture of recovery and rehabilitation as part of the RECONNECT service. I know I have talked to a lot of my providers, and we have not been in a prison where a governor or a director has not said



it has been a game-changer, but it is about working with the probation service; we are not the probation service. With the new independent sentencing review, it is an opportunity to extend further and do more work on the reduction of reoffending.

Q266 Josh Babarinde: You used the word opportunity a couple of times to refer to one of the assets that the RECONNECT programme affords offenders when it comes to managing their health, particularly drug and alcohol challenges. I am struck by that because this Committee has spoken a lot about the SDS40 early release scheme as an example, where we saw 3,000 people across two tranches released early overnight. The opportunity to engage with a 12-week pre-release programme was therefore basically pulled from underneath their feet. We know from His Majesty's Prison and Probation Service that 30% to 50% of those who were eligible for the SDS40 early release scheme had drug and/or alcohol needs. It would be good to understand from you what impact you feel that scheme, and indeed prior schemes, but this scheme in particular, had on engagement with the RECONNECT service and prior similar early release schemes.

Kate Davies: Those are great questions and ones I am professionally passionate about. Ultimately, some quotes about RECONNECT being the game-changer have come from SDS40 because that was the element that really was used massively within SDS40. Where SDS40 was not as mature or rolled out, there was a gap. We could evidence that within the SDS40 element. SDS40, obviously, is released at 40% with the new statutory requirements brought in by the Government. What NHS England did was actually run SDS40 in the two tranches as an official incident management requirement. I am going to look at Hansard and see that I used the word opportunity an awful lot, but it gave us a real opportunity to look at how we then work with our GPs, mental health services, nursing staff and our safeguarding requirements in the community to remind people and look at how that was being rolled out as part of those two tranches on release.

We were still talking to people within the broader NHS and recovery services who did not even realise that people were being released from prison every day of the week, let alone SDS40. It was a really good way of giving our GPs a lot of seminars and webinars, particularly around electronic patient systems. We are still doing that now, as to part of your question. The new recall legislation, as well as what that means for home curfew orders, means that this week alone 600 people are being released because of new elements and requirements. It is no good if those people are released without a package of offender management care and healthcare.

We would really welcome through the RECONNECT programme and the peer support work we are doing, particularly around the announcement on additional prioritisation of substance misuse funding, being able to build on that model. We are seeing some really good feedback from



service users and a lot of people who are moving into employment within the RECONNECT service. We did not think it would be this successful, but it has been. It also has a women's pathway. We have looked at what that means for black and minority men and women and different ages, particularly 18 to 25. Thank you to the providers and some community partners and charities that have really put a lot of evidence around it very quickly.

We also have enhanced RECONNECT, which is for high-risk offenders, so there are lower numbers. In some very sad cases it has gone wrong, going back to your colleague next to you, where unfortunately because of their release planning people's offending behaviour has had very difficult consequences. In respect of counter-terrorism, sex offenders, people who are released with higher tariff offences, that is also a pathfinder to look at how we do that better.

Dr Green: To come on to the SDS40, although it was somewhat frightening when we discovered it, as Ms Davies said, it shows that when you focus on release planning—because we had to and we knew it was that—and you put the resource there, you can actually plan this stuff. Ironically, I heard from some prisoners that in some ways the release planning was smoother because we had the focus and we moved resource to do it in a way that does not always happen when sudden releases are happening.

I definitely echo that an area we need to focus on which can give really good outcomes for people is that transition through the gate into the community and working with people to understand what healthcare in the community is. Their experience in prison will be quite different, and the challenges they will face in accessing healthcare in the community perhaps more so. The RECONNECT service definitely provides for that.

Q267 **Warinder Juss:** You have said that you are not the probation service, but we have heard evidence in the past, for example from His Majesty's chief inspector of prisons, that those prisoners who have access to healthcare in prison but do not have that same access to healthcare out of prison are more likely to reoffend. There is also a bit of a postcode lottery in terms of how much access they can get to healthcare services after being released from prison. Are you aware of that pattern, and is NHS England doing anything to mitigate that?

Kate Davies: The whole RECONNECT programme was commissioned exactly for that impact and purpose. It is from the public purse. We are obviously spending public funds both in reoffending terms and in health terms. We need to maintain that level of impact and positive elements.

I have the responsibility and the accountability with NHS England to commission armed forces healthcare. One of the things that is often compared is that parity with how veterans and people leaving the armed forces adjust as civilians to how to use the health service. My comparison is how people learn to use their NHS services and have confidence as an



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offender to access those services—drug and alcohol services, mental health services and their GP particularly. Those are the elements where we will get the most outcomes from the work that we are doing collectively and with the probation service; we work very closely with our colleagues.

Ultimately, everybody is trepidatious. I am quite an experienced woman in this world, but I am still trepidatious when it comes to my own personal healthcare with a GP or whatever. It is about giving people the peer support to access that at a time where there may be lots of other life priorities. I agree with Charlie Taylor that it is one of those things that is absolutely essential, but we particularly should target substance misuse services, physical healthcare conditions that are diagnosed in prison, mental health services and neurodiversity services. We also hit those barriers that we sometimes hit within community facilities and community capacity.

Dr Green: The other reality is the population of people in prison are not a sample of the general population. The healthcare we have in prison is set up to support people who often have not accessed healthcare and who may not appreciate how seriously they need to take it. A simple example would be if someone misses doses of medication, staff will go out and check on them. If they do not come for their meds, the pharmacy tech will go and find them and ask, “Why didn’t you take your medication?” That just does not happen in the community.

Again, the practical ability to get healthcare is much easier in prison. It is about how we help people transition into the realities of what healthcare is in the community. We are not going to be able to recreate prison healthcare out in the community because no one is going to be checking. If you do not collect your medication, it is unlikely your GP will notice. If you do not turn up to the appointment, you may be contacted but probably not. We need to learn how to support the group of people who have failed to access healthcare in the community to access the realities of what is in the community, because it is challenging to access healthcare. They are quite different delivery models because of the population we look after. You could not mimic that in the community.

Q268 **Warinder Juss:** Is working with the probation service a way forward?

Dr Green: You can do more and more and RECONNECT is better. In prisons, like I say, we encourage as many people as possible to have their medication in their possession, but some people will come and collect it from the meds hatch, which does not happen in the community. It is a big transition from how you experience healthcare in a prison. I suppose there is much more support really in the prison and much more monitoring. In the community, you are much more on your own. That is why RECONNECT is really important, to try to help people work with the realities of what healthcare is going to do for them in the community.



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Kate Davies: Traditionally, it has had different mechanisms over the decades, but it is a wrap-around approach to individuals. This is why it is so important that NHS England's services for health and justice are part of a 10-year plan—we saw that from the very first question on this Committee. Some great work has been done to look at hospital to community and prevention services within the broader NHS. I am very pleased to say that I am in the middle of making quite sure that this patient pathway is as important as any patient pathway. When you are in a GP surgery, nobody knows whether you are an offender or not. That is the reality, quite rightly. Ultimately, if someone chooses to say, "This is my pathway. I've come out of prison, I'm really a bit worried and a bit scared," that is probably what we should be trying to increase.

Q269 **Pam Cox:** I have more of a reflection than a question. We were talking about reality; I just want to talk about some realities. Many prisoners are released without a home, an address, access to a GP, access to a social worker, or access to a form of employment or volunteering. These are barriers to their effective rehabilitation; they contribute to the very high levels of recall that we see. How is RECONNECT, which has been going for two years, actually making a dent in that situation?

Kate Davies: I do not want to be a broken record, but ultimately that is exactly why RECONNECT has been put together.

Pam Cox: Recall levels remain really high.

Kate Davies: One of the biggest negotiations that we are doing with my colleagues in HMPPS on the governance around recall and rehabilitation is around housing and homelessness, good accommodation, and the basics that are necessary for those outcomes that we need to have. Going back to SDS40, we had some good examples in covid where infection control meant that we had systems that were slightly tighter in the prioritisation of finding housing and accommodation for people leaving prisons and establishments. That has to be a priority going forward, because it really is quite difficult for you to maintain your healthcare and your prescriptions or your substance misuse recovery lifestyles if you are also worried about your and your family's housing, homelessness, or what that means around the quality of your housing and homelessness. That is an absolutely key priority that RECONNECT will need to dovetail into in order for us to support.

Q270 **Pam Cox:** Is it not doing that already?

Kate Davies: It is, but we are not there to provide the housing or the other elements. Dame Carol Black said the same in her review, which I thought was excellent, that many of those barriers that kept coming up in the consultation around substance misuse were around the quality of housing and homes and family integration as part of the same element of what that means as part of the community.



Dr Green: It is a really good point. Probably one of the most risky things is when someone is leaving the prison with no fixed address, because your healthcare follows from your address. It is my understanding that RECONNECT is focused on health and does not have the access to the housing.

Kate Davies: All our providers that are RECONNECT providers—I know that PPG, The Forward Trust and many other NHS trusts are moving into that field—are to do with the negotiation and the navigation with the community-based services. Of course the local authorities are very much part of that responsibility. It is a really big challenge. It is an important stumbling block for many, but it is also an important solution if you get it right.

Q271 **Linsey Farnsworth:** I would like to move away from prisons a little and talk about community sentence treatment requirements as an alternative, whether that be drug rehabilitation requirements, alcohol treatment requirements, or mental health treatment requirements. As a former prosecutor seeing the same defendants back in court time and time again, I am interested in delving into rehabilitative opportunities. Kate, you mentioned the recent sentencing review, and it is a key moment in time to look at this sort of thing.

The recent evaluation by the Ministry of Justice concluded that sentencing with a community sentence requirement had a positive effect on preventing reoffending compared with short prison sentences. I know we have touched upon the limitations of that with the SDS40. What evidence are you aware of that these sorts of community sentences continue to work well to improve not just reoffending outcomes, but also the health and wellbeing of offenders over a longer period of time?

Kate Davies: Drug and alcohol requirements and mental health treatment requirements as part of community sentences have been around for a very long time. I declare an interest here that I was a probation officer 20 or 25 years ago. There was a period about seven, eight, nine or 10 years ago when—I have Rosanna O'Connor sitting behind me who was part of advocating this as well—as part of drug and alcohol treatment requirements, we were not getting the understanding, particularly among magistrates and Crown courts, of how those were the good option for the right assessment of people when sentencing. What was needed was more infrastructure, more policy, and more funding for drug and alcohol treatment requirements, and particularly for me, with NHS England's responsibility, for mental health treatment requirements, ultimately primary care mental health treatment requirements, we are doing some pathfinders on secondary mental health treatment requirements.

It is not a large amount of additional funding, but it has gone an awfully long way to working with our judiciary, probation services, patients, clients, offenders and services to roll out and increase the number of mental health treatment requirements significantly over the last four to



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five years, to the point where in some areas they are to a degree a victim of their own success around options to use that within sentencing courts of all descriptions. I absolutely welcome that as an alternative to custody for the right people, because you have better outcomes on offending behaviour than you do if you have those short-term or remands in a busy, chaotic, drug-filled prison. Ultimately, what you are also doing is addressing people's—Russell said this earlier—broader healthcare needs, family needs, and societal needs that may well be part of that package of care. Combined orders with mental health and drug and alcohol have become the most popular because it is about that dual diagnosis and integration.

I know that part of the sentencing review and the work that we have been doing with different Government Departments has also been about how those CSTRs, as they are known—community sentence treatment requirements—are an opportunity to really see that in appropriate assessment and sentencing terms. I have sat in many courts, seen many reports and many individuals being brought back to the same bench in the same court as part of the success of those orders and seen a bit of a slap on the wrist sometimes to say, "Hang on a minute, two strikes and maybe you're out."

The controversial element to it is that it is about consent. It is not a mandatory requirement, but of course you can be breached on it if you do not meet those conditions. We are seeing a massive success rate, particularly with women, substance misuse, and particularly with the integration with our community partners in the probation service.

Q272 Linsey Farnsworth: Brilliant. That sounds really interesting. The evaluation from the MOJ and our written evidence identified some limitations on community sentence treatments when they are not person-centred, or are not used consistently, or there are delays in starting the treatment. What is NHS England doing to mitigate those challenges, and if the use of these sorts of orders is expanded following the sentencing review, what would be your ask?

Kate Davies: Ultimately, we invested an additional £5 million into scaling up MHTRs and supporting the work that was done and a different funding stream for alcohol rehabilitation and drug rehabilitation requirements. We have seen the issue around how they are not as successful if you have to wait once you are sentenced. We have recently put in an additional £2 million, which is revenue funding, to support the backlog of waits; that has been very successful. I have one of my team members here who is responsible for it behind me, who has been monitoring the decrease in those waits as part of our performance for NHS England. That is what we are doing. We have also put an additional £2 million in recently, which is non-recurrent money, to support some areas where it is a little more tricky, in parts of the north and the midlands where there has been real impetus from the courts and from sentences for that element going forward.



Through the independent sentencing review, we would like to see that this is recognised as a health requirement as much as it is a criminal justice requirement. We obviously welcome Secretary of State for Justice Mahmood's announcements for the probation service. When I was on annual leave last week, I listened to a senior police officer saying that the independent sentencing review had to have an impact and considerations on policing. It also needs to have an impact and a consideration on the health pathway; that is my ask.

Chair: Thank you very much. Thank you, Dr Green and Ms Davies for your comprehensive answers this afternoon. In the interest of time and if you would not mind giving way to the second panel, I will not suspend the meeting. We will continue straight on.

Examination of witnesses

Witnesses: Dr Will Haydock and Mike Trace.

Q273 **Chair:** Apologies for the late running through votes and just the general commerce. I will ask Dr Haydock and Mr Trace if you would briefly introduce yourselves and then we will have some questions from the panellists.

Dr Haydock: Thank you for the invitation to come and talk to you today; I really appreciate it. I am the executive director at Collective Voice, which is the national alliance of charities that provide treatment for people with issues around alcohol and other drugs across England.

Mike Trace: I also thank you for the invitation. I am the chief executive of The Forward Trust, one of the providers that Kate referenced. I have been working in prisons since the 1980s, particularly around the drugs issue. For six years, I was actually responsible for the prison drug strategy in the previous Labour Government, where I was involved in the writing of the strategies that are now being reviewed. So I come from both a provider and policy angle.

Q274 **Pam Cox:** We will go straight to commissioning, if we may. What is your experience—good or bad—of being commissioned to provide substance misuse services in prisons?

Mike Trace: In The Forward Trust?

Pam Cox: Yes.

Mike Trace: We are commissioned and run services in about 20 prisons. We are subcontracted through healthcare providers, as described in previous evidence. It is a very complicated commissioning structure, and I presume I will come to the point of suggesting how commissioning could be tightened up at some point. Generally, there is a commissioning system and a set of partnership relationships through NHS England and the healthcare providers, and substance misuse is commissioned as one of those subcontracts from the healthcare providers.



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Of course, as a substance misuse specialist, we would prefer—as I think Collective Voice members would—to be directly commissioned, where we can talk more directly about the specifications and the quality. But generally, the commissioning system results in us being able to provide services, so we cannot complain about that.

Q275 Pam Cox: Perhaps we could elaborate on that. What would be the advantages of a directly commissioned service?

Mike Trace: It can be directly quality controlled. At the moment, the substance misuse element of healthcare is a subcontract, so it obviously gets hidden behind the much more widespread, whole healthcare commissioning to some extent. It is one section of a very complex specification and competition. As Kate said, the market is very competitive, so when there is a healthcare contract in a prison, there are a lot of NHS providers and private and third sector organisations, which Collective Voice represents. We are all trying to deliver what we specialise in, and it is a very competitive contracting market.

Q276 Pam Cox: Dr Haydock, you mentioned this in your written evidence to us.

Dr Haydock: I would come back to the nature of substance use issues. A general understanding of those would be that it is a biopsychosocial problem, and I have heard addiction described as a problem of living. This is something broader than just a physiological thing, and so the issue itself is cross-cutting. The interventions that are therefore provided are, of necessity, cross-cutting as well.

We have already heard Kate and Russell talk about the importance of employment, housing, and that wider social setting and context to make sure that people have a chance to achieve recovery. The outcomes that come from the services are also cross-cutting. We talked about reducing reoffending in the previous session, and that is not necessarily the priority of a solely healthcare-focused system.

So I would look, for example, at how the wider system and strategies can help facilitate that focus on substance use specific outcomes and therefore the delivery. For example, if you were to look at the national partnership agreement that is between the relevant organisations—including the Prison Service and NHS England—there is mention of reducing reoffending in there; that is part of what they are trying to do as a whole partnership. But that does not necessarily then translate into, say, NHS England's health and justice framework, where the focus—as Mike says—almost inevitably will have to be on some bigger, larger priorities for healthcare services. So it runs right through there from the nature of the problem, the solutions that we are trying to help people reach, and therefore the outcomes that we are going to see. It needs that whole partnership approach.

Q277 Pam Cox: Do you think there is space for prison governors to be more directly involved in the commissioning process of such services?



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Dr Haydock: There is definitely an opportunity for that in terms of having that partnership, not only with governors and the prison as an institution. We have talked a lot about reducing reoffending and continuity of care, and there are also stakeholders in terms of community healthcare and substance use, whether that is the local authority commissioners or the providers. They will have an interest and expertise to offer in this process. If we think of commissioning as something more than procurement but also about trying to improve outcomes and service design and drive system change, all those people would ideally be really closely involved.

Q278 **Chair:** Just a couple of questions from me. What impact does having a high proportion of prisoners with identified drug needs have on the ability to provide drug treatment services and access recovery support effectively?

Mike Trace: If the Committee allows, I was thinking of saying a few things about the scale of the problem and the need for robust action. The drug market in prisons is worse than it has ever been. As I say, having worked there since the '80s, there was a drug market before then and there has been a drug market ever since. But I have never seen such a large-scale drug market. This is seen in Charlie Taylor's inspectorate reports; the scale of the drug market is higher than it has ever been.

The dealing and supply mechanisms in prison are more damaging than they have ever been. In the '90s and '00s, a lot of people used to talk about a cottage industry where somebody would get a little through visits or different ways. It is an organised, gang-led structure now, which means a lot more drugs are coming in and there is a lot more violence and intimidation than ever before.

Q279 **Chair:** Can you explain why that is? This is obviously central to what we are looking at. Is it to do with the type of drugs that are available, the means of access or the organisation?

Mike Trace: It is complex. For the sake of time, I will try to be as brief as possible. There are many different routes to bring drugs in, but the people who are making a lot of money out of supplying drugs into prisons are much more organised than they were 10 years ago. Basically, you can double, triple or quadruple your money by getting it from outside the gate to inside the gate.

The range of drugs through which profits can be made is also much more diverse than it was 10 years ago. We look back fondly on the days when we had to worry about cannabis and heroin; there is now an entire sweet shop. You will be aware that new psychoactive substances are colourless, odourless liquids and powders and much easier to smuggle and get past supply and testing efforts. There are many more ways to make money.



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Those are just some reasons it has become as bad as it has. I do not want to give a fatalistic view; I am not one of those who say that you can never stop it. There are a lot of things that the system can do on supply and demand to actually make the situation better, but we have to recognise and confront the reality that we are in a pretty low ebb at the moment and have been for some years.

I want to pick up the questions or references earlier to say things are pretty bad now. The gentleman asked if there is enough rehabilitation. Absolutely not. The fact of the matter is—as the data you have seen and heard about—of the tens of thousands of people who come into prison every year with a pre-existing drug problem and drug-seeking behaviour, very few come out of prison with their behaviour changed. That is not as it should be, but it is the reality now.

Your last question refers exactly to that. The reality is that most people walking out of that prison gate are not looking for their health appointment or probation appointment; they are looking for the drug dealer. That is a really uncomfortable reality for an organisation that works in that system, and you have heard from Kate and others about how many well-intentioned, well-resourced organisations try to change that reality. Tessa Munt got to the root of it saying that unless you have real life-changing, behaviour-changing rehabilitation in every prison, then it is going to be very hard to turn those realities around, and at the moment we are managing uncomfortable realities. Sorry to start on a downer, but it is important to confront reality.

Q280 Chair: I had another question for you, Dr Haydock. Did you want to say anything on that matter first?

Dr Haydock: Just to briefly say that obviously, in terms of what that environment means for people who are trying to achieve recovery—if we go back to that idea of what the nature of the issues are and what is supportive—the idea of stability and security are really important for a good therapeutic alliance and trust. What makes the most difference when we talk about supporting people is that trust and therapeutic alliance, regardless of the specific intervention. It is hard to generate that in a system where there is churn and insecurity. To pick up on Mike's point, we know that lots of people develop an issue with substances in prison, so that is exacerbating the situation. A context in which drugs are readily available and people are using them around you makes it doubly hard to achieve and sustain recovery.

Q281 Chair: There are two things that should help tackle that. One would be comprehensive drug testing policies, but are there national standards and are they followed to the same extent in every prison? The second point is that we mentioned incentivised substance-free living wings earlier. That surely only works if you have people who have a problem with drugs and want to get off them. If they are used for either people who are still taking drugs or people who have not had a problem in the first place, then they are not working properly, are they?



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Dr Haydock: On drug testing, what I would say about that is that it is an opportunity to create a culture in which using drugs is less likely, but with those kinds of interventions, the question is always that there needs to be swift and certain consequences as a result. Otherwise, the intervention does not work. I am not sure that we are in a place where we can say that there is that consistency of swift and certain consequences. Mike might be able to talk in more detail about this, but I do not believe there is that consistency in the application of how drug testing is used and how much.

In terms of incentivised substance-free living, again Mike will be able to talk about the detail more than I can, but these can be really useful oases, I suppose, of calm and stability in a prison, where you are more likely to be able to develop that therapeutic alliance that I referred to, but they will be in that isolated oasis, whereas, as Mike has described, the scale of the issue that we are really looking at is much broader than any single wing or ISFL would be able to provide. We need to be thinking more broadly than that about how we serve all those in prison who have an issue with alcohol or other drugs.

Mike Trace: The two things you mention are both part of the solution, which is the good news. Over the years, drug testing has tended to be what is called mandatory drug testing, and a relatively small number of prisoners are chosen to be tested in any given month. It is not a big deterrent or effect on behaviour.

As Will says, what has worked really well in the past is ISFLs. ISFLs are just the latest terminology for dedicated locations where people move within the prison to do something about their drug problem or stay away from the drug market. They are trying to do the right thing. We used to call them drug recovery, drug-free or drug programme wings; they have had different names over the years. But they have never been determinedly implemented across the prison system.

We had lots of these drug recovery wings back in the 2010s, but they were all closed down in austerity. We are starting to build them up. ISFLs is the collective noun for them at the moment. As Will says, you have to implement them with very clear determination. So for every ISFL, you only get on there if you are committed to staying away from the drug market, sign up to a compact, drug testing and a programme of behaviour change, and unless you prove you are complying with that process, you do not stay on the wing.

Very few of the current initiatives tick all those boxes. A wing is dedicated. If people are allowed on the wing who are not really serious about it, then the wing has some drug dealing. If it has some drug dealing, it is not a drug-free wing and there is no rehabilitation so you are not achieving your goals. There are some great ones, and where it is done properly that should be replicated across the prison system. That is a big part of how we turn around the unpleasant realities at the moment.



Q282 **Tessa Munt:** Can I just ask a quick follow-up? Give me an example of where it is done properly.

Mike Trace: Obviously I will mention The Forward Trust ones: Cardiff, Rye Hill and Swansea. Fifteen years ago, I would have reeled off 20 for you; it is a real tragedy that we are now talking about a handful. I should have said at the start that it is a great time for you to be doing this report because this is a year where things could be turned around. There is the intention within the Ministry of Justice and NHS England to get this right. They are calling it ISFL but the ambition is higher. There are three or four well-run The Forward Trust wings, and probably another dozen well-run by other organisations, but that is not enough to change the nature of prison drug markets.

Q283 **Tessa Munt:** I might invite you to put the three or four names forward to the Chair in writing after this meeting.

Mike Trace: I am feeling a bit embarrassed about being biased. I will send three or four names of other providers as well.

Tessa Munt: I understand that. Thank you very much indeed.

Chair: Before you go on, could I let in Josh because he has another appointment?

Tessa Munt: Of course.

Q284 **Josh Babarinde:** We heard, as you did, from your predecessors in those chairs about the success and results of the RECONNECT initiative. It would be great to hear a little from you, from a different perspective, about what your assessment of that initiative is.

Mike Trace: My perspective is that of a provider of RECONNECT, so I declare an interest. As Kate said, it is the right response to the right identification of a problem. I want to read this across to the Gauke review because that is a great opportunity to make a step change now. Linking what goes on inside prison to how people continue their recovery—or whatever we call it—after prison is a crucial step. I talked about people coming out of prison looking for the dealer; it really does happen that way. Some staff are out in prison car parks daily at the moment trying to encourage individuals coming out to attend appointments to do the right thing, rather than go off and see the dealer.

The RECONNECT model is NHS England's initiative to try to make that work as well as possible. Generally, it is a good initiative. The big challenge is what you will all be used to in your Committee experience: government silos. The RECONNECT model is an NHS England contract and creates a team that tries to work with people around their health issues. Justice is responsible in resources, probation and offender management processes. There are employment and accommodation pathways, and there is a joining-up problem. There are a lot of people working with offenders in the 12 weeks up to release, trying to get the



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perfect package ready for the day of release. There is a lot of room for better coherence, but we were really pleased to see that RECONNECT as an initiative is working well on the ground within its health terms.

Dr Haydock: Can I comment on that? As Mike says, from a system perspective, there are several schemes that are relevant here. As well as RECONNECT, there is the probation notification and actioning project and the work that is commissioned by local authorities and overseen by the Department of Health and Social Care to do in-reach to prisons and boost continuity of care. When we look at those statistics of people who are leaving prison with a treatment need for alcohol or other drugs, that has gone up from 33% in 2019 to 56% now. It is not as high as we would like it to be, but it shows what can be achieved. So there are real positives there about the continuity of care for substance use treatment.

It is no coincidence that that coincides with having clear strategic priorities, and that is one of the outcomes that is included in the national combating drugs outcomes framework. It is something that has been focused on by the Department of Health, the joint combating drugs unit and local commissioners for that community treatment as well. We have lots of different organisations; the PNAP system is HMPPS, and there is the NHSE bit and the local authority/Department of Health and Social Care bit. They have delivered good outcomes and we have made really good progress, but we can do that more efficiently and effectively if we co-ordinate that better across the different departments and organisations and get them working together.

Q285 **Warinder Juss:** Mike, you mentioned that we have a situation where if somebody is addicted to drugs and goes into prison, they come out in the same situation or even worse, but the actual situation is even worse than that, is it not? Because there is a high percentage of prisoners who are not on drugs when they go in but they become addicted. You said you are not a fatalist, but do you foresee that situation getting better, whereby there is less addiction for prisoners going in?

You would have heard with the previous panel I made the comment that we have heard evidence in the past that where there is access to healthcare provision in prisons but not the same kind of access out of prison, reoffending has increased. What is your solution to that? Do you have your own view on that?

Mike Trace: We could do a lot better, whether we call it a solution or something else. There will always be a drug problem in prisons and people struggling with addiction who go through prisons, but we can do an awful lot better to make rehabilitation much more available to more people and to improve their health situation when they come out.

As we say, part of that is creating those dedicated wings, how we use drug testing and how we do our pre-release planning, but it all comes back to the single human process: do those individuals have anything happening to them while they are in prison to help them move away from



the patterns of behaviour that brought them in there? You are absolutely right: there are many who come in maybe with a tangential relationship with drugs—recreational use or something—but by the time they come out of prison, they are fully addicted. That does happen.

The two key circumstances to create are, first, to make it easier for prisoners to opt for the right decision. There is a lot of peer pressure, violence and intimidation for people to be drug users in prison. There are the people who generally control the wings and want customers. So there is a lot of pressure on individuals to become drug users, part of the market, and to play a role in the market. We have to give prisoners the option of shielding themselves from that pressure, and that is why these dedicated locations are so central to any strategy. You have to be able to say to the prisoners—I flippantly call it join the winners—“You have the option of going across to this wing where you’re not exposed to the gang dealing and you are doing something to give yourself a chance to come out with a different story.”

The other key element of that is the offer of the treatment; there has to be meaningful treatment. I often refer to a mismatch in what we are doing at the moment. There are a lot of people with drug problems getting treatment and good healthcare in prison. But there is a mismatch between the level of their addiction and need and what they are receiving from the psychosocial service that Will mentioned. Most prisoners who need it are receiving some form of treatment, but most are getting a couple of appointments with their caseworker, an assessment, a meeting with a nurse, maybe a couple of workshops. If your life has been one of trauma, neglect, abuse, fighting authority, and not trusting anybody, a couple of meetings with your caseworker are not going to change the direction of your life. The treatment has to be sufficient to achieve those turnarounds, and that is what we have failed to do well over the last 10 or 15 years.

Q286 Warinder Juss: You said that some prisoners get good healthcare in prisons. How do we extend that to when the prisoners are out in the community?

Dr Haydock: That can or should happen through the key local partnerships. It is effective if you have an integrated care partnership that is trying to tackle health inequalities, and we have examples of good local practice particularly in relation to rough sleeping, where you have substance use services, local community health services and the GP all working together to make sure that that is really tightly co-ordinated. But that is through specific projects and funding streams that have been designed specifically around people who are rough sleeping. That is part of it.

The other thing I would highlight in terms of people leaving prison is that it would be helpful for a significant cohort of individuals to have access to and to go straight into residential substance use treatment. So for those who are not in a place where they can easily sustain employment or



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accommodation at that stage, that opportunity to go directly into a residential environment that provides support could mean that after that stay they are then in a place to sustain a more stable life in the community outside that level of support.

At the moment, those pathways are again quite difficult because the access to residential treatment is generally through local authority-funded processes and services and does not always knit. We have already talked about release timings and that there is not always continuity, but that access to residential treatment would be really helpful.

Q287 Tessa Munt: I was talking earlier about access to healthcare and wellbeing services and I want to continue on that same thing. I am going to ask you both how often prisoners are unable to access health and wellbeing services and what the common reasons might be for preventing that access in some way.

Mike Trace: Broadly, prison healthcare has improved a lot over the last 10 years. Previous comments were that NHS England has made a lot of progress in that area, and I would agree. The front-end access to healthcare, access to health assessment and the identification of need have really improved an awful lot. So the problem is not the initial access; it is what happens next.

Access to specialist care—you raised a case yourself—gets a lot more difficult, and the access to structured interventions, whether they are a pure healthcare, mental health or psychosocial intervention, just gets very difficult and there are a lot of people who fall through the net because this is not prioritised in the prison system. You mentioned an example of somebody with very clear healthcare needs. Everybody knew what should have happened; it did not happen, and there was a bad outcome. That happens daily. We could expect to do better, and the Committee should urge the Departments to do better with that.

There is a large problem with accountability within HMPPS. I will talk about substance misuse, but we could talk about mental health as well. Fifteen years ago, every governor had it as part of their weighted scorecard—which is what worked out whether they got promoted or sacked—to make sure they had the proper range of drug strategy activities in their prison, supply and demand, and they were measured on some achievements of those. That was dropped around 2012.

If you are working in substance misuse—it is true of our healthcare colleagues as well—that makes the daily battle in prison to do what you are paid to do very difficult. If you are not on the top layer of priorities, you do not get a room or chairs and you do not get the prisoners to the appointment they need to be at, and that has been our lived experience for many years now. So you battle and fight it. Russell described how they try to fight it, but you do not really make that process easier until it becomes part of the governor's responsibilities to say if the numbers are not good on access to healthcare or rehabilitation, then you have some



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answering to do. There are some great governors out there; this is a system problem, not individuals.

Q288 **Tessa Munt:** I fully understand that. Do you want to add anything, or are you happy?

Dr Haydock: I would echo everything Mike says. I would just highlight that we have seen more people accessing substance use treatment in prisons over the past few years. It has gone up slightly, so that is a positive and shows that there is something that is accessible and attractive to people, but it is still well below the pre-covid levels, and our member organisations tell me there are still hangovers in terms of access to rooms and people's ability to get to appointments, as Mike said. If we have that flexibility or ability for people to access support, we have an offer that is engaging people and delivering some positive outcomes, but it is making sure that people have access to that.

Q289 **Tessa Munt:** That takes me quite neatly to my next question, actually. In your written evidence, you said you had noted that there was a steady increase in the number of people accessing support over the last three years, but that level is still below the pre-covid level. So what is happening there and why, and what should change to improve it?

Dr Haydock: I will just briefly say that I have been told by people who are in our member organisations working in prisons that there are just competing priorities for a limited amount of time in someone's day where they are able to engage in activities. There might be other activities that they are engaging in that are higher up that priority list in terms of the time they can spend, either from the prison's perspective or their own. As Mike says, we are not sure that substance use support is always high enough up that list or that there is enough time for people to engage in those. Instead what you then have is precisely the factors that drive substance use, so that fear, boredom and lack of access to meaningful, purposeful activity. Mike would be able to talk about the detail of that more than me.

Mike Trace: I mainly have a note of caution about using activity levels as your main measure of success. It creates a very strong incentive for providers and prisons to say, "Look, everybody was assessed." But somebody being assessed and seen once is not going to do much. I refer back to the mismatch. The most important thing is how many prisoners are meaningfully engaging in behaviour change processes. There is a real resource problem there because the budget is available for this, for Kate and others; there is just not enough to do meaningful interventions with 60,000 people a year. So there is a dilemma there, but it is avoiding that dilemma of saying, "At least we have seen everybody once," which is not going to change the outcome.

Q290 **Tessa Munt:** I would invite all four of you to write to the Chair with your ask of Government and try to give that cascade of priority stuff and how one does it well.



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Mike Trace: I am very happy to do that.

- Q291 **Tessa Munt:** Can I just ask one other question? I know we are late; I am sorry. I want to know about assessment for ADHD and how often that happens in prison. I recognise it has an impact in custody and the prison system and is something that Charlie Taylor has written about, has he not? How often is that done and done well? How often does that inform the behaviours of the authorities after that?

Mike Trace: Yes, it is fundamental. Charlie Taylor has written about it; it is true. Basically, when you look at the patterns by which the vast majority of people end up in this behaviour cycle—in and out of prison and addiction—ADHD and trauma are in there. So all those mental health issues are intertwined with what we call the substance misuse. It is basically a mental health service.

Responding to it, there is good recognition in NHS England and good guidance around trauma-informed work, but it hits against that resource reality again. If you are really going to grapple with the ADHD of an individual, the trauma they have experienced, sometimes the trauma they have caused and the guilt around that, and the mental health problems that go with that, that needs quite a structured, intensive intervention. At the moment, most people are just scratching the surface.

Most of my caseworkers who work out in the prisons have the unenviable position where we ask them, "Don't go too deep with people because you won't see them again." So if you start opening up diagnosis, trauma and suicidal ideation in your assessment, that is unprofessional if you are going to start that and then not see them again. So there are big practice dilemmas here, and I am sorry I keep going back to the mismatch, but you have to find a way of intervening meaningfully with a proportion of those people, or they will come out with exactly the same behaviours they went in with.

- Q292 **Tessa Munt:** It is a great deal when they just carry on and nothing changes.

Mike Trace: But there is good news. We have an opportunity to do it. They are a captive audience.

Pam Cox: Would you like me to move to data sharing, Chair?

Chair: I would love you to move to data sharing.

- Q293 **Pam Cox:** Could you tell us what data The Forward Trust holds on individual prisoners and how you share it with the appropriate services to enable joined-up working around those people?

Mike Trace: We are a health service commissioned service in prisons. Primarily, our data systems are the NHS data systems. As a non-NHS body subcontracted by an NHS body, we try as far as possible to collect our data through SystmOne in the healthcare systems, and that information is accessible by all the health systems in the prison.



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The data we collect is partly health data, so it is about substance misuse and healthcare needs. We have to be very careful that we do not duplicate that with our general healthcare partners, so we focus on the substance misuse aspects of it. It is almost like supplementary data on each individual when it works well. There are a lot of prisons where the data systems do not talk to each other so it does not work well.

The specific substance misuse dataset we collect is called the national drug treatment monitoring system, which collects personal and needs data: your drug and offending history, your employment and housing situation. That information is submitted in aggregate form to the national drug treatment monitoring system in the Department of Health.

Q294 Pam Cox: Thinking about the connected piece, is that NHS dataset connected to GPs or someone's NHS number more generally? Do prison governors have access to that NHS data?

Mike Trace: SystmOne is a system that tries to have the healthcare data available to all healthcare professionals. Where that works well—with no firewalls in there—it should be available and there can be continuity. In a lot of cases, as a substance misuse provider, we are not allowed access to SystmOne because we are not an NHS body, and that is a big barrier to us sharing data. As you have alluded to, there is a big problem with the read across between the health system data and the offender management data, which is probation.

Q295 Pam Cox: So your average prison governor would not be able to see the data you are inputting, collecting and collating from the population?

Mike Trace: Your average prison governor probably would not ask. Generally, it is not their responsibility to manage substance misuse in their own prisons. It is a system problem.

Pam Cox: No further questions, Your Honour. That was really what I wanted to ask about that. We were going to ask if there is sufficient data sharing between services but you have just answered that, so thank you.

Chair: Warinder is going to ask what may be the last question.

Q296 Warinder Juss: We are aware—I have experienced it in my own constituency in Wolverhampton West—that voluntary sector organisation providers fill in the gap for statutory services. In Wolverhampton, we have an organisation called SUI—*the Service User Involvement Team*—which provides a drug and alcohol service as part of voluntary and community action. How sustainable are these models, and do you think these providers are given enough support to carry on with that kind of work?

Dr Haydock: I would phrase it not so much as filling gaps, but that there are different providers with different specialisms, and they should be complementary. Our services—our members of *Collective Voice*—can vary from large national organisations that provide a whole spectrum of



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healthcare and substance use support to smaller, local organisations, or ones that have a very particular specialism. Maybe they work in particular communities or with particular cohorts, such as children and young people.

We really benefit from having that diverse group of organisations. I am not sure that current structures of commissioning are always accessible to all those, but we have loads of examples of good partnership between those organisations. So to me, it would be ideal to have that mixed economy that is able to make sure that anyone who needs support is able to access it. I am not sure I have entirely answered the question.

Mike Trace: Just to supplement, first to say SUI is a great organisation, so I will get that on record in Parliament; they will appreciate that. We bid with it as partnerships, but as you can probably see and I have said before, even we—as contracted substance misuse providers—are subcontracted by a bigger provider. The only way organisations like SUI can get resources is to be subcontracted by us, so they are boom, boom, boom, like that. Our responsibility is to make sure we have those partnerships because local community organisations are really good at what we want to see happening; SUI is a good example of that. But as Will has said, it is very hard for small, local organisations to bid for these contracts because they are multi-million-pound contracts and you need all the organisational structure that goes with it.

You want to have community-led, peer-led interventions available in the prisons, particularly for the continuity of care aspect, but under the current system, the only way for them to get into the market is to be subcontracted by people like The Forward Trust. We are keen to do that. I could not let it go without saying that even though we are one of the big contracted organisations, 40% of our staff are lived experience, so it is not that the bigger organisations are horrible and bureaucratic. We may look it sometimes, but we are a lived experience organisation as well. For that community in Featherstone, SUI is best placed to provide services there, but it needs to find a partner and be subcontracted.

Dr Haydock: Can I just come back on a couple of things that I forgot? You will see that lived experience figure that Mike quoted mirrored across all the different charities throughout our sector. It is hugely lived experience-led and involvement, so sometimes that distinction does not quite hold, even for the bigger organisations. Turning Point recently surveyed its staff and 65% had either direct or indirect family lived experience, so that runs across.

In terms of funding, the thing I would really highlight is having security and stability around that funding. We often hear quite late. For example, last year, we were almost on the verge of organisations having to start redundancy procedures so that that could be implemented from 1 April. So we really need that early notification of funding. That affects the staff we can recruit and retain because it is sometimes seen as a less-than-



stable role or contract to hold, which is sometimes particularly challenging for organisations that have less to fall back on.

Q297 **Warinder Juss:** I have one last quick question. The independent sentencing review has recommended that there should be more community supervision in some cases. In that regard, if you had an ask, what would it be?

Mike Trace: I am so glad you asked that because I wanted to finish on a higher note; I know I have been a bit of a downer most of today. The Gauke review is a very broad range review around sentencing, but on this issue it gets a couple of things really right.

The first thing it says is about the continuity of behaviour change, to incentivise people in prison to change behaviour and continue those incentives through early release schemes and into the community. That is a massive opportunity to change the realities I talked about before; you can create your whole prison release scheme around, "Do something in prison to address your drug and alcohol problem. If you're showing us that you're making some changes, you get a much better shot at early release." That will be a game changer and David Gauke suggests how to do that.

If I could write to the Committee with the sort of things I was sending to David Gauke about how you operationalise that, there are great opportunities. I do not know the timing of your report, but if it comes out at the right time, it will land just as the Ministry of Justice is trying to say, "What are we going to do with these Gauke recommendations?" Our spending review settlement—while never generous—gives more room for manoeuvre for Justice Ministers than they have had in my recollection. This can be turned around this year, and the Committee's report could be quite influential in that regard. There are some Gauke recommendations that set the scene and I urge the Committee to pick up on that because this can be turned around.

Dr Haydock: I would look at the example of community substance use treatment and try to learn from that, whether we are talking about in prison or people who are in the community and being supervised there. You have an example in a report, incidentally by Dame Carol Black, who has carried out a similar report in prisons. There was a strategy and a set of priorities that were set. Although progress has not been as quick as we would like, we have seen dramatic progress on the key two outcomes that were prioritised for community-based treatment. So there are far more people in treatment, more than there have been since 2010, and continuity of care has gone up by over 20%.

We have really seen those changes because those outcomes were prioritised and partnerships were set up that brought together all the relevant stakeholders in the community. If we can learn from that and have that clear funding, strategic approach and outcomes prioritisation, we can deliver real change both in prisons and the community.



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Chair: That is a very good note to end on. Again, thank you, Dr Haydock and Mr Trace, for your time and particularly your answers, which were very concise but full of information. That has been a very good session. Thanks very much to the Committee. I am sorry for the delays we had, but that is the way we like to do things here, in the old-fashioned way. With that, I will draw the Committee session to a close.