

Foreword

There has been an unfortunate, destructive tendency, led by politicians worldwide, to stereotype opiate users – and those addicted to other substances – somewhere on a scale between 'the undeserving authors of their own misfortunes', and 'the sub-human criminal enemies of society'. The Panel began its inquiry from a very different perspective, refusing to be judgemental and concentrating instead on assessing addicts' needs for healthcare support, and evaluating, on the basis of the evidence, the extent to which services in Jersey fairly meet those needs.

As our investigations proceeded, we became more and more aware of addicts as a number of communities within the community, almost invisible to the majority of us, yet comprising roughly one percent of the community (and, if alcohol, solvents, benzodiazepines and other substances are taken into account, probably somewhere between five and ten percent of us all).

Equally, as the inquiry proceeded, we were forced to confront – as I believe this and other societies will have to confront – troubling questions about the appropriateness of some of society's officially endorsed approach to addicts – in particular, the question of effective use of resources.

The inquiry cannot claim to be exhaustive. Indeed, the Panel has been at pains to confine its investigations to our original terms of reference, which were to review the implementation of recommendations made three years ago in the Imperial College School of Medicine report on the Alcohol and Drugs Service. Even so, this present report, as well as making recommendations within its strict remit, has identified issues beyond its original terms of reference, some of which we believe should be considered as a matter of urgency, some of which may well warrant a subsequent dedicated report on their own account.

I must thank all those who have taken the trouble to give us the benefit of their professional and personal experience – and, of course, our officers, who have provided the Panel with sterling support. I hope that all those who have provided us with oral and written evidence would agree that the Panel has carried out its work in the true spirit of scrutiny – courteously, searchingly, and above all, fairly.

This, our first investigation, has been a learning experience for Panel Members. Its production has greatly assisted us to envision how effective scrutiny might be structured in the future ministerial form of government. This learning process was, of course, a principal aim for the current period of shadow scrutiny.

Beyond that first aim, I also sincerely hope that our work will also be seen as helpful to the professionals who, in various spheres, are presently working with opiate addicts, and of interest to other politicians and the wider community.

Most of all, though, this report is for those courageous human beings – users and families of users - who braved stigma to come forward and tell us their personal story. I hope that, for them, this report will start to make a difference.

Deputy Jerry Dorey
Chairman, Shadow Scrutiny Panel

CONTENTS

FOREWORD

GLOSSARY OF TERMS

1. INTRODUCTION
2. THE WORK OF THE PANEL
3. STATUTORY SERVICE PROVISION: ALCOHOL AND DRUGS SERVICE
 - 3.1 Needle Exchange Programme
 - 3.2 Arrest Referral Scheme
 - 3.3 Opiate Substitution Programmes - Methadone and Subutex
 - 3.4 Detoxification Programme
 - 3.5 Access to Services
 - 3.6 Co-ordination with other Agencies
 - 3.7 Training and Education - raising awareness for Professionals
 - 3.8 A Medically Supervised Injecting Centre for Jersey?
4. STRENGTHENING THE EVIDENCE BASE
5. MEDICAL CARE FOR SUBSTANCE MISUSERS
6. LINKS WITH THE CRIMINAL JUSTICE SYSTEM
 - 6.1 Cost to Society of Keeping Addicts in Prison
 - 6.2 Sentencing Policy in Jersey
 - 6.3 Development of a Drug Strategy for H.M. Prison La Moye
 - 6.4 Sentence Planning and Post Custodial Supervision
 - 6.5 Aftercare of Prisoners
7. SUPPORT FOR VOLUNTARY AGENCIES
8. ADDITIONAL COMMUNITY SUPPORT FOR SUBSTANCE MISUSERS
9. COLLABORATIVE FORUM
10. KEY FINDINGS AND RECOMMENDATIONS
11. CONCLUSION
12. REFERENCES

APPENDICES

All the items in the appendices are available on the Scrutiny website

www.statesassembly.gov.je/shadow

1. Imperial College School of Medicine - Responding to Alcohol and Drug Use in Jersey - Key Findings Report (April 2001)
2. Call for evidence - Letters, dated 19th and 20th April 2004 to President of Health and Social Services Committee and other witnesses
3. Written Submissions to Shadow Scrutiny Panel -
 - a. Alcohol and Drugs Service, Director, Mr. M. Gafoor
 - (i) Study to measure risk taking behaviour among injecting drug users in Jersey (May 2004)
 - (ii) United Kingdom Home Office Findings on Arrest Referral Schemes
 - b. Health Promotion Officer (Drugs), Mr. L. Shobbrook
 - c. Health and Social Services, Mr. I. Dyer, Adult Mental Health Services
 - d. Customs and Immigration, Chief Executive, Mr. S. Cole
 - e. States of Jersey Police, Chief Officer, Mr. G. Power
 - f. Consultant Psychiatrist, Adult Mental Health Services, Dr J. Sharkey
 - g. Consultant Microbiologist, Health and Social Services, Dr I. Muscat
 - h. Medical Practitioner, Member of Drug Dependency Advisory Group, Dr M. Marks
 - i. Medical Practitioner, Dr D.J. Bailey
 - j. Home Affairs Committee, Sentencing Outcomes, 2003
 - k. Part B Recommendation No R (98) 7 concerning the Ethical and Organisational Aspects of Health Care in Prison (1998) from the Council of Europe
 - l. Substance Misuse Counsellor, H.M.P. La Moye, Miss T. Rodrigues
 - m. Health Care Manager, H.M.P. La Moye, Mr. C. Russell
 - n. Jersey Probation and After Care Service, Chief Probation Officer, Mr. B. Heath
 - o. Jersey Addiction Group, Programme Director, Mr. I. Rodger
 - p. Jersey Council on Alcoholism, Director, Mr. B. Jordan
 - q. Roseneath Centre, Manager, Mr. J. Huelin
 - r. The Shelter Trust, General Manager, Mr. J. Hodge
 - s. Mr. D. Wimberley
 - t. 'Chris' - soapbar cannabis
 - u. Deputy J-A Bridge

- v. Ten personal submissions (names of witnesses retained)
4. Notes on evidence given in confidence to Panel Chairman
 5. Notes on Site Visits made by the Panel during the Review -
 - a. Informal visit by Panel to Alcohol and Drugs Service, dated 21st May 2004
 - b. Narcotics Anonymous, open meeting dated 23rd May 2004
 - c. Ian Rodger and Frank Laine, Silkworth Lodge, dated 4th June 2004.
 - d. Residents of Silkworth Lodge, dated 4th June 2004
 - e. Families Anonymous, open meeting dated 2nd June 2004
 - f. Needle Exchange and Arrest Referral Workers, dated 7th June 2004
 - g. H.M. La Moye Prison, dated 18th June 2004
 6. Notes of Public Hearing sessions
 - 16th July 2004
 - a. Mr. M. Gafoor, Director, Alcohol and Drugs Service
 - b. Mr. I. Dyer, Director, Adult Mental Health Services
 - c. Dr I. Muscat, Consultant Microbiologist
 - 23rd July 2004
 - d. Mr. B. Heath, Chief Officer, Jersey Probation and After Care Service
 - e. Mr. B. Jordan, Jersey Council on Alcoholism, and Mr. J. Huelin, Roseneath Centre
 - f. Dr D. Bailey, General Practitioner
 - g. Senator W. Kinnard, President, Home Affairs Committee
 - h. Mr. K. O'Donnell, Shelter Trust
 - 30th July 2004
 - i. Mr. I. Rodger, Programme Director, Jersey Addiction Group
 - j. Senator S. Syvret, President, Health and Social Services Committee, accompanied by Mr. M. Pollard, Chief Executive, Health and Social Services
 - k. Dr M. Marks, General Practitioner, member of Drug Dependency Advisory Group
 - l. Mr. D. Wimberley
 7. Notes of Confidential Hearing session, 22nd July 2004
 - a. Mrs G

- b. Mrs E
 - c. Mrs H
-
- 8. 'Supervised Injecting Centres', Nat M.J. Wright, Charlotte N.E. Tompkins, British Medical Journal, Volume 328, 10th January 2004
 - 9. 'Needle Exchange Programs in Prisons in Spain', C. Menoyo, D. Zulaica, F. Parras - Canadian HIV/AIDS Policy and Law Review, Volume 5, Number 4, 2000
 - 10. Jersey Evening Post, Selected articles -
 - a. 'A Love torn apart', June 2004 - the tragic story of an addict's suicide
 - b. 'Turning points', September 2003 - the help offered to addicts in La Moye Prison
 - c. 'Out of the cycle' September 2003 - the work of the Alcohol and Drugs Service
 - d. 'The Road to Recovery', May 2003 - addicts are not bad people - they have just lost their way - help such as that at Silkworth Lodge is essential for them and the community-
 - e. 'Clean bill of health', April 2004 - Silkworth Lodge - the struggle to conquer addiction
 - f. 'No waiting zone' September 2003 - a mother calls for immediate action

GLOSSARY OF TERMS

Abstinence-based approach Treatment and therapy methods designed to support recovering addicts in remaining clean of drugs.

Additional drug paraphernalia The United Kingdom has recently legalised the provision of additional items through the Needle Exchange schemes. Jersey will soon follow suit. These items include sterile water, spoons and filters.

Alcohol and Drugs Service The Island's statutory community-based service for all substance misusers and their relatives, funded by Health and Social Services and the States' Substance Misuse Strategy. It is based at Gloucester Lodge, Stopford Road, St. Helier.

Arrest Referral schemes Aimed at forming a point of contact for all those arrested by the States of Jersey Police or Customs and Excise Department with problems relating alcohol and/or drug use. The Arrest Referral worker actively visits arrestees in custody and encourages individuals to consider treatment and support options.

Care pathways approach A draft Service Specification document was developed in November 2003 by Mr. Ian Rodger, Programme Director, Jersey Addiction Group, in collaboration with Mr. Ian Dyer, Director, Adult Mental Health Services. This document outlines the collaboration necessary between existing services to offer a seamless continuum of care to meet the needs of the substance misuse population of Jersey and the Channel Islands.

Community Safety and Substance Misuse Strategy 2005-2009

'Building a Safer Society' Jersey's new five year strategy aimed at minimising the harm caused by crime, anti-social behaviour and substance misuse. Copies may be obtained from the Home Affairs Department.

Detoxification (detox) Withdrawing from a substance misuse habit can be a difficult process and may pose significant risks to health. A medically supervised detox is designed to help addicts through the process with the help of prescribed medication. It may be carried out in a hospital setting, a

registered rehabilitation centre or with the individual remaining at home under medical supervision (community detox).

Drug Dependency Advisory Group Established in 1998 as a monitoring body for the Methadone programme, its role has since expanded to deal with any inappropriate prescribing issues. The Group meets bi-monthly and currently consists of the Director, Alcohol and Drugs Service, as chair, Medical Officer of Health, Dr Sharkey (Psychiatrist), 2 GP's, Dr Porcherot and Dr Marks, Janice Wadell (Social Security) and Paul McCabe (Chief Pharmacist).

Fitpacks They contain a supply of sterile needles and syringes, citric acid sachets and pre-injection swabs.

Half-way house Hostel accommodation for released prisoners or recovering addicts leaving a rehabilitation centre. It is designed to support the individual to re-integrate into living outside the protection of a full-time residential environment.

Harm reduction approach Based on the premise that some people will continue to use substances despite the risks involved, this approach is designed pragmatically to limit the harm addicts may cause themselves while encouraging access to treatment options.

Imperial College Report A report commissioned by the States of Jersey in 2000 to inform policy initiatives '*Responding to Substance Misuse*' and '*The Crime and Community Safety Strategy*'. It conducted a seven-month research study aiming to describe the nature and extent of drug and alcohol use in Jersey and to develop indicators which could be used to monitor the progress of the strategies. Its detailed findings were reported to the States in January 2001. A Shorter document was produced in April 2001 to disseminate the study's key findings to the public.

Methadone A legally prescribed opiate used in the treatment of addicts to gradually reduce dependence on illegal substances.

Needle Exchange schemes - Their aim is to make contact with the 'hidden group' of injecting drug

users. Needle Exchange schemes have three functions; to give out sterile injecting equipment; to provide a safe place to dispose of used 'works'; and to provide information on safer injecting practices and how to get help.

Opiate Substitution A programme to provide an addict with a legally prescribed alternative to illegal drugs. Use of Methadone or Subutex is supervised by licensed GPs and available through registered pharmacies. Strict controls are operated in Jersey to prevent leakage of the medication onto the street market.

Post custodial supervision Support which may be provided by the Probation Service to prisoners on release from La Moye, aimed at helping the individual to re-settle into the community.

Randomised anonymous testing A research tool enabling a study of the extent and prevalence of infection throughout the Island. The proposed study of Hepatitis C in Jersey would involve 200 tests on six different groups of patients reflecting the general population.

Sentence Planning A means of working with inmates at H.M.P. La Moye throughout the course of their sentence to identify and implement factors which will assist the individual not to re-offend once he/she returns to the community on release.

Substance misuse A generic term to describe any use of drugs, whether legal or illegal (including alcohol) which leads to social and health risks for the individual. In the context of the Scrutiny report, the focus is on the misuse of opiates, particularly heroin, which appears to be the drug of choice in Jersey.

Subutex Trialled in Jersey over a six month period in 2002, this opiate substitute has a number of advantages over Methadone. Clients report fewer withdrawal symptoms during detox. Clients can take higher doses and so can take the drug on alternate days, which is less disruptive than Methadone. Also, at certain doses, Subutex blocks the effects of other opiates.

Supervised injecting centre Legally sanctioned and supervised facilities designed to reduce the health

and public order problems associated with illegal injection drug use. Their purpose is to enable the consumption of pre-obtained drugs under hygienic, low risk conditions. They differ from illegal 'shooting galleries', where users pay to inject on site. Also referred to as health rooms, supervised injecting rooms, drug consumption rooms and safer injecting rooms or facilities.

12-step approach Abstinence-based treatment, therapy and support programme developed by Alcoholics Anonymous; used by Narcotics Anonymous and Jersey Addiction Group.

Wool Report 2004 A confidential report entitled 'Health Needs Analysis HM Prison La Moye, 2004', carried out by Dr R. Wool for the Home Affairs and Health and Social Services Committees. This report was commissioned in response to the 2001 report of the HM Chief Inspector of Prisons.

USEFUL CONTACTS

Alcohol and Drugs Service www.alcdrug.gov.je

Drugscope www.drugscope.org.uk

Government drug strategy website www.drugs.gov.uk

International Harm Reduction Association www.ihra.net

1. INTRODUCTION

1.1 THE SHADOW SCRUTINY PANEL

1.1.1 The Shadow Scrutiny function was established by the States of Jersey as part of the reforms of the Machinery of Government. The principles and guidelines of Shadow Scrutiny in Jersey are set in the report and proposition of the Privileges and Procedures Committee P.186/2003, adopted by the States on 27th January 2004.

1.1.2 Deputy J.L. Dorey was appointed as Chairman of one of the Shadow Scrutiny Panels. The full membership of this Panel is as follows -

Deputy J.L. Dorey, Chairman
Connétable M.R. de la Haye
Connétable D.J. Murphy
Deputy M.F. Dubras

Deputy G.P. Southern contributed significantly to the Review but left the Panel before it was finalised.

1.1.3 The Panel is grateful for the tireless support provided by the lead officer for this Review, Mr. Mike Haden, whose work has been invaluable.

1.2 THE SCRUTINY REVIEW

1.2.1 In April 2001, the Imperial College School of Medicine, commissioned by the Jersey Substance Misuse Strategy Group, published the findings of the first comprehensive study on drug and alcohol use in Jersey. This report, entitled 'Responding to Drug and Alcohol Use in Jersey', highlighted the major health and social problems in the Island caused by the use of both alcohol and illegal drugs, and set out clear recommendations for responding to this challenge. (See: **Key findings and recommendations - Appendix One**).

1.2.2 In April 2004, the Shadow Scrutiny Panel, chaired by Deputy J.L. Dorey, decided to review the progress made in reducing the harmful effects of drug use, in particular opiates, which had been identified in the report as the main drug of choice in Jersey. In doing so, the Panel was conscious that the Health and Social Services Committee was developing proposals for addressing the other strand of this important study in its alcohol strategy for the Island

(P.110/2003, subsequently adopted by the States on 27th July 2004).

1.2.3 The Panel agreed the following terms of reference -

To examine the implementation by the Alcohol and Drugs Service of the recommendations contained in the Study of the Imperial College School of Medicine, published in April 2001, in respect of drug use in Jersey.

1.2.4 In undertaking this review, the Panel is conforming with two key objectives of Strategic Priority 3 of the States Community Safety and Substance Misuse Strategy 'Building a Safer Society 2005-2009' ([1]), namely -

Objective Five. Continually review evidence-based interventions in order to extend the range and availability of options for problematic drug users.

Objective Six. Where appropriate, provide offenders within the criminal justice system with access to alternative and effective programmes.

1.2.5 The Review is also in line with the principles of the United Kingdom Drugs Strategy 'Tackling Drugs to build a better Britain: the Government's ten year strategy for tackling drugs misuse' (2). This strategy identifies treatment as one of its four key elements and recognises that there is growing evidence that treatment works. The Strategy aims to -

'enable people with drug problems to overcome and to live healthy and crime-free lives.'

This means ensuring that -

'all problem drug-misusers - irrespective of age, gender, race and drug of choice - have proper access to support from appropriate services - including primary care...'

1.2.6 It should be made clear at the outset that the Panel was not undertaking the review from the point of view of professionals working with drug addiction, although one member of the Panel, Deputy Southern, brought his experience as a qualified drug and alcohol counsellor. The review focuses on the provision of services to individuals and the wider community and the ways in which opiate abuse affects the lives of addicts and their families. The Panel believes that its role is to take an overview as 'outsiders'. Panel members approached the review with a 'layman's knowledge' of the issues involved and sought, as a priority, to give due value to the views of the

service-users themselves and their families.

- 1.2.7 The Panel has based its findings on the evidence it has gathered from a wide range of sources from statutory as well as voluntary organisation, politicians as well as members of the public. This evidence has been in the form of written submissions, interviews with individuals, site visits and research into service developments elsewhere.
- 1.2.8 As evidence came into the Panel in the course of the Review, the Panel became increasingly aware of the broad scope of issues affecting substance misusers.
- 1.2.9 The Panel sought to question the evidence it had received from witnesses in a series of public hearings. The Panel has attempted to report fairly the evidence it has received and has drawn conclusions from what it has heard.
- 1.2.10 While it does not have the resources to check every statement used as evidence, the Panel has given relevant States Departments and all witnesses the opportunity to comment and correct any factual errors. It was made clear to all witnesses that they were responsible for the accuracy of what they told the Panel in public evidence sessions.
- 1.2.11 The Panel trusts that its recommendations are pragmatic and proportionate and that they will contribute towards the continual development and improvement of services for substance misusers which are being carried out with considerable commitment and devotion by professionals in the Island's statutory and voluntary agencies.
- 1.2.12 The Panel is pleased to note that a number of issues raised in the evidence received in the course of the Review are already being addressed by relevant Departments.

2. THE WORK OF THE PANEL

- 2.1 The Panel wrote to the Health and Social Services Committee on 15th April 2004 setting out the key information it wished to consider in its review and requesting that the **Alcohol and Drugs Service**, the Island's statutory community based service for substance misusers, be directed to prepare a report on progress to date in implementing the recommendations of the Imperial College report (**Appendix Two**).
- 2.2 The submission from the Director of the Alcohol and Drug Service, received at the end of May 2004, gave evidence regarding the expansion of the Needle Exchange programme, the introduction of the Arrest Referral Scheme (two of the key Imperial College recommendations) and other harm reduction treatments and interventions. (This submission, together with copies of all written submissions to the Panel, is contained in **Appendix Three**).
- 2.3 The Panel subsequently received a report from the **Manager, Adult Mental Health Services**, outlining the full context of addiction treatment services provided by Health and Social Services, voluntary agencies and specialist off-Island placements.
- 2.4 The Panel also received a submission from the **Health Promotion Officer (Drugs)** on drug education and training programmes. The Panel recognised the important role played by the Health Promotion Department in spreading harm reduction messages but decided to maintain its focus on front line services provided to substance misusers.
- 2.5 A key Imperial College recommendation was that the extent of HIV and HCV infections among injecting drug users should be established. In this connexion, the Panel received a submission from **Dr I. Muscat, Consultant Microbiologist**.
- 2.6 The Panel sought the views of the enforcement agencies, **States of Jersey Police** and **States of Jersey Customs and Excise**, on the current prevalence of illegal drugs in the Island. The Panel noted that intelligence-led policing and joint operations between the two agencies had led, in the last few years, to the seizure of ever-increasing quantities of Class A drugs. The Panel was informed by the Police that, overall, it did not appear that there had been a corresponding increase in the police having to deal with problematic drug users. The Chief Officer, States of Jersey Police, wrote in his submission -

'Law enforcement at the higher level of the illegal drugs market may well be impacting upon the amount of drugs available for the lower level dealers and potentially may force them to seek the treatment they need through the appropriate health and

advisory services. So, whilst seizures of drugs by law enforcement continue apace, the police perception is that drugs problems are not developing in the same way.'

The Panel decided that, as the focus of the Review was on the support available to substance misusers, it would not pursue further enquiries into the work of the enforcement agencies.

- 2.7. The Panel received submissions from **two medical practitioners** involved in the Community Opiate Substitution programme, Dr D.J. Bailey and Dr M. F. Marks. The latter is a member of the Drug Dependency Advisory Group and runs three clinics a week at Gloucester Lodge for substance misusers. In addition, it received the comments of the **Consultant Psychiatrist** on the Opiate Substitution programme.
- 2.8 The Panel was conscious that many drug users are drawn into the **criminal justice system** and that prison becomes a 'revolving door' experience. In this context, the Panel was grateful for being given access to a report entitled 'Health Needs Analysis HM Prison La Moye, 2004', carried out by Dr R. Wool for the Home Affairs and Health and Social Services Committees (Wool Report 2004) ⁽³⁾ The Panel also received information from the **Prison Medical Officer** on the developing drug strategy at H.M.P. La Moye and from the recently appointed **Substance Abuse Counsellor**. In addition, the **President of the Home Affairs Committee** gave oral evidence in a Public Hearing on the Committee's views on sentencing policy and after-care for newly released prisoners.
- 2.9 The Panel received evidence from the Jersey **Probation and After Care Service** which offers a range of evidence-based services for offenders with substance misuse problems, many delivered in partnership with the Alcohol and Drugs Service.
- 2.10 The Panel contacted four agencies in the voluntary sector providing shelter, support and a way forward for substance misusers - the **Shelter Trust**, the **Roseneath Centre**, the **Jersey Council on Alcoholism** and the **Jersey Addiction Group**. These groups raised issues of co-ordination with statutory services, financial support and sharing of information.
- 2.11 The Panel issued a **public call for evidence** requesting the views of substance misusers and their families on the services available to them on the Island. In view of the sensitive nature of the subject, the Chairman agreed to accept calls on his private number on a confidential basis. This offer was accepted by several individuals who gave forthright evidence about the assistance as well as the obstacles they had encountered. (Notes of these testimonies can be found at **Appendix Four**)

- 2.12 In order to develop a better understanding of the operation of services, the Panel undertook various **site visits**. It met the staff team, as well as a group of clients, at Gloucester Lodge and subsequently interviewed the Needle Exchange Worker and the Arrest Referral Worker. It had group discussions with residents and former residents of Silkworth Lodge and inmates on the female wing at H.M.P. La Moye. Members also attended open meetings of Narcotics Anonymous and Families Anonymous. (Notes from these visits can be found at **Appendix Five**.)
- 2.13 Once the Panel had considered the written submissions, it invited key selected witnesses to a series of **public hearings** in July 2004 in order to discuss their evidence with them in person. Witnesses included the **President and Chief Executive of the Health and Social Services Committee**. This Committee holds overall responsibility for statutory addiction treatment services. (Notes from these hearings can be found at **Appendix Six**.)
- 2.14 The Panel also offered the opportunity for individuals affected by addiction to attend a **confidential hearing** session with the Panel. This offer was accepted by three mothers of substance misusers who provided powerful testimony concerning the impact of addiction both on users and their families. (Notes from these hearings can be found at **Appendix Seven**.)
- 2.15 The Panel was conscious that the issue of de-criminalisation of illegal drugs was a matter of public debate. It received a submission in this respect from one contributor who was invited to discuss his views with the Panel at one of the Public Hearings. However, the Panel agreed that this issue was outside the remit of the current Review and decided simply to note the views presented (See notes **Appendix Six**).

3. STATUTORY SERVICE PROVISION: ALCOHOL AND DRUGS SERVICE

3.1 NEEDLE EXCHANGE PROGRAMME

3.1.1 The Imperial College Report noted the high rate of injecting drug use and sharing of syringes and paraphernalia in Jersey and recommended the expansion of Needle-Exchange services to prevent the spread of HIV and other infectious diseases, firstly among injecting drug users and then, via sexual transmission, to the wider population.

3.1.2 The Panel noted many positive outcomes following the appointment of the Needle Exchange worker in 2002, including -

the level of needle sharing has dropped significantly from 91% to 60%;
an expansion in the number of outlets including pharmacies in Gorey and St Brelade where fitpacks (containing a supply of clean needles and syringes, citric acid sachets and pre-injection swabs) are available;
an improved liaison with other agencies such as Accident and Emergency, where a confidential 24 hour service is now available to substance misusers;
positive co-operation between the States of Jersey Police and the Needle Exchange worker in highlighting areas where needles have been found in order that the message is passed back to users in an effort to reduce risk; and
an indication that the majority of users were satisfied or very satisfied with the service (60% and 32% respectively - De La Haye, May 2004) ⁽⁴⁾ .

3.1.3 The Needle Exchange worker plays an active role in building a relationship of trust and confidence amongst the 'hidden group of users'. She told the Panel that it is difficult to quantify the impact of this work as many clients of this service are not at a stage where they are contemplating treatment. However, she is able to lay the foundations for a message of harm reduction. She also provides overdose prevention and management training to all drug users presenting for treatment, and has run harm reduction sessions to inmates at H.M.P La Moye.

3.1.4 The Panel was informed that there was an initial increase in take-up of fitpacks in the first year (2002) in which the Needle Exchange worker was employed (68,260 needles and syringes distributed). Following that in 2003, despite increased access and availability, there was a decline in the take-up of fitpacks (60,025). The Director, Alcohol and Drugs Service, suggested that this reduction indicated a decrease in the overall number of drug injectors in the Island', relating to the fact that 44 new drug users had entered treatment during the year

- 3.1.5 The Panel was informed that lawdrafting instructions had recently been agreed with a view to amending the relevant legislation in order to regularise the position of the Needle Exchange scheme and to enable the provision of additional drug paraphernalia, including sterile water, spoons and filters, in line with legislative changes in the United Kingdom. It is estimated that supplying the extra equipment with each fitpack will cost a minimum of £12,810 or a maximum of £19,320 (depending on the supplier chosen). The Panel was informed that there was currently no budget allocation for this purpose.
- 3.1.6 The Needle Exchange scheme has attempted to encourage greater access on the part of Portuguese drug users through the inclusion of Portuguese language leaflets in the fitpacks. The Needle Exchange worker reported that the number of injecting users within the Portuguese community is not known at present. This has proved to be a difficult group to target as they tend to remain closely within their own groups. It is recognised by the Alcohol and Drugs Service that further work needs to be done generally to ensure equity of access for the Portuguese community.
- 3.1.7 The Panel was informed that the Needle Exchange worker regularly liaises with each outlet participating in the Community Needle Exchange scheme. Fitpacks are available free to drug users at Gloucester Lodge and at Accident and Emergency but there is currently a charge when collected from community pharmacies (£1.50) This charge provides a payment to the pharmacy for covering the service; the fitpack itself is provided free of charge by the Alcohol and Drugs Service. This differs from the position in the United Kingdom where provision of fitpacks to injecting users is free of charge, a set annual fee being negotiated with the pharmacies for the service provided. The Panel was advised that the provision of fitpacks free of charge from pharmacies would be likely to broaden distribution and increase take-up. However, this would also have a budgetary impact on the Needle Exchange scheme, in the region of £6,750 on the basis of current take-up (4215 fitpacks from community pharmacies and other outlets in 2003) but increasing as take-up developed.
- 3.1.8 The Police reported an increase since 2001 in reports of discarded needles being found, possibly due to the greater and more readily available supply. Substance misusers are encouraged to return used needles when collecting new ones. However, they remain wary of carrying used equipment in case they are stopped by police. The Panel was informed that suggestions have been made that posters might be displayed in communal areas or housing estates where discarded needles have been found and that sharps bins could be installed to improve public safety. However, residents have so far resisted these ideas.

3.1.9 The Panel, on its visit to Gloucester Lodge, noted the difficulties caused by the current cramped accommodation. This has the following implications for the NE scheme -

Clients currently pick up fitpacks from Reception. This raises issues of confidentiality for some who are on the Methadone Programme, as clients should not be injecting heroin whilst on the scheme. But if they should lapse, it is important that they use clean injecting equipment to avoid the possible transmission of blood born viruses. The Alcohol and Drugs Service has a policy that Needle Exchange is anonymous and staff who give out fitpacks do not inform key-workers that a client on the Methadone programme has collected a fitpack. However, difficulties arise from the fact that clients have to come to the same building to collect a fitpack and may risk meeting their key-worker by chance.

The Needle Exchange worker shares a small office with the Arrest Referral Worker. This creates difficulties for interviewing clients, when one of the workers has to vacate the room. The same office is also used to hold weekly GP clinics. In addition, there is no dedicated clinical area in Gloucester Lodge set aside for testing.

3.1.10 The Panel understands that accommodation for the Alcohol and Drugs Service will be improved once the Health Promotion Department moves to St. Saviour's Hospital.

3.1.11 The Panel recognises the achievements of the Needle Exchange scheme since the publication of the Imperial College Report in 2001 and believes that further development of the scheme should be promoted to build on this success. The Panel suggests that priority consideration should be given to the following -

The provision of the necessary funding for additional drug paraphernalia in fitpacks (estimated £13,000 - £19,000);

The provision of additional funding to enable the provision of fitpacks without charge from pharmacies (estimated rising cost £6,750+);

The provision of sharps disposal bins on a trial basis in key selected areas to promote the safe return of needles;

Further work to ensure equity of access for the Portuguese community

Separate accommodation for the Needle Exchange scheme and a dedicated office for the Needle Exchange worker.

Recommendation

The Needle Exchange scheme should be further developed to build on its initial success.

3.2 ARREST REFERRAL SCHEME

- 3.2.1 The Imperial College Report noted that Jersey's law enforcement agencies made contact with large numbers of individuals with drug problems. However, at the point of arrest opportunities to encourage offenders into contact with welfare agencies were under-exploited. It recommended the introduction of an Arrest Referral scheme which is designed to put offenders with drug-related problems, who have been arrested by law enforcement agencies, into contact with treatment services. Home Office evaluation of these schemes in the United Kingdom⁽⁵⁾ identified significant reductions in offending and in proportions of offenders using heroin and found that there were also significant improvements in health and psychological health.
- 3.2.2 An 18 month pilot Arrest Referral scheme was established through a joint venture between the Alcohol and Drugs Service and the States of Jersey Police in May 2003 and became operational in September 2003. The Panel was informed that, in the first four months of the scheme, 57 full referrals were completed (covering both alcohol and drugs), equating to approximately 5% of persons detained during that period. Of these, 50% had entered treatment, compared to the Home Office average in United Kingdom of 25%. Harm reduction information had been provided to a further 15 individuals.
- 3.2.3 The prime role of the Arrest Referral worker is to point offenders towards treatment services. She can also support offenders through the judicial process. The Arrest Referral worker comes into contact with a proportion of young offenders and first time offenders who may often be at the early stages of developing serious problems with drug abuse and who may not have previously accessed the Alcohol and Drugs Service. The scheme offers them an opportunity to deal with their problems sooner rather than later. Repeat offenders who may have declined or dropped out of treatment are also encouraged to make renewed attempts to change their lifestyle.
- 3.2.4 The States of Jersey Police reported that Arrest Referral has become a specific part of the custody process. It is intended to apply to *all* persons detained at the police station having been arrested for an offence, not just those arrested for drug or alcohol related offences. This ensures that a problem drug user committing any criminal offence to fund a drug habit can be included in the scheme. The opportunity can only be offered to a detainee who will choose to accept or

decline the offer. However, the Arrest Referral worker is able to offer an open door invitation to the Alcohol and Drugs Service to those who are reluctant to commit to an appointment when seen in custody.

3.2.5 The Panel was informed by the Arrest Referral Worker that, although some custody officers had initially seen her role as a disruption of their time, as they had been obliged to accompany her on visits to the cells, there has been growing acceptance of the scheme.

3.2.6 The Customs and Excise Department reported that, on average, customs officers had been responsible for the arrest and prosecution of 81 people per year for drug offences. According to the Wool Report 2004⁽³⁾, a third of people convicted as a result of Customs and Excise operations are probably drug dependent. However, as the Arrest Referral worker had focussed her attention on Police Headquarters a large proportion of people arrested by Customs Officers were not being seen. A rehabilitation opportunity was thus being missed. The Arrest Referral worker reported that discussions were soon to be initiated with the Customs and Excise Department. The Panel has subsequently been informed that Customs and Excise can now access this service.

3.2.7 The Panel noted that the Arrest Referral worker was subject to the same pressures of office accommodation as the Needle Exchange worker.

3.2.8 The language barrier is also a significant obstacle to engaging the Portuguese community in the Arrest Referral scheme.

3.2.9 The Panel recognises that the Arrest Referral scheme is still at an early stage. It was advised that a progress report on the impact and development of the Arrest Referral scheme would be completed in September 2004, one year after its operational introduction. The Panel believes that an informed view of the potential of the Arrest Referral scheme to encourage offenders into treatment will be possible when this report becomes available.

As an essential element of its follow-up to the present report, the Panel will consider the progress report on the Arrest Referral scheme after its first year of operation.

3.3 OPIATE SUBSTITUTION PROGRAMMES - METHADONE AND

SUBUTEX

- 3.3.1 The Director, Alcohol and Drugs Service, reported that 347 people had been treated through the Methadone programme since its inception in 1998 of whom one third had completed at their first attempt, an outcome which was *'vastly superior to the United Kingdom where research has shown only 17% of clients successfully completed treatment'*.
- 3.3.2 The Panel was informed that the Methadone programme in Jersey is carefully controlled to prevent 'leakage' onto the streets. For this reason, Methadone is taken under strict supervision in registered pharmacies and clients have to present themselves on a daily basis to receive their dosage.
- 3.3.3 The Panel heard criticism from witnesses who said that this method of supervision could be degrading for substance misusers in circumstances where they had to take their daily prescription in public view. The Panel was told by Senator Syvret that the policy of the Health and Social Services Committee was that appropriate discreet accommodation should be provided by registered pharmacies for this purpose. The Panel was advised by participating pharmacies that they recognised the need for privacy and, in cases where a separate consulting room was not currently available, plans were in hand to modify premises to improve the situation.
- 3.3.4 One witness reported that, while staff at the pharmacy were generally very understanding, his daily visits to the chemist to obtain the daily supply meant that he could be easily identified as an addict. This situation might cause difficulties with work colleagues, for example; or make him vulnerable to those pushing drugs. The Panel was advised by Dr Bailey, however, that it was important to maintain strict daily supervision of the dispensing of Methadone in order to prevent leakage of the medication onto the street market.
- 3.3.5 The Panel was informed that the Methadone programme is not intended as a long-term maintenance regime. Its aim is to help substance misusers reduce and ultimately cease their dependency on opiates. The programme is designed to assist individuals to manage the withdrawal symptoms experienced in stopping use of opiates while at the same time helping them to improve their health and social functioning. In practice, however, some users stay on the programme for a considerable period of time.
- 3.3.6 Subutex, which has been introduced by ADS following a recent successful trial, offers an alternative treatment option which has distinct advantages over Methadone. It acts as a blocker to opiate use rather than just a replacement for heroin. It is easier to withdraw from and requires

less medical supervision. Some anecdotal evidence was given to the Panel that Subutex could be abused by mixing with other drugs but the Panel was advised that it is prescribed under careful supervision to avoid it being diverted.

3.3.7 The Panel heard criticism from witnesses who consider that the Methadone programme is expensive and ineffective. A number of recovering addicts told the Panel that, in their view, the Methadone programme simply involved the substitution of one addictive substance for another, and that, in their experience, it was just as difficult to stop using Methadone as to come off heroin itself. They said that they did not feel that the attempt to control the use of drugs through a gradual weaning process was ultimately a realistic approach. The Panel was told that many addicts actually welcomed the message they were given by this programme that drug use can be moderated. The reality was that they do not wish to stop using. A programme which did not address the underlying causes of addiction, they said, was bound to fail in many cases. The Panel was also told that many addicts regard the Methadone programme simply as a cheap way of remaining on drug use for a period until they can get a further supply of heroin.

3.3.8 Dr J. Sharkey, Consultant Psychiatrist, expressed the dilemma of the Methadone programme sharply -

'ADS time is taken up unduly playing cat and mouse with habitual long-standing drug users who want a supply of Methadone and valium for free to make their addiction less oppressive. These individuals are given restricted access to Methadone and buprenorphine on the understanding that they will not use heroin. If they use heroin they incur penalties based on the yellow/red card system in football. This results in a substantial cohort of drug users who remain on Methadone for a few months - are off the programme for a few months and then are back on to repeat the cycle. ... There are a group of people who will always absorb an almost infinite amount of resource for no or very modest gain....These individuals need to be offered counselling and needle exchange and any other services other than substitution prescribing, once they have proven resistant to reasonable attempts with substitution prescribing. The Methadone programme should be limited to those who demonstrate their commitment.

.....This is just one example of the fairest way to ration tax-payers money to public services. With limited resources it is our duty to make the most of those resources with distribution on the basis of effect rather than emotion.'

3.3.9 The Director, Alcohol and Drugs Service, argued that this criticism of the Methadone

programme was unfair. He stated that it was the duty of the Service to work with a range of substance misusers with differing motivations. The Service has to deal with individuals as they are and try to work with them to reduce the harm they are causing themselves. It cannot simply deal with those most motivated to change their lives while choosing to ignore those who continue to live chaotic lives.

Addicts are a diverse group needing a diverse range of treatments, including community-based as well as residency-based, primary and secondary care facilities. ...Substance misusers are most likely to respond within a community-based service where they can learn the skills needed to live in the real world, including avoiding dealers and other users.

3.1.10 The Panel was told by the staff team at Gloucester Lodge that Methadone treatment should be seen as a long-term programme. They said that, while the ultimate aim of the programme might be abstinence, it is necessary to take an incremental approach. Building self-esteem and confidence among substance misusers is a long, slow process. This might start simply on the basis of safer injecting practice through not sharing needles. Repeated relapses are a common experience among addicts. However, it is in the best health interests of substance misusers to get them started on a treatment programme, even if they fail time and time again. The staff team told the Panel that they could point to cases where people have been genuinely helped to change their lifestyle and have, to date, remained clean of opiate misuse. Other people, still in the Methadone programme, are being supported to lead more positive lives in the community, free of illegal drugs, and with good family relationships.

3.3.11 Dr Bailey also defended the prescribing of Methadone in a properly controlled manner. As with any medication, he said, it is necessary to weigh up the pros and cons: the Methadone programme offered many advantages to addicts compared to the health risks associated with misuse of opiates and the potential for addiction to turn individuals to crime to feed their drug habit.

3.3.12 The Panel heard criticism from a number of witnesses regarding the warning (yellow/red) card system used as part of the monitoring controls to check whether a client on the Methadone programme was relapsing into use of illegal opiates. By doing so, clients would appear to be using the Methadone programme as a way of obtaining a cheaper substitute until they could afford a further supply of heroin. It was suggested to the Panel that this system discouraged substance misusers from being totally honest with their counsellors and that a reward system might be better than a system which effectively acted as a punishment. The Panel was advised by Dr Bailey, however, that some form of control was necessary. Using heroin while on the

Methadone programme was potentially risky. He said that he would not be comfortable in continuing to prescribe to someone attempting to cheat the system.

3.3.13 The Panel acknowledges that there is a difficult balance to be struck in dealing with the insistent demands of substance misusers, some of whom may only be looking for a short-term solution to a drug-related crisis in their lives, while others are genuinely striving, despite failures, to reduce their dependency on opiates. Many substance misusers are leading chaotic lives and there is generally no smooth route to achieving a clean lifestyle. The Panel recognises that the provision of effective harm reduction measures, such as Methadone and Subutex, is, by its nature, costly in the time and energy required by counsellors and medical practitioners, and that there are no guarantees of success. In addition, the consequence of withdrawing such support from a vulnerable section of the community support would be spiralling additional costs and pressures on the health and social services of the Island, as well as the criminal justice system.

3.3.14 The harm reduction approach is a relatively recent initiative in Jersey and, from the evidence it has considered, the Panel believes that it is helping many substance misusers to lead more positive and healthy lives. The Panel does not want to undermine in any way the hard-won resources which have been allocated to the opiate substitution programme. Nevertheless, it believes that the criticisms expressed by many witnesses should be addressed in the light of best practice elsewhere.

Recommendation

A review of the opiate substitution programme should be carried out by an appropriate external medical body.

3.4 DETOXIFICATION PROGRAMME

3.4.1 Detoxification (detox) treats the physical effects of addiction. It may be undertaken by a substance misuser, either through a hospital admission or in the community/home under medical and nursing supervision, in order to alleviate the symptoms of withdrawal. An addict may instead decide to attempt withdrawal from opiate use without medical supervision. This carries less risk to health for an opiate addict than for an individual attempting to withdraw from alcohol dependence.

- 3.4.2 The Alcohol and Drugs Service reported that it completes on average approximately 110 community detoxes a year of which 60% are for opiates, the rest for alcohol. (In 2002, 43 alcohol and 68 drug detoxes were carried out; in 2003, these figures were 47 and 70 respectively) It was further reported that 42% of the total number who had undergone a community detox in 2002 enjoyed some degree of abstinence or were still abstinent by the end of the year.
- 3.4.3 The Panel was told by the Director, Alcohol and Drugs Service, that a detox may be requested by addicts for many reasons other than to achieve long-term abstinence from substance misuse - they may be seeking a short-term break from drug use for health reasons or to alleviate a temporary crisis. For example, they may want to get clean for a court appearance or they may have family visiting. They may be under pressure from work or from a partner.
- 3.4.4 The Panel heard criticism from service users that it commonly takes a long time to access the detox programme once the addict makes a request. It was advised by the Alcohol and Drugs Service staff team that, as detox is a medical procedure, there has to be an adequate assessment of the appropriate treatment for the client's own safety. Detox also involves a considerable commitment of nursing time which can't necessarily be scheduled with immediate effect. The Director, Alcohol and Drugs Service, quoted in an article in the Jersey Evening Post in September 2004, said that

'A detox programme is always planned in advance and nearly always carried out at home in familiar surroundings. This is because they need time to make the necessary changes and be psychologically prepared. In most cases we hope the families would be there to support them. To come off the drug that has been part of their lives for many years is like a bereavement to them. Being mentally prepared and having a set date for detox, rather than being admitted on the spur of the moment, means people are more likely to complete it. (see Appendix Ten for full article)

- 3.4.5 The Panel also heard criticism from a number of witnesses of the long-term effectiveness of the community detox programme, due to inadequate social and psychological aftercare and support. It was asserted that the majority of substance misusers inevitably relapse into their former drug using habits. The Panel was told that an addict detoxing at home can rarely avoid contact with the peer group of fellow substance misusers. This makes it difficult for the misuser to maintain the motivation to complete the treatment successfully and to remain clean.
- 3.4.6 One witness (identified as Mrs E), quoted in an article in the Jersey Evening Post in June 2004,

said -

'I found out what banging your head against a brick wall meant. I was appalled at the cavalier attitude of the authorities and their pretence that addiction was not a problem in Jersey. The system did not offer what I knew [my son] required, which was time out from the outside world, a chance to re-learn life skills, a need to re-examine his own weaknesses and abilities and the opportunities to be understood. All that was on offer was Methadone, clean needles, poor counselling, spells in prison an utterly miserable lifestyle. Of course there were detoxes in hospital, but these were for a mere five days, which cleared the body of heroin but did little else. As far as I'm concerned it's a waste of valuable resources because there is no proper structure for after-care. I lost count of the number of times I heard [my son] begging them to keep him in hospital where he knew he was safe.

I don't mind admitting that I had a lot of run-ins with the Alcohol and Drugs Service, who just seemed to want to promote the Methadone programme or home detoxes. Their aftercare service is negligible. It is time the authorities opened their eyes and invested in proper rehabilitation facilities.' (see Appendix Ten for full article)

- 3.4.7 The Panel was told by the Programme Director, Jersey Addiction Group, that clients wishing to access the treatment and rehabilitation programme at Silkworth have to undergo a detox before admission. This has commonly resulted in a delay of a number of weeks in commencing the programme. In order to promote a speedy initiation into rehabilitation, the Programme Director, a qualified nurse, has offered to conduct detoxes in Silkworth Lodge, under appropriate medical supervision provided through the Alcohol and Drugs Service. This offer has not yet been accepted. However, the Programme Director reported that the situation has now improved following the appointment of a liaison officer.

'This is a huge step in the right direction, but there is still a long way to go.'

- 3.4.8 The Programme Director also criticised the fact that, until recently, clients who had undergone a community detox through the Alcohol and Drugs Service had not been offered the opportunity of accessing the rehabilitation programme at Silkworth Lodge.

'I'm concerned that of around 600 referrals a year to Alcohol and Drugs Service and over 100 reported community detoxifications carried out by them, until very recently not one has been invited to go and chat with us with a view to accessing our rehabilitation programme. There is not a system of referral in place to give the

people who could benefit from our services, who are repeatedly using the Alcohol and Drugs Service, the opportunity to come to Silkworth Lodge.'

The Programme Director clarified the point he was making. He said that individuals, who came to Silkworth Lodge for assistance of their own volition, had to be sent to the Alcohol and Drugs Service before admission, for assessment for financial support. He said that no admissions to Silkworth had originated from Alcohol and Drugs Service.

3.4.9 The Director, Alcohol and Drugs Service, advised the Panel that between August 2003 and August 2004, his Service had assessed and funded 23 clients for Silkworth Lodge at a total cost of around £71,000. He pointed out that many clients referred to Silkworth Lodge do not take up the offer either because they are unable to take time off work or are not attracted to a 12-step, Christian-orientated philosophy. Some might prefer a more behavioural-type approach in order to develop social and inter-personal skills, while others may need to address complex psychological problems, such as sexual abuse, post-traumatic stress or personality disorder.

3.4.10 Dr Marks told the Panel that, in his view, a centralised medical facility could provide an improved detox service for substance misusers. (See paragraph 5.7) He supported the use of community detoxes, but stressed that adequate medical and psychological aftercare must be available. In his view, psychiatric wards were not generally the appropriate setting for detoxing substance misusers. The psychiatric service was currently providing this facility only because adequate alternative hospital facilities do not exist. Addiction, for the most part, should be treated in the community.

3.4.11 The Panel believes that enhanced social and psychological support for substance misusers undertaking detoxification is essential in order to promote greater long-term effectiveness of the programme. In its view, the introduction of the proposed integrated care pathway system of assessment, treatment and aftercare (see paragraph 3.6.7) will be an important step towards this objective.

Recommendation

Current detoxification practice should be reviewed within the context of the introduction of the proposed integrated care pathway system of assessment, treatment and aftercare.

3.5 ACCESS TO SERVICES

- 3.5.1 The Panel noted the client care aspirations for the Alcohol and Drugs Service, as set out in paragraph 1.2 of the Director's submission. He reported that the Service receives between 550 and 600 referrals a year and of these a third are for opiates (approximately 148), with a male/female ratio of 2:1. This equates to a weekly average of approximately 15 referrals (for both alcohol and drugs), which have to be prioritised within the resources available and the on-going caseload of the staff team (each worker has a caseload of around 58 clients). Around 150 opiate users have entered treatment since the publication of the Imperial College Report in 2001, with 68% of the Island's opiate users now in contact with the Alcohol and Drugs Service (compared to 50% in 2001 and a 20% average in the United Kingdom).
- 3.5.2 An initial appointment with the Alcohol and Drugs Service includes an assessment of the individual's needs and motivation in order to determine the appropriate choice of treatment options. There is a counsellor on call at Gloucester Lodge during office hours and on two evenings a week, but not at weekends.
- 3.5.3 The Director, Alcohol and Drugs Service, told the Panel that the service attempts to respond quickly when substance misusers come for help. The average response rate is between two to three weeks, compared to an average in the United Kingdom of 4.6 to 9.1 weeks. Some vulnerable people, such as a pregnant woman or a young, chaotic teenager, will be seen more quickly. The Director told the Jersey Evening Post in the above article (See 3.4.4) -

We will see anyone with a drug or alcohol problem. Our objective is to make the service very flexible, to encourage people to seek help and stay in contact. Some people don't turn up for their first appointment. They tend to refer themselves in a time of a crisis when they are in trouble. Then they change their mind when the crisis is over and their motivation has disappeared.

It is important people don't feel embarrassed or ashamed. Our clients must feel they are being valued and listened to. If you don't treat them with respect they won't come back and then you can't help them.

- 3.5.4 The Panel noted the high levels of satisfaction with the service indicated in an anonymous questionnaire by 45 respondents ⁽⁴⁾. However, the Panel also heard a number of complaints from witnesses regarding the quality of service received by themselves or their family members from the Alcohol and Drugs Service. The Panel believes that it is important to acknowledge client views in this report. The chief criticisms come under the following main headings -

Slow response to requests for assistance
Narrow approach and restricted treatment options
Communication
Counselling

(a) Slow response to requests for assistance

3.5.5 A number of witnesses reported that they had faced significant delays in getting appointments to get an assessment or to see a counsellor. They argued that the 'window of opportunity', the moment when an addict is motivated to change their lifestyle, should be seized. A delay in response from services might mean that an individual, especially one with a chaotic lifestyle, fails to return. In some cases, this delay might have serious consequences for the health of the individual. Several witnesses complained that Gloucester Lodge was only open during office hours except for a couple of evening sessions, and not at all at weekends. One witness (identified as Mrs G) said that her son had been ready to go into Silkworth Lodge to start their rehabilitation programme but funding had had to be approved by the Alcohol and Drugs Service

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'Typical - no appointment till next week. Then their decision on my son's life. I drove to Drugs and Alcohol with him and begged for help. Everyone was in a meeting. But someone was supposed to phone me back yesterday. I am still waiting. My son was so desperate. Now I don't know where he is.'

The Panel was subsequently told that her son had been admitted to Silkworth Lodge. Alcohol and Drugs Service had insisted that he should remain on the Methadone programme, although this was at odds with the rehabilitation programme at Silkworth Lodge. In the event, her son had lasted only a few days before being asked to leave Silkworth Lodge. On returning to the Alcohol and Drugs Service he was told that he could not re-start the Methadone programme until three months had elapsed.

3.5.6 The Director, Alcohol and Drugs Service, told the Panel that it was a common feature of addiction that users seek immediate gratification or response to their requests for help. He said that, if an individual had been using a substance for a number of years but could not wait for a period of two or three weeks for an appointment, then the motivation required to make a fundamental change of lifestyle had to be questioned.

3.5.7 The Director suggested that it did not necessarily follow that a rapid service response led to a better outcome in terms of persistence in counselling and treatment. He reported that he had undertaken a study in Oxford on drop out rates from the point of referral. Average drop out rates were 20 to 25%. It was found that those who were seen promptly were more likely to drop out of counselling and treatment than those who had to wait for maybe two weeks. It was concluded that there were a lot of factors affecting addicts and their persistence in counselling and treatment, besides the service response rate to an initial referral. The Director said that even if additional resources allowed for a more rapid response, there would still be a certain drop out rate. He told the Panel that he believed that the current balance of response time in Jersey was about right. The drop out rate was currently only 10%.

3.5.8 In the view of the Panel, this line of thinking fails to recognise that the drop-out rate is bound to be concentrated in the early days of a programme. Those people with limited motivation for change are more likely to drop out of a programme in the early stages. A period of waiting was likely to undermine whatever motivation they might have, while a prompt response might bolster their confidence in their ability to make a change in lifestyle and dissipate their reservations.

3.5.9 The Programme Director, Jersey Addiction Group, told the Panel that he believed that a rapid response to addiction problems determines the treatment success rate. He said that Silkworth Lodge can respond to a referral within a couple of hours -

'I have no doubt that the ability to get people quickly into the treatment chain is essential for successful treatment and outcomes.'

3.5.10

The Programme Director said that he believed there was a 'time of readiness' for everyone which a treatment service can use to give an individual a chance to work towards recovery -

'It's a fallacy that you have to wait for an alcohol or drug misuser to ask for help; Silkworth Lodge staff have expertise in motivational therapy. People come to us through different motivations - the wife is going to divorce them; the boss is going to sack them - their motivation may be not because they accept the need to address the problem, but they get that in treatment. They begin to see that what they get is an opportunity to sort their lives out, not a punishment or deprivation.'

3.5.11 The Panel noted the view expressed by the Chief Executive, Health and Social Services, that the most effective way to address client care issues was through the development of an integrated care pathway (see 3.6.7).

3.5.12 The Panel accepts the difficulties in meeting the expectations of clients and their families within the busy caseload faced by the Alcohol and Drugs Service. Addicts and their relatives often only come to the service for assistance in moments of crisis in their lives and are desperate for a response and assistance. Nevertheless, the Panel believes, based on the weight of comments it has received from witnesses, that the Alcohol and Drugs Service should review the manner of its response to requests from substance misusers and their relatives for assistance.

Recommendation
The Alcohol and Drugs Service should seek to promote a more rapid and sensitive response to requests for assistance.

(b) Narrow approach and restricted treatment options

3.5.13 A common criticism of the Alcohol and Drugs Service from a number of witnesses was the view that the Service took a narrow, harm reduction approach to addiction. It was said that the Alcohol and Drugs Service focussed on means of controlling or moderating drug use through needle exchange, counselling, and Methadone treatments but failed to promote alternative, abstinence-based opportunities. A number of witnesses attributed this to the fact that counsellors at the Alcohol and Drugs Service had not themselves experienced the problems and difficulties of going through recovery from addiction. One 'grateful recovering addict' (identified as Mr. I) wrote to the Panel -

For about 18 months I was attending the Alcohol and Drugs Service. At this point in my life I knew that I did not want to continue on the path of self-destruction, just constantly drinking and taking pills, but I could not arrest my addiction on my own. ADS offered me many alternatives to help me reduce my alcohol consumption which mostly consisted of mood altering medication and charts to show me how many units of alcohol a week I should consume and said that I should continue to take the anti-depressants that I was getting from my doctor. That was not the sort of help an addict like me, or any other addict for that matter, needs. What I needed was total abstinence from any mind or mood altering chemicals including alcohol. On many occasions when attending ADS I told the counsellors (who incidentally do not have a recovering addict or alcoholic on their team) that all I wanted was to stop using pills

and alcohol, but they would persist on the path of reduction and control. Never once was Alcoholics Anonymous or Narcotics Anonymous suggested by their counsellors. I had to ask about AA and was told that it wasn't something they endorsed but if I wanted to go to an AA meeting that was up to me. As far as I am aware, not one of their counselling team or their director has ever been to an AA or NA meeting, and really all I wanted to be able to do was talk to someone who knew exactly how I was feeling.

(It should be noted that the above account relates specifically to addiction to alcohol and anti-depressants rather than opiates. However, it reflects the views expressed to the Panel by a considerable number of substance misusers and their relatives who pointed out the inherent irony in controlling substance misuse with other prescribed substances.)

3.5.14 The Director, Alcohol and Drugs Service, pointed out that, contrary to the opinion expressed above (3.1.13), the service did offer abstinence-based opportunities. A key aspect of the work of the Alcohol and Drugs Service, he said, involved Relapse Prevention in order to help those clients whose goal is abstinence.

3.5.15 The Programme Director, Jersey Addiction Group, expressed his sense of frustration about the lack of referrals from Alcohol and Drugs Service.

'I don't criticise the Alcohol and Drugs Service for the work they do. They have a huge task and do exceedingly well with the resources they have. All I am asking for is a quicker response and for the Alcohol and Drugs Service to offer the opportunity for those who need it, for an abstinence-based treatment of proven value - which the Service itself cannot offer.'

3.5.16 In the course of the Review, members of the Panel attended open meetings of Narcotics Anonymous, Families Anonymous and residents of Silkworth Lodge. Participants at each of these meetings commented that there appeared to be reluctance on the part of the Alcohol and Drugs Service to acknowledge the value of the 12-steps rehabilitation programme (originally developed by Alcoholics Anonymous) and the support that could be provided to recovering addicts through attendance at such meetings. Some even said that they had been advised not to attend these meetings. It had been intimated by the Alcohol and Drugs Service that drugs would be available at the meetings. In contrast, members of the Panel had been impressed by the openness and sense of commitment expressed by participants at the said meetings.

Recommendation
Substance misusers wishing to access treatment should be made fully aware of the comprehensive range of options available in the Island, including abstinence-based approaches, and the support available through Narcotics Anonymous and other agencies.

(c) Communication

3.5.17. The Panel, on its visit to Gloucester Lodge, heard from one witness who thought that there should be better communication between clients and the management of the Alcohol and Drugs Service. He said that there was a feeling among clients that the Service didn't really listen to what addicts themselves have to say about their needs. Clients of the Service had no knowledge of the way the Service might be developing.

3.5.18 The Panel was advised by the Alcohol and Drugs Service staff team that a number of attempts had previously been made to establish a client user group to give clients a stronger voice and to enable a more consistent and informed communication between management and clients. These efforts, however, had been unsuccessful, despite some initial expressions of interest from clients. It had proved to be difficult to maintain initial enthusiasm. Another important factor had been fear on the part of clients that meetings would be monitored by the police. Similarly, a support group, Parents Against Drug Abuse, had soon folded due to concerns among participants about confidentiality and identification.

3.5.19 The Panel accepts the difficulties in establishing suitable forums for substance misusers and their relatives. However, it believes that continued efforts should be made to listen to the concerns and opinions of those who currently use the Service, as vital lessons may be learnt from those who have gone through the experience of addiction themselves. Innovative methods may be needed to instil confidence in people who are suspicious of outsiders, due to the illegal nature of substance misuse.

(d) Counselling

3.5.20 Some clients of the Alcohol and Drugs Service referred to a lack of choice over counselling. They recognised that it was not feasible to have an open choice of counsellor but they also

pointed out that personality clashes could sometimes arise. The formation of a bond of confidence is an important element in a counselling relationship. These witnesses requested that their preferences receive some consideration, wherever possible.

3.5.21 Other witnesses told the Panel of their perception that counselling at Alcohol and Drugs Service was narrowly-based as counsellors seemed not to have the time to address the wider social and psychological needs of their clients.

3.5.22 The Panel is not qualified to comment on the issues addressed in the counselling programme conducted by the Alcohol and Drugs Service. It sees its role as reporting the views of service-users and believes that these comments would best be considered in the context of the introduction of the integrated care pathways approach. (See paragraphs 3.5.11 and 3.6.7)

3.5.23 It should be noted that it is argued elsewhere in this report (Section 5.8 to 5.10) that a community-based multi-disciplinary service should be a key priority in the future development of services to substance misusers in the Island. The Director, Alcohol and Drugs Service, in his oral evidence to the Panel stated that this would be his chief aspiration for the service.

3.6 CO-ORDINATION WITH OTHER AGENCIES

3.6.1 The Imperial College Report noted that, from 1997 onwards, a concerted effort had been made in the Island both to improve access to services for opiate drug users and to extend the range of interventions provided. This had resulted in a network of specialist drug agencies and a larger number of generic agencies whose client base also included drug users.

3.6.2 The Director, Alcohol and Drugs Service, reported that his service has in recent years developed close working relationships with a range of statutory and voluntary agencies.

It is widely recognised that no single agency can by itself effectively deal with the wider social issues commonly associated with problematic drug use, such as housing, unemployment and educational problems.

3.6.3 The Director cited various projects in both his written submission and oral evidence to the Panel, including improvements in communication and data collection with GPs (Pink List); bi-monthly meetings of the Drug Dependency Advisory Group; consultation workshop for the development of the new Crime and Substance Misuse strategy.

3.6.4 Further evidence of inter-agency collaboration was reported to the Panel by the Shelter Trust (introduction of an open-door clinic); the Roseneath Centre and the Jersey Council on Alcoholism (improved protocols for the sharing of relevant information and bi-monthly meetings for caring agencies); the H.M.P La Moye (harm reduction courses and pre-release work); Silkworth Lodge (appointment of liaison officer).

3.6.5 The Manager of Adult Mental Health Services reported to the Panel that it was recognised that more work was needed to develop collaborative working between agencies -

'During November 2003 the Alcohol and Drugs Service came under the management of the manager of Adult Mental Health Services. It became apparent that although a lot of good work is being achieved and a vast remit of local services are available to people with substance misuse problems more needs to be done to provide better co-ordination and improve pathways into and out of specific services.'

3.6.6 A similar comment was voiced by the Programme Director, Jersey Addiction Group, who told the Panel that, in his view, there were many agencies providing good services to substance misusers on the Island but they were not well co-ordinated to maximise the benefits they offered -

'They are generally dealing autonomously with individual parts of a much greater problem which could be dealt with more effectively through collaboration.'

3.6.7 The Manager, Adult Mental Health Services, told the Panel that a draft paper had been prepared, in collaboration with the Programme Director, Jersey Addiction Group, identifying and standardising integrated care pathways ⁽⁶⁾. More recently the Director, Alcohol and Drugs Service, has taken a lead with the Programme Director, Jersey Addiction Group, to further develop the draft pathways strategy document. Consultation would soon commence with key stakeholders for their input and support with this piece of work. The Panel was subsequently informed by the Director, Jersey Council on Alcoholism, that a meeting had been arranged to involve other voluntary agencies such as the Roseneath Centre, the Shelter Trust and the Jersey Council on Alcoholism at the end of October 2004.

3.6.8 The Chief Executive, Health and Social Services, also endorsed this approach. He said that it was important to develop a rigorous system of co-ordination, a clear line from presentation through to intermediate care and specialised services, where professional roles were clearly understood. The integrated care pathway approach, he said, should be a rigorous regime for practitioners but a flexible service for the client.

3.6.9 The Panel believes that the introduction of the integrated care pathway approach is a constructive development for the better integration of services for substance misusers in the Island. As part of its follow-up to the present report, the Panel requests that it receive a report from the Health and Social Services Committee on the progress and the outcome of the consultation exercise on this approach.

Recommendation

The integrated care pathways approach should be developed as soon as possible following appropriate consultation.

3.7 TRAINING AND RAISING AWARENESS FOR PROFESSIONALS

3.7.1 The Director, Alcohol and Drugs Service, told the Panel that over the previous three years the Service had been able to provide training opportunities for approximately 30 GPs to raise awareness of the primary role in the identification and treatment of substance misusers and to challenge negative attitudes which existed amongst some doctors. The Panel was advised that it was important to ensure that substance misusers have good primary care, regardless of the fact that they were using illegal drugs.

3.7.2 The Programme Director, Jersey Addiction Group, expressed the view that GPs in the Island were not sufficiently proactive in directing clients towards the right kind of treatment. He referred to recent media reports which had highlighted the small amount of time given over to drug awareness during medical training programmes. He informed the Panel that a seminar had been organised in 2003 by the Jersey Addiction Group, aimed at assisting GPs to help substance misusers more effectively in their surgeries and to develop awareness of the availability of the treatment programme offered at Silkworth Lodge. Only 18 GPs had signed up for the occasion and of them only had eight turned up on the day.

3.7.3 Dr M. Marks told the Panel of his concern that that the majority of GPs in Jersey effectively opted out of treating substance misusers. He warned that this trend was likely to be further strengthened if new GP contracts were adopted in line with those introduced recently in the

United Kingdom. He said that there was a common perception that the patient's activities or lifestyle contributed to the condition for which they were seeking treatment. However, he occasionally liked to remind his colleagues of the following statement by the General Medical Council -

It is unethical for a doctor to withhold treatment for any patient on the basis of a moral judgement that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise the question of serious professional misconduct.

3.7.4 The Panel was told by some witnesses that substance misusers commonly faced judgemental attitudes from healthcare professionals. They gave an example of the undue pressure sometimes placed on young pregnant women who were addicts. This resulted in some women being frightened to seek the right kind of help. The Panel was advised that Alcohol and Drugs Service staff were working to challenge and change such attitudes.

3.7.5 The Panel was informed by the Director, Alcohol and Drugs Service, that there was, currently, only a limited number of GPs in the Island licensed to prescribe Methadone and Subutex. The Service hoped to expand the number of licensed GPs but this needed to be carefully controlled to avoid the risk of over-prescribing. Licensing requires GPs to undertake a certain amount of training.

3.7.6 The Panel was informed by the Director, Alcohol and Drugs Service, that there were concerns that budget cuts would limit training opportunities for GPs. The Alcohol and Drugs Service staff team also raised concern that professional training opportunities, which had been available to them through funding provided through the Substance Misuse Strategy 1999 - 2004, would no longer be forthcoming under the recently approved five year Community Safety and Substance Misuse Strategy 2005 - 2009, 'Building a Safer Society'..

3.7.7 Dr Bailey expressed similar concern at the possible reduction of training opportunities for medical practitioners. He said that training and keeping abreast of latest developments were part of the professional responsibility of all GPs.

3.7.8

The Panel believes that training for professionals dealing with substance misuse is crucial to the development of a broad-based multi-disciplinary service in the Island. It is argued elsewhere in this report (paragraph 5.11) that an innovative solution is required to replace the current reliance on the voluntary commitment and good will of a small number of individual doctors. This would be undermined if training opportunities were curtailed.

3.7.9 The Panel is pleased to note that the concerns regarding possible budget cuts for training opportunities appear to have been allayed. It has been advised that the research budget of the Community Safety and Substance Misuse Strategy 2005 - 2009 had been re-prioritised to include funding for training initiatives. GPs will be able to access this budget providing the training is directly related to the treatment of drug users.

Recommendation

Further opportunities should be offered to GPs to raise awareness of the impact they might have on the health of substance misusers.

3.8 A MEDICALLY SUPERVISED INJECTING CENTRE FOR JERSEY?

3.8.1 The United Kingdom Home Affairs Select Committee, in its review of the Government drug ten-year drug policy⁽⁷⁾, recently recommended *‘that an evaluated pilot programme of safe injecting houses for heroin users is established without delay and that, if this is successful, the programme is extended across the country.’* This recommendation was rejected by the Home Secretary; however, this decision was challenged in an article in the British Medical Journal ⁽⁸⁾, dated 10th January 2004 (Appendix Eight). Pointing to the success of similar schemes in other countries, the authors (Wright and Tompkins) argue that safer injecting rooms reduce the risk of harm to drugs users, and, by reducing injection on the street, also reduce the risk to the general population. Medically supervised injecting centres enable safe oversight by nursing staff of self-injection of street drugs in an explicitly clinical setting. Staff are not entitled to help drug users to inject drugs, but are trained to deal with overdoses and offer advice on safer methods of injecting.

‘For the policy to be effective it needs to be integrated into service provision, of which medically supervised injecting centres are one important aspect of a range of harm reduction initiatives. We would argue that medically supervised injecting centres are not a panacea for drug related deaths but a proxy marker of a policy commitment to a broad based health promotion framework for working with drug users.’

3.8.2 A number of witnesses, including the Director, Alcohol and Drugs Service, and the President,

Health and Social Services, told the Panel that they would be opposed to establishment of such a scheme in Jersey. The President said that he was not convinced that such a facility was necessary in Jersey, given all the other harm reduction work going on. It would indicate that the States had become resigned to the fact of illegal drug taking. Instead of maintaining substance use, the approach adopted by Health and Social Services was to take people onto a substitution programme aimed at gradually reducing and stopping their dependence on drugs.

3.8.3 On the other hand, a supervised injecting centre was supported by Dr Marks, Deputy J-A Bridge and some individuals who contacted the Chairman in private, not only on the grounds of harm reduction for injecting users but also for general public safety in promoting safe disposal of injecting equipment.

3.8.4 The Panel acknowledges that the introduction of a safe injecting centre in Jersey would be a bold and controversial development. Nevertheless, it believes that the results of the trials in other countries should be monitored in order to see whether lessons might be learnt for Jersey.

Recommendation

Further investigations should be carried out into the operation of supervised injecting centres in Europe and should be reported in due course to the Health and Social Services Committee, with recommendations as to whether or not this practice might be implemented in Jersey.

4. STRENGTHENING THE EVIDENCE BASE

4.1 The Imperial College Report noted in 2001 that there were at least 20 different agencies in Jersey which regularly collected data on problematic drug and alcohol users but that for the most part the information collected by these agencies could not be used to answer questions central to effective policy-making and planning. It said that further research was needed to measure changing patterns of substance misuse, using its own study as a baseline, and to understand issues such as factors influencing HIV transmission in more detail. This was central to the development of the Responding to Substance Misuse Strategy. The Report warned that, without action, it would be difficult to establish the present extent of substance use, related harms, illness and death or the impact and cost-effectiveness of initiatives to reduce these. The Imperial College Report recommended that -

(a) immediate measures be taken to improve a number of individual agency reporting systems; and

(b) longer-term activity be focussed on the co-ordination and combination of multiple data sources;

4.2 The Director, Alcohol and Drugs Service, reported to the Panel that, despite considerable efforts to establish a central substance misuse database within the Island as recommended by the Imperial College Report, it had not been possible to find a company that could develop a database compatible with the systems used by local GP's and Health and Social Services. It was subsequently felt that the investment of public funds in a stand-alone data base was inappropriate. However, various methods were cited in his submission to demonstrate a more systematic and co-ordinated approach towards data collection than previously.

4.3 The Manager, Adult Mental Health Services, informed the Panel that Health and Social Services were currently considering a new information-based package called FACE, due to be introduced into Adult Mental Health Services by the end of the year. The Alcohol and Drugs Service had recently been asked to assess how useful it would be and how it would tie in to other systems as recommended by the Imperial College Report.

4.4 Dr I. Muscat, Consultant Microbiologist, told the Panel that a proposed pilot study, recommended by the Imperial College Report, and based on unlinked anonymous testing, designed to monitor the spread/prevalence of blood-borne viruses had not been progressed due to a lack of immediate resource.

4.5 Dr Muscat explained the possible consequences of failing to obtain a clear picture of the prevalence of blood-born viruses in the Island. He advised the Panel that it would be cheaper to treat Hepatitis C infection rather than allow the disease to progress and then treating late complications. In support of this view, he quoted two excerpts from a recently written report (as yet unpublished) by the Director of Health Promotion on Hepatitis C in Jersey

(i) The cost of treating Hepatitis C viral infection is high but much lower than the (medical only) cost of not treating the infection. (Conclusion of a city of Bristol health economics model)

(ii) Hepatitis C figures in Jersey are higher than we would expect - this could be because we have a better detection rate or a bigger Hepatitis C population or both.

4.6 Dr Muscat acknowledged that the complications of Intravenous Drug Abuse such as HIV and Hepatitis C, which largely affect young people, might be regarded as a self-inflicted problem. However, he argued that, even if their diseases were self-inflicted, it should be addressed with the same vigour as other self-inflicted diseases affecting an older population, for example diseases arising from smoking or inappropriate diet. If rehabilitated, the young will have many productive years ahead. He concluded -

The increasing burden of managing Hepatitis C (both prevention and treatment) must be recognised now to help both current individuals and the future burden on the health service if the disease and its spread goes unchecked.

4.7 The Panel was also informed by Dr Muscat that sponsorship of a half-time Hepatitis C and HIV sister for 2 years had been agreed by a drug company. Match funding by Health and Social Services, however, had not yet been approved.

4.8 The Panel was subsequently advised by the President, Health and Social Services, that the failure to implement the pilot study to monitor the extent of HIV and Hepatitis C in the Island had been a serious omission. The matter had been considered at officer level, as one of several bids competing for funding within the Committee's budget, but had not been brought back as an issue for consideration by his Committee. The President was now determined that the research would take place, after a period of appropriate public consultation regarding the role of unlinked anonymous testing. He also indicated that funding for the half-time Hepatitis C and HIV sister would now be found.

4.9 The President, Health and Social Services, agreed that the costs of not addressing the medical

complications arising from infections such as HIV and Hepatitis C were likely to be greater in the long-term if they were ignored in the short-term. He also accepted that increased diagnosis of HIV and Hepatitis C was likely to result in a demand for more treatment and the identification of a requirement for further resources and expenditure.

4.10 The Chief Executive, Health and Social Services, pointed out that it was important to consider the implications of the proposed pilot screening programme in business terms, including how this would be conducted. It would be senseless, he said, to conduct a screening programme without appropriate planning for meeting the consequences. The budgetary implications of meeting the treatment needs for HIV and Hepatitis C, in a worst case scenario, could be significant.

4.11 The Panel understands the argument for sound business planning but feels that this reasoning runs the risk of being misinterpreted as a basis for further delaying the introduction of an appropriate screening programme out of concern for immediate budget pressures. The Panel believes that it would be short-sighted for Health and Social Services not to investigate fully the potential health risks posed by the spread of infections in the Island.

4.12 The Panel welcomes the commitment finally to instigate the unlinked anonymous testing pilot scheme to monitor the spread/prevalence of blood-borne viruses and requests to be kept informed of the progress and outcome of the study.

Recommendation
A pilot scheme, based on randomised anonymous testing, designed to monitor the spread/prevalence of blood-borne viruses should be instigated as soon as possible.

4.13 The Imperial College Report recommended that its study of drug use in Jersey should be used as a baseline for future research to understand changing patterns of substance use and misuse. It concluded that building local capacity within Jersey to undertake this research should be a key future activity. As the Panel has discovered, however, the recommended research has not been given due priority and attention by the Health and Social Services Committee. Plans to implement this specific recommendation had not been reported back to the Committee.

4.14 The President, Health and Social Services, agreed that the failure to track the specific recommendations of the Imperial College Report in respect of research into HIV and Hepatitis C prevalence had been a serious omission, commenting that it was a feature of large complex

departments that certain issues did not always achieve full recognition within a busy agenda. He had already taken steps to ensure that such issues were reported systematically in future to the Committee.

Recommendation
Whenever a Committee commissions a major report, such as the Imperial College Study of Drug and Alcohol Use in Jersey, the implementation of its recommendations should be earmarked for an update report to the Committee on a regular basis.

5. MEDICAL CARE FOR SUBSTANCE MISUSERS

- 5.1 The submission provided by the Manager, Adult Mental Health Services, sets out the various tiers of treatment options available to substance misusers in the Island. He also points out a problem, common on a national basis, regarding the identification of problems and appropriate treatment options -

Often substance misuse is not identified until latter stages of the problem and, once identified, the appropriate treatment option is not always sought. An analogy can be made with physical ill health, very few friends or family would watch a friend or loved one suffering with a chest infection without at least encouraging them to visit their doctor. This is not always the case when we become aware of someone suffering from substance misuse problems.

- 5.2 The Panel was told by numerous individuals who had discovered that a family member had become addicted to an illegal substance that they had generally been unaware of the addiction counselling and treatment options that were available in the Island. For many, the first point of contact with services tends to be their GP. However, as reported to the Panel at an open meeting of members of Families Anonymous, awareness of treatment options, even among GPs, is limited. The Panel was told -

It appears to be something of a lottery to find a GP knowledgeable and willing to help addicts.

- 5.3 The Chief Executive, Health and Social Services, commented that private medical practice in Jersey militated against the involvement of GPs in the care of substance misusers.

- 5.4 This comment was echoed by Dr Bailey, one of the limited number of GPs licensed to prescribe Methadone, who described the constraints faced by GPs interested in helping substance misusers. He said that he had been consistently offering free medical care for a number of years -

Drug users have very little contact with medical services in Jersey and obviously general practice being private practice does mean that drugs users are particularly reluctant to seek help. There are a lot of issues that general practitioners can help with, both in general help, contraceptive measures, routine health screening and providing a stable link with general medical services as well as their links with the Alcohol and Drugs Service, the legal services and links to other services such as

social security. General practitioners who are interested in helping drug users can offer an awful lot. We do however have constraints upon us and we are obliged to earn a living and offering free medical care to drug users limits the number of people we can see.

5.5 Dr Bailey proposed a funding solution, in the form of a voucher scheme for GPs treating registered addicts, which he believed would encourage more general medical practices to open their services to substance misusers.

5.6 Dr Marks provided the Panel with a copy of chapter one of the United Kingdom Department of Health 'Drug Misuse and Dependence - Guidelines on Clinical Management', 1999, ⁽⁹⁾ in which it is stated -

Drug misusers have the same entitlement as other patients to the services provided by the National Health Service. It is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs. This should include the provision of evidence-based interventions, such as hepatitis B vaccinations, and providing harm minimisation advice. Every doctor must provide medical care to a standard which could reasonably be expected of that practitioner in his or her position.

5.7 Dr Marks told the Panel that, in his view, the Island was providing only a 'Cinderella' service to substance misusers - expenditure on staff, facilities and resources to run addiction services was almost non-existent by comparison with the expenditure on facilities at the prison. He told the Panel that many substance misusers avoided attending a GP for financial reasons, maybe because of debts previously incurred. He also pointed out the difficulties of providing an effective follow-up service to the opiate substitution programme. Although patients could receive free Methadone or Subutex treatment at his addiction clinic, they were then expected to pay for further treatment once they had ceased the substitution programme.

5.8 Dr Marks underlined the importance of developing and improving services for substance misusers -

We are dealing with the future of young people, the future of our society... Many young people come into contact with drugs at an early age - under 16. We could have a major impact on this group

5.9 Dr Marks explained that he provided a non-contractual service to the Alcohol and Drugs

Service, operating a free clinic for its clients on an out-of-hours basis at lunch time or in the evening.

This clinic functioned essentially on a voluntary basis and did not operate in his absence. He told the Panel that, in his view, a key priority for the Island should be provision of a centralised GP-based community service, on the lines of the Spittal Street centre in Edinburgh, with a group of young professionals carrying out the service he was currently providing but in a recognised, contractual way. Such a service, he asserted, would provide an answer to the Island's need to provide an adequately resourced community detox and after-care programme for substance misusers.

5.10 Dr Bailey also pointed out that substance misusers generally have a range of social and psychological issues which are currently not adequately addressed through the heavy demands on both GPs and drug counsellors at the Alcohol and Drugs Service. He said that addicts often lead very chaotic lives which can be disruptive to other members of the family as well as themselves. GPs have only a limited time available in a consultation to deal with the range of health-related issues that may face a substance misuser. Dr Bailey suggested that a dedicated drug-related social worker would be able to take up these issues freeing the time of the GP and counsellor to concentrate on drug issues with the individual.

5.11 The Panel believes that the current reliance on the voluntary commitment and good will of individual doctors cannot be a long-term solution to the effective care of the large 'hidden population' of substance misusers in the Island. It agrees with the importance of developing a community-based multi-disciplinary service accessible to substance misusers. A dedicated social worker could form an important element within a team of professionals within such a service. The Panel acknowledges the difficulty of challenging long-established medical practice and attitudes in the Island. However, it believes that an innovative solution must be found as a matter of urgency to encourage the provision of good quality, accessible health care for the large number of people caught up in substance misuse problems and to do everything possible to identify and rectify problems at an early stage.

Recommendation
A strategy should be developed, as a matter of urgency, to promote the provision of good quality, accessible primary medical care and treatment in the community for substance-misusers, with particular emphasis on targeting vulnerable young people.

6. LINKS WITH THE CRIMINAL JUSTICE SYSTEM

6.1 COST TO SOCIETY OF KEEPING ADDICTS IN PRISON

6.1.1 The Imperial College Report in 2001 reported that

'It is currently estimated by key informants in the prison service that 60 and 70% of all inmates entering H.M.P. La Moye already have a drug-related problem (primarily with heroin), whilst the Jersey Community Survey indicated that imprisonment is not uncommon amongst problematic drug users, with almost one in five respondents reporting a sentence in La Moye during the previous twelve months (23/110).'

6.1.2 The Panel was told by Dr Marks that he knew of 30 addicts in prison serving a cumulative total of 100 years. Based on the estimated cost of keeping a prisoner at La Moye of approximately £42,000 per annum, the cost of keeping this group of sick people in La Moye amounted to £4.2 million. (The figures quoted by Dr Marks were corrected by the Home Affairs Committee, as follows: the average cost of keeping a prisoner in La Moye, based on the 2003 Prison Annual report was £32,681. This equates to £3.2 million for the 30 prisoners mentioned by Dr Marks)

6.1.3 The Panel was told by the Director, Alcohol and Drugs Service, in his written submission, that Home Office research states that for every £1 spent on treatment, the criminal justice system saves £3.

6.1.4 It appears self-evident to the Panel that attempts to divert substance misusers away from the prison system as far as possible, or to ensure that their period in custody is used as effectively as possible to encourage and support a change in lifestyle, will bring a long-term financial benefit to society, as well as a benefit to the health and well-being of individuals. This is in line with Objective Six, Strategic Priority Three, of the Community Safety and Substance Misuse Strategy 2005 - 2009. The Home Affairs Committee report 'Building a Safer Society'⁽¹⁾ states -

'In order to break the cycle of crime, certain offenders need opportunities to address their dependency issues. The Strategy sees appropriate targets as the 'victims' of addiction, rather than the profiteers.'

6.1.5 The Panel, having considered the evidence presented in the course of its Review, has been convinced of the urgent need, within the criminal justice system, to place greater emphasis on providing offenders with access to alternative and effective programmes.

<p>The Panel fully supports Objective Six, Strategic Priority Three, of the Community Safety and Substance Misuse Strategy 2005 - 2009, which states: Where appropriate, provide offenders within the criminal justice system with access to alternative and effective programmes.</p>

6.2 SENTENCING POLICY IN JERSEY

6.2.1 Jersey Courts maintain a strict sentencing policy in relation to the importation and drug trafficking of illegal drugs. This has contributed to a changing profile of sentencing over the last ten years with longer sentences being served at H.M.P. La Moye. The Wool Report 2004 stated

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'Overcrowding has become a significantly increasing factor in the last few years. Drug-related offences increased by 92% from 1992 to 2002 and in response, sentence lengths were increased.... An increasing number of prisoners dependent on drugs, particularly heroin, are received into custody year on year and these require careful management by the health care staff.'

6.2.2 The Wool Report 2004 highlighted the 'huge load' carried by H.M.P. La Moye in managing drug users entering the prison from the community.

'Over the course of a year, the prison is in contact with around 80 heroin users out of a total of 390 into custody.... The resources needed to treat that number to equivalent standards in the community, would put a considerable strain on the prison's budget and the manpower resources.'

6.2.3

The Panel received evidence from the President of the Home Affairs Committee that the majority of drug-related custodial sentences in 2003 were for importation and trafficking (included in Appendix Three: Written submissions). She told the Panel that the Courts already had the ability to consider delaying sentences in favour of treatment orders. Those charged only with possession of illegal drugs for the most part received a fine or a referral order to the Jersey Probation and After Care Service. The role of the Probation Service in developing the creative use of alternative sentence options to divert offenders with substance misuse problems into treatment or community service was highlighted in the draft Criminal Justice Policy, currently

being prepared by her Committee.

6.2.4 The President said that the Review of Criminal Justice Policy in Jersey ⁽¹⁰⁾ carried out by Professor A Rutherford in 2002 (the Rutherford Report) had identified '*very substantial increases in lengths of prison sentences*' as the contributory factor in prison overcrowding. The Rutherford Report commented that the tough sentencing policy did not appear to have led to any decline in trafficking. On this basis, and in the light of experience elsewhere, the Home Affairs Committee intended to request the Royal Court to review its policy on sentencing for drug-related offences.

6.2.5 The Director, Alcohol and Drugs Service, told the Panel that significant progress had been made in the past three years in moving away from mandatory custodial sentences and towards non-custodial sentences and treatment programmes for drug users. He stressed that this diversion policy was only appropriate for individuals whose offences were directly attributed to their addiction rather than those who are trafficking drugs for profit.

6.2.6 Dr Marks told the Panel that, in his view, many young people were wrongly pushed into the prison system, rather than treatment, on charges of possession with intent to supply. He told the Panel

You might be under the impression that we have a lot of hard core drug users in Jersey. I think we are dealing with a very different situation in the sense that there are young people who come into contact with heroin at an early stage in their lives..... These people we could impact on a great deal. We should go at them with every possible option - they are not yet dyed-in-the-wool addicts.... We should be trying to save people from a disease which results in short life expectancy, misery, marginalisation and debilitation. We have a very vulnerable young population in this Island..... They are the ones being targeted by the very, very few professional people who are getting drugs into this Island. And I can identify them any time you like, because with a piece of hair I can tell you how much drug use they have been [having]. If they haven't been using drugs for six months they are professional drug dealers. If they have been using, they should be treated in a completely different way.

The conviction of a confirmed addict for possession with intent to supply should be struck from the book.'

6.2.7 The Panel met a group of young women in the Prison who had been caught up in illegal drugs use in a variety of ways. Some were facing long periods of their life behind bars for the mistakes they had made in getting mixed up with importation of drugs. One inmate told the Panel -

'Four or five years is a long time just to teach someone a lesson because of their use of drugs.'

The Panel members heard how drugs had impacted on the lives of these young people, making them heedless of the consequences of using and dealing with opiates. Members were told that a prison sentence was a waste of a young life -

'Nothing is solved by a long sentence - the result is that you come out hating the world even more. It doesn't help you to deal with the real problem.'

6.2.8 The Panel believes that the warnings, issued with convincing force by Dr Marks as well as other witnesses, about the vulnerability of large numbers of young people in the Island, should be taken seriously. It believes that there are cogent reasons for undertaking a review of the Island's sentencing policy, not just from a cost saving point of view and to solve the problem of overcrowding in La Moye, but more importantly, from an urgent need to divert young people away from misuse of substance which has the potential to destroy their future and bring serious disruption to their families.

6.2.9 The Panel has not sought the views of the Island's judiciary on its sentencing policy in the course of this Review. However, it puts forward the view that the current strict sentencing policy of the Royal Court regarding drug-related offences has the potential to send large numbers of young people into long periods of custody, and to consume a vast amount of resources, which far exceeds the resources currently available to preventative and treatment services for substance misusers. The Panel concurs with the President of the Home Affairs Committee (paragraph 6.2.4) that the Court should seek to set more constructive alternatives to custody, such as treatment orders or probation orders, wherever possible.

Recommendation
The Panel supports a review of sentencing policy for drug-related offences, particularly in relation to young people.

6.3 DEVELOPMENT OF A DRUG STRATEGY FOR H.M.P. LA MOYE

- 6.3.1 The Wool Report 2004 pointed out that the harm reduction services available to drug users in the prison were not equivalent to those currently available in the community, although it recognised that increased links had been made with the Alcohol and Drugs Service. It reported that, at present there was no Methadone, or equivalent available; no needle exchange scheme and the detoxification method used did not conform to current medical practice.
- 6.3.2 Dr Marks told the Panel that prescribed medication was currently removed from all prisoners, including those on remand, on reception to La Moye Prison. Those on a Methadone or Subutex programme were allowed to go into withdrawal, possibly with the use of dihydrocodeine. He commented that he could see no medical justification for this treatment of people who had not even been convicted. In his view, it was a questionable practice in terms of Human Rights. He had raised the matter with medical officers at the prison who had justified the policy for administrative reasons. This concern was also raised by the Arrest Referral Worker.
- 6.3.3 The President of the Home Affairs Committee clarified the strict guidelines followed by the prison in terms of the treatment of substance misuse.

On arrival at the prison a prisoner receives a health assessment which is carried out by nursing staff. This includes investigation of use of alcohol, illegal drugs, tobacco and prescribed drugs. If, as is often the case, the prisoner is on diazepam (prescribed by their doctor) they are kept on this, and gradually detoxed. The duration of the detox depends on a number of factors including the level of the dose and how long they have been taking the drug.

If the prisoner is using methadone/heroin they are given two detox options.

1. *Lofexidine – this brings on an acute withdrawal, and it is extremely rare for any prisoner to opt for this.*
2. *Dihydrocodeine syrup – the amount prescribed is reduced every 3rd day, over a period of 8 days. Physical withdrawal from opiates normally takes place over 5/8 days. The Dihydrocodeine syrup helps relieve the physical symptoms, but the prisoner will still experience ‘flu-like’ symptoms.*

The exception for keeping someone on Methadone, would be in the case of a pregnant female. It can be traumatic for the unborn infant if the mother withdraws from methadone.

6.3.4 The President disputed Dr Marks contention that withdrawal of methadone or subutex *'was a questionable practice in terms of Human Rights'*. She drew the Panel's attention to Part B Recommendation No R (98) 7 concerning the Ethical and Organisational Aspects of Health Care in Prison (1998) from the Council of Europe, entitled: Addiction to drugs, alcohol and medication: management of pharmacy and distribution of medicine (full extract contained in Appendix 3k). She maintained that, as far as is possible, the protocols used by the prison in respect of prisoners with substance misuse problems conform to the above European legislation.

6.3.5 Notwithstanding the President's contention above (6.3.4), the Panel shares the concern expressed by Dr Marks regarding the practice of compulsory detoxification of prisoners on remand at H.M.P. La Moye. It calls upon the Home Affairs Committee to review the policy of not permitting such inmates to continue medication which has been prescribed as part of the opiate substitution programmes.

Recommendation
The practice of compulsory detoxification of prisoners on remand should be reviewed.

6.3.6 The Rutherford Report recommended a harm reduction approach throughout the criminal justice system in Jersey to managing drug users. The Wool Report 2004 agreed that harm reduction measures were

'crucial in preventing the spread of blood-borne viruses in a population that injects drugs and in which we know Hepatitis and HIV already exists'.

However, the Wool Report 2004, also found

at present conditions at the prison are such that it would be difficult to maintain safety and security were Class A drugs to be prescribed and a needle exchange scheme established.

6.3.7 Dr Marks told the Panel that, in his view, it made common sense to have harm reduction measures in place in the Prison. Since there was a large number of addicts in the Prison (and there was evidently a ready supply of drugs getting in and needle sharing happening) they

should have access to similar harm reduction measures available in the community, to minimise the impact of their being in custody. Otherwise, there was a risk of spreading infection within the prison and beyond into the community.

6.3.8 Dr Muscat, Consultant Microbiologist, said that in his view it was important to make sure that individuals were not disadvantaged in health terms by the fact of being in prison, but it was also reasonable to understand that what works in open society may not translate into a closed society that has own rules and problems. He informed the Panel that a needle exchange scheme had been piloted in prisons in Spain.

6.3.9. The President of the Home Affairs Committee agreed that it was a matter of concern that illegal drugs might be found in the prison. Fortunately, this was currently at a very low level in Jersey compared to some prisons in the United Kingdom. She said that there were already a number of measures in place in the prison to combat the spread of blood-borne infection. Prisoners with a history of intravenous drug use could request an appointment with the Consultant Microbiologist who visited the Prison twice a month. Hepatitis B vaccinations were offered to all prisoners serving over three months. In addition, the introduction of enhanced drug-free accommodation in the prison had been a great success. She believed that condoms should be available to prisoners. She would not, however, be in favour of the introduction of a needle exchange programme.

6.3.10 The President of the Health and Social Services Committee shared the view about having a needle exchange scheme in the prison. In his view, this would amount to a tacit acceptance that it was impossible to achieve a drug-free environment. He would prefer to see a more rigorous security approach.

6.3.11 The Panel heard evidence from several witnesses with family members who had been in custody in H.M.P. La Moye testifying that drugs were available to prisoners and expressing concern at the spread of infectious diseases through sharing needles. One witness (identified as Mrs G) told the Panel that her previously healthy son had contracted Hepatitis C during his sentence. In addition, she explained how she had had to pay off drug dealers for supplies of heroin obtained by her son while in custody at La Moye.

6.3.12 The Panel believes that the concerns expressed above by both professionals and private individuals should be taken seriously. The Panel believes that it is necessary to take a realistic view which accepts, however reluctantly, that drug use persists among prisoners at H.M.P. La Moye. In its view, the pragmatic ethos of harm reduction, which was adopted by the Island for

the community in general five or six years ago, should apply equally to the Prison population. In the Panel's view, it is unacceptable that an unrealistic policy, posited on the unachievable goal of eradicating all drug use at the prison, should result in people entering in an essentially healthy condition, only to emerge at the end of their sentence, infected by blood-borne viruses.

6.3.13 As a first stage, an investigation should be carried out into the experience of introducing needle exchange schemes into prisons in other countries. For example, a report ⁽¹¹⁾ of two years of experience of a needle exchange programme in the Bilbao Prison appears in **Appendix Nine**. It will be seen from this report that the conclusions to this experiment were overwhelmingly positive: the programme did not create conflict; needles were not used as weapons at any time; the programme did not give rise to greater drug use; and drug users were encouraged to turn to other kinds of drug programmes. As a result, the programme had been extended to five additional prisons and it had been proposed that it be implemented in all prisons nationwide.

Recommendation
The policy on harm reduction measures available to prisoners should be reviewed, in the light of best practice elsewhere. As a first stage, further investigations should be carried out into the possible introduction of a needle exchange scheme into H.M.P La Moye.

6.3.14 The Wool Report 2004 called for the development of a comprehensive drug strategy as a priority. It stated in its conclusion -

'Prisoners come into the prison from the community and return to the community. The interval in prison represents a unique opportunity to benefit not only individual prisoners but ultimately their effect on the overall public health.'

6.3.15 The Panel was advised by the President of the Home Affairs Committee that action had already been taken to implement those recommendations of the Wool Report 2004 which could be achieved within existing resources and to identify where additional resources would be required. The current over-crowding at the prison presented a considerable challenge but improvements, such as the establishment of a drug-free wing, had begun to make a significant difference. The Panel also received information from the Prison Medical Officer on the developing drug strategy being prepared by a group of health professionals.

6.3.16 The Panel received a report from the recently appointed Substance Misuse Counsellor. Counselling is available to prisoners on the basis of self-referral. In addition, a member of the Alcohol and Drugs Service attends the prison on a weekly basis for pre-release counselling and advice.

6.3.17 The Panel acknowledges that H.M.P. La Moye is currently in the process of implementing changes in response to the Wool Report 2004 and that it is in the early stages of developing a comprehensive drug strategy. The Panel believes that it would be right to review the progress in the implementation of this strategy after an appropriate period of time.

Recommendation
The implementation of the Wool Report on Health Needs in the H.M.P. La Moye should be the subject of a review by a Scrutiny Panel once the full Scrutiny function has been established after the elections in 2005.

6.4 SENTENCE PLANNING AND POST CUSTODIAL SUPERVISION

6.4.1 The Chief Probation Officer told the Panel that sentence planning was essential to the provision of a consistent, effective service to prisoners with substance misuse problems. Sentence planning was about behaviour change - looking at how a person had ended up in prison and about how those factors might be changed; it was about engaging with prisoners and working with family, dependents and potential employers, to maximise the chance of successful re-integration into society upon release; it was about ensuring that time spent in prison was as constructive as possible. It included, in the case of substance misuse, recording whatever makes someone vulnerable to self-harm or overdose.

6.4.2 The Panel, on its visit to H.M.P. La Moye, spoke with a group of female inmates about their views of preparing for release. What was most important, one inmate told the Panel, was for a prisoner to develop goals to aim for on their release. Each individual needed to look at the broad picture of their life, to identify the positive elements open to them in their life outside the prison and the factors that could draw them back into drug use. Drug awareness programmes and counselling provided by the prison were helping inmates to come to terms with their situation. An essential part of this was the temporary release scheme. Its suspension, because of the abuse

by one or two individuals, had had a profoundly demoralising impact on those prisoners who had been making positive use of this opportunity to re-build relationships and a life on the outside.

6.4.3 The Chief Probation Officer said that sentence planning had been introduced with the assistance of the Jersey Probation and After Care Service into the Young Offenders wing and was soon to be introduced into the female and enhanced wings at La Moye. However, the resources to develop sentence planning further had not been approved in the Fundamental Spending Review process.

6.4.4 The Chief Probation officer explained that Jersey was currently the only British jurisdiction without statutory provision for post-custodial supervision. After-care of adult prisoners continued to be on a voluntary basis. Funding to implement post custodial supervision, in the sum of approximately £100,000 per year, had been refused on three occasions in the last three years in the Fundamental Spending Review process.

6.4.5 The President of the Home Affairs Committee concurred that the lack of resources to provide post custodial supervision was a major obstacle to good rehabilitation work started while offenders were in custody at La Moye. She said that it was recognised that prisoners were particularly vulnerable once they had left the protective environment of the prison and that for many substance misusers it was extremely difficult to remain free of drugs without a system of support in place. She told the Panel -

'I cannot emphasise strongly enough how much I believe that, not just in this area but in all areas of the criminal justice system, if we were to have post-custodial supervision we could be incredibly more effective in reducing overall crime in the Island in the long-term and in reducing overall harm to victims and also to individuals who find themselves involved in substance misuse. We have an opportunity here to make a great difference.'

6.4.6 The President said that there was a tendency in the Fundamental Spending Review process to concentrate on the short-term at the expense of long-term initiatives. Committees were given a budget and were told to make of it what they could.

'The Home Affairs Committee has several unavoidable statutory responsibilities and it was difficult to shift resources to areas such as Probation and After Care to improve effective treatment services and post custodial supervision working together as a seamless transition from prison onto the outside. Getting resources to do that when you are literally fire fighting in many circumstances, in terms of the prison, with the

overcrowding the numbers the pressures and so on, - it is very difficult to shift the resources into something we believe will be a long-term benefit. We've got to find a way out of that. I'm hoping that on the back of the Criminal Justice Policy, once it has been consulted upon and firmed up, that we may be able to persuade the public and our political colleagues that we need to take a longer view about effectiveness.'

6.4.7 The Panel finds it difficult to see any justification for the current lack of statutory provision for post-custodial supervision, which is a key element in the sentence planning process and effective support for prisoners on release. The importance of post-custodial supervision should be highlighted in the next round of the Fundamental Spending Review.

Recommendation
Funding should be made available for the establishment of a comprehensive statutory system of post-custodial supervision as soon as possible.

6.5 AFTERCARE OF PRISONERS

6.5.1 The Panel heard from a number of individual witnesses about the difficulties faced by prisoners on release from the protective environment of the Prison. Former prisoners commonly face difficulties with accommodation, employment and re-establishing relationships. In addition, in a small island, individuals with substance misuse problems find it difficult to avoid renewing past contacts with other substance misusers. Several witnesses spoke of the need to develop some form of half-way hostel dedicated to help former prisoners with substance misuse problems re-integrate into society.

6.5.2 Ironically, the risks are particularly high for prisoners who have abstained from drugs during their sentence. One witness, (identified as Miss D) who is a support worker/counsellor working in Brighton, told the Panel -

On their release, they have nowhere to go and are directed to the Shelter, where they can easily relapse, back into the same miserable existence, because they are being put back into an environment where they are in contact with drink or drugs. This is also a very vulnerable time for them because the body cannot tolerate them using the same amount of drugs as they used to, so overdosing is often a high risk

factor."

The health risks facing substance misusers on release from prison were highlighted in a study carried out for the Home Office ⁽¹²⁾.

6.5.3. The former Prison Governor was quoted in the Jersey Evening Post -

Rehabilitation and after-care is very important, especially in Jersey. In the United Kingdom people can ask to be relocated so they are away from their former environment and the people they used to know but it's impossible to do that in Jersey. Here they don't just need external motivation; they have to work on their internal motivation too.

The first few weeks after release are the critical time... When people are in prison they become reliant and they have to learn to become responsible again and make their own decisions ... Once they come in here and start to change then go back outside, they have to deal not only with being released but being responsible and coping with the simple things that other people take for granted. (See Appendix Ten for full article)

6.5.4 The former Prison Governor's comments were echoed by several private individuals who spoke of their experience of seeing relatives struggling to cope with life outside the prison walls. One witness (identified as Mrs G) said that there was no aftercare support for her son to help him find a job or a place to live, apart from the Shelter, once he was released from prison. He had nothing worthwhile to do with his time. Another witness (identified as Mrs H) spoke of the difficulties faced by her daughter who had gone into the Shelter at Midvale Road after her release from prison. She was unable to look after her baby daughter in these circumstances and it was necessary, for the child's safety and well-being for the child to remain with Mrs H rather than her mother. Mrs H saw how her daughter was drifting back into substance misuse through boredom and renewal of former contacts with drug-using friends.

6.5.5 The Panel is aware that there is a range of types of accommodation available in Jersey to those in need when leaving prison. This includes hostel accommodation provided by the Shelter Trust and specialised residential facilities provided by organisations such as Margaret House, the Roseneath Centre and Silkworth Lodge. The Panel was told of developments being introduced by the Shelter Trust to provide individual occupancy rooms which would be a particular benefit to those who are trying to address addiction issues, who need their own space and the possibility of avoiding other users.

6.5.6 The Chief Probation Officer acknowledged that accommodation was a particular difficulty for many prisoners on release from La Moye, particularly for those without residential qualifications. He warned that a half-way house facility for the prison would be very expensive to operate. The Probation Service had evaluated the feasibility of a hostel for its own clients but had concluded that it would double the cost of its current service provision.

6.5.7 The Panel nevertheless believes that the possibility of a supervised hostel for suitable prisoners near the end of their sentence deserves further investigation.

Recommendation
A feasibility study should be carried out into the establishment of a half-way house for prisoners close to release.

6.5.8 The President of the Home Affairs Committee told the Panel that she had had an informal discussion with the Programme Director, Jersey Addiction Group, regarding the possibility of Silkworth Lodge taking on a role with some prisoners released on licence who were willing to commit to the rehabilitation programme available there for the final few months of their sentence. This would be based on some form of pre-assessment to determine those who would be motivated to respond to treatment. The Programme Director was in favour of this proposal.

6.5.9 The Panel believes that the suggestion that suitable prisoners be offered the possibility of completing part of their sentence in the rehabilitation programme at Silkworth should be actively pursued. The scheme appears to offer good value for money - in general terms, the cost of keeping a prisoner at La Moye amounts to approximately £32,000 a year compared to the cost of a year's residential treatment at Silkworth Lodge of £28,000. The scheme would also contribute towards relieving the current over-crowding at La Moye. More importantly, the Panel believes that an established rehabilitation programme offers a better possibility of establishing the foundations for a real change of lifestyle than further months in prison. The Panel recommends that a Service Level Agreement should be drawn up setting out the conditions and funding arrangements for an experimental pilot scheme.

Recommendation

A pilot scheme should be established, in conjunction with Silkworth Lodge, for selected prisoners who wish to access residential treatment and rehabilitation as part of an early release programme.

7. SUPPORT FOR VOLUNTARY AGENCIES

- 7.1 The Panel recognises the important role played by voluntary agencies in providing services for substance misusers in the Island. Reference has already been made to co-ordination between these agencies and the Alcohol and Drugs Service (Section 3.6). This section focuses on the support provided to these agencies by the States.
- 7.2 The Jersey Council on Alcoholism reported that it had recently considered widening its remit to include provision for residents whose problems lay with drugs rather than alcohol. Having undertaken a pilot placement for an individual, it was apparent that care of such residents by the organisation required an increased level of supervision and skill and additional cost. (The Panel was subsequently provided with further details of the costings of the Jersey Council on Alcoholism - included at Appendix 3).
- 7.3 The Panel was advised that the Council had developed a high degree of expertise in dealing with substance misusers (with predominantly alcohol problems) in over twenty years of operation and was regularly fully occupied (11 beds). It was concerned that its funding from the States was coming under increased pressure due to the squeeze on States expenditure.

"Not a single penny of the tax revenue from alcohol is directly allocated to coping with its ill-effects, despite a recent hike in the cost of drinking. During 2003, the total tax revenue from all forms of alcohol was £15,258,000... By contrast, the Council is shortly to appear before [the Shadow Public Accounts Committee] to defend our current States subsidy of £26,500."

- 7.4 The Panel was informed that annual funding in the sum of £90,000 has recently been secured from the Confiscated Assets Fund for residential treatment of substance misusers. Assessment for suitable uses of this funding is under the responsibility of the Alcohol and Drugs Service. Some funding has been used to send individuals for treatment to the United Kingdom while some placements have also been financed at Silkworth Lodge. The Director, Alcohol and Drugs Service, reported that seven such referrals had been made in the past six months.
- 7.5 Notwithstanding the funding mentioned above (paragraph 7.3) the Programme Director of Silkworth Lodge expressed concern at the lack of financial support from the States -

'16 of the 19 people who have been funded by the States of Jersey for treatment at Silkworth Lodge have completed the residential programme and have remained clean and sober ever since. That's over 80%. What more do we have to do to

convince the Alcohol and Drugs Service and the States of Jersey that what we have is a facility that is making people well? What better way to stop a criminal from being a criminal than to change his values in life and make him aware that he can actually live a fulfilled and useful life without drugs or alcohol. That's what we do. It's not just about stopping them drinking or using drugs. It's about making them live well.'

- 7.6 The Programme Director told the Panel that, at the time of the Public hearing on 30th July 2004, there were no residents being funded by the States of Jersey. He said that he could not understand the reason for the apparent resistance to utilising the facility -

Silkworth Lodge is a unique, independent and successful service. It is not duplicating any other existing statutory service. This is very sad. I would have expected the obvious need for the service and the success rate of treatment to attract more support from Government agencies.

It has been surprising to find that the government's financial resources are so limited, but it has also been my observation that maybe the money that is there could be better apportioned. When we are aware that a considerable amount of Jersey money is used for treatment in the United Kingdom that could purchase just as good if not better treatment here on the Island - we are not looking for money that isn't available - we are just looking for it to be re-directed.'

- 7.7 The Programme Director outlined the Jersey Addiction Group's development plans including the establishment of a half-way house to assist recovering addicts who had been through the treatment programme at Silkworth Lodge to reintegrate into the community. In addition, he said that the Jersey Addiction Group recognised the need to address the problem of the growing numbers of young people below the age of 18 who were getting caught up in drug use. These plans however were at risk because of the current lack of support. He said -

'We would like to see a separate facility for young people as an adjunct to what we already do, once we are established. However if the current Jersey Addiction Group service does not get the support it needs to maximise its use, cover operational costs, and provide benefit to those who need it, progress will be restricted.

- 7.8 The Manager, Adult Mental Health Services, recognised that the co-ordination between the Jersey Addiction Group and statutory services had been slow to develop but said that the use of Silkworth Lodge in the treatment of both opiates and alcohol was now expanding. Ideally, he said, Health and Social Services would like to establish a Service Level Agreement with

voluntary agencies. In the case of Silkworth Lodge, this could be established in order to pay for a certain number of rehabilitation beds or a form of half-way house in return for regular funding.

7.9 The President, Health and Social Services, agreed with the need to support voluntary agencies. He told the Panel that the way forward was for public administration to interact more effectively with them, forging new professional relationships through the development of Service Level Agreements in return for good value service. He said that he had already requested the recently appointed Chief Executive to examine the whole area of community forums and the involvement of stakeholders from the voluntary sector.

7.10 The Panel visited Silkworth Lodge and held a discussion with residents. It was extremely disappointed by suggestions of a historical unwillingness on the part of the Alcohol and Drugs Service to promote the treatment and rehabilitation programme at Silkworth Lodge as a positive option for substance misusers wishing to change their lifestyle. The Panel welcomes the recent indications that both the President of the Home Affairs Committee and the President of the Health and Social Services Committee recognise the value of the work done at Silkworth Lodge and wish to explore ways of developing its potential contribution. The Panel believes that its own investigations should help to reinforce the early steps taken in this direction.

7.11 The Panel also received details in evidence of successful, evidence-based initiatives from other voluntary agencies: for example, the Jersey Council on Alcoholism outlined a pilot scheme for the inclusion of provision for poly-drug users (those who abuse alcohol and other substances); and the Shelter Trust described the development of open-door clinics, individual room occupancy and resettlement support. The Panel believes that these initiatives equally deserve the support of the States of Jersey. Such agencies provide cost effective services to substance misusers, and complement existing statutory services.

7.12 The Panel believes that the States cannot afford to take a short-sighted view of budget cuts by reducing its subsidies to voluntary agencies providing proven and effective services to vulnerable members of society. The Panel also recalled the evidence provided by the Director of the Alcohol and Drugs Service (see paragraph 6.1.3 above) that every £1 spent on treatment can save the criminal justice system £3. The Panel feels that it is incongruous that considerable sums of public money are expended on incarcerating large numbers of substance misusers through non-productive punitive sentences, while agencies providing constructive programmes are squeezed of funding.

Recommendation

Clear partnership funding arrangements should be established with voluntary bodies providing proven and effective rehabilitation and aftercare support for substance misusers.

8. ADDITIONAL COMMUNITY SUPPORT FOR SUBSTANCE MISUSERS

- 8.1 The Panel wishes to draw attention to a suggestion raised by a number of witnesses who spoke of the need for a drop-in centre for recovering addicts, a 'safe' place for those trying to make a positive change in their lives, where they could meet others in the same circumstances and find support. One witness, currently living in the St James Street Hostel said -

'There should be drop-in centre as in the United Kingdom for people in recovery. People relapse because they have nothing to do, living in the pub and getting into trouble with drink. There's a need for a place where you can get a cup of tea and a sandwich and spend time.'

Another witness, Mrs E, said that addicts needed a place where they could be treated as human beings, not as scum on the street -

'They are kids with an illness. They are Jersey's future. They could be making a positive contribution. Maybe they shouldn't have been tempted in the first place - but it's a sign of the times and it's happening more and more. They are someone's sons and daughters.'

- 8.2 The Panel is aware that networks do already exist for addicts in recovery to socialise and have on-going support. The need for such support post treatment is recognised as an important feature of the rehabilitation programme at Silkworth Lodge. Aftercare meetings for ex-residents take place on a weekly basis. In addition, many respond to the invitation to drop in at any time for a cup of tea, or stay for lunch, and interact with residents and staff, or seek advice and support in times of difficulty or crisis. A core part of the rehabilitation programme involves motivating and promoting the understanding and developing residents' commitment to the on-going need for the self-support meetings of Narcotics Anonymous. These provide an opportunity for recovering addicts to keep in contact with clean and sober friends.
- 8.3 The Panel understands that not all recovering addicts have been through the rehabilitation programme at Silkworth Lodge. Some, for example, leave the protective environment of the prison having been clean for a period of time and might benefit from a mutual support network of people who understand their situation. The Panel believes that an initiative for a drop-in centre, which might be best taken up by a voluntary agency, would provide an important addition to the range of services available to substance misusers in the Island. Any such initiative should receive the active encouragement of the Health and Social Services Committee through partnership funding.

Recommendation

Well-founded new initiatives to establish further community support for substance misusers should be favourably considered for support by the States through partnership funding.

9. COLLABORATIVE FORUM

- 9.1 In his written submission to the Panel, the Programme Director, Jersey Addiction Group, stated that, in his view, the Imperial College Report recommendations for harm reduction appeared to be being implemented to some degree. However, other recommendations which he felt to be equally if not more important, referred to ‘the identification of interventions and programmes which reduce harm’, ‘evidence of treatments that are working, that can measure change and have an end product’, adopting a methodology of ‘rapid assessment and response approach’ and most importantly ‘interagency collaboration and reporting systems’.

‘No collaborative forum currently exists to my knowledge, which is measuring the response to these recommendations, which I consider to be minimal, and are of primary importance in identifying effective care pathways for addressing the range of interventions required of substance misusers to maximise positive treatment outcomes.’

- 9.2 The Programme Director told the Panel that a collaborative forum would provide agencies with the opportunity to meet regularly to discuss co-ordinated care for their clients. Such a forum should be client-focussed, rather than service-led, looking at the broad picture of problems experienced by substance misusers and the people around them. It should seek, as part of the development of the integrated care pathways approach, to establish a continuum of care to address all problem areas (See paragraph 3.6.7). He felt that GPs should also be part of this forum which would help to raise awareness of addiction problems. The expertise of the many voluntary agencies, in his view, had not been properly valued in planning the development of services for substance misusers.
- 9.3 The Panel was advised by other voluntary agencies that regular communication did take place with the Alcohol and Drugs Service and other agencies. The Shelter Trust said that the flow of information between agencies had not been good in the past but was now improving. The Roseneath Centre and the Jersey Council on Alcoholism reported that they had convened bi-monthly meetings between various caring agencies to discuss and share information on clients, policy and liaison between services. However, such meetings were only sparsely attended. Neither organisation had been consulted, at the time of the public evidence sessions, on proposals for the development of the integrated care pathways approach.
- 9.4 The Director, Alcohol and Drugs Service, advised the Panel that a Senior Officer cross-departmental group already existed, co-chaired by himself and the Director of Home Affairs. This group, which met bi-monthly, had operational responsibility for the Island’s Substance Misuse

Strategy and had overseen the implementation of the Imperial College Report findings.

9.5 The Panel notes that there has clearly not been full consultation to date in the development of plans to implement the integrated care pathways approach. It supports, therefore, the development of a truly comprehensive, collaborative forum with a clear sense of purpose and direction to foster the further involvement of both statutory and voluntary agencies in plans for the extension and improvement of existing services for substance misusers. Such a forum could

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- monitor the implementation of further service initiatives in the treatment of substance misusers;
- give a voice to the service providers from the voluntary sector;
- enable good co-ordination between the statutory service providers;
- provide an opportunity for renewed attempts to establish a group in which the views of clients and their relatives could be heard in a consistent and organised way; and
- monitor the response to recommendations of the present report.

Recommendation
A collaborative forum should be established, bringing together both statutory and voluntary agencies to monitor and promote service initiatives for substances misusers.

10. KEY FINDINGS AND RECOMMENDATIONS

10.1 Key Findings

Implementation of 2001 Imperial College Report

- (a) Two of the key recommendations of the 2001 Imperial College Report on drug use have been implemented: the Needle Exchange scheme has developed into a strong and active service; the Arrest Referral Scheme is in the first year of its operation and will be the subject of a progress report at the end of that period. (Sections 3.1 and 3.2)
- (b) A third recommendation - regarding measures to co-ordinate multiple data sources - is finally in the process of being implemented. (Section 4.3)
- (c) Important research to strengthen the evidence base regarding the spread/prevalence of blood-borne infections - another key recommendation - has not been undertaken to date. (Section 4.4 - 4.14)

Alcohol and Drugs Service

- (d) The Opiate Substitution Programme is well controlled to prevent leakage on the street drug market. This harm reduction approach is helping many substance misusers to lead more positive and healthy lives. Subutex has been successfully trialled recently in Jersey. Concerns were raised by witnesses about the effectiveness of the Methadone treatment programme (Section 3.3)
- (e) The Community detoxification programme must be supported by social and psychological aftercare. (Section 3.4 and Section 8)
- (f) Concerns were expressed by a number of witnesses about aspects of the service provided by the Alcohol and Drugs Service; in particular, regarding waiting times for appointments and the range of treatment options offered to clients. (Section 3. 5)

- (g) There appears to have been unwillingness in the past on the part of the Alcohol and Drugs Service to promote the treatment and rehabilitation programme at Silkworth Lodge. (Section 3.5; 7.4 - 7.9)
- (h) Supervised injecting centres, designed to reduce health problems associated with illegal injection drug use, have been set up in a number of European countries. (Section 3.8)
- (i) It is recognised that further work is required to promote equity of access to services for the Portuguese community. (Section 3.1)
- (j) The introduction of the integrated care pathways approach will be a constructive development leading to the better collaboration and co-ordination of services. (Section 3.6)

Medical care for substance misusers

- (k) Medical care for substance misusers in the Island currently relies heavily on a small number of GPs. (Section 3.7 and Section 5)
- (l) Training opportunities for professionals and GPs working with substance misusers should be improved. (Section 3.7 and Section 5)

Substance misusers within criminal justice system

- (m) The Island pays a high cost for keeping a large number of addicts in prison. (Section 6.1)
- (n) Home Office research shows that every £1 spent on treatment can save the criminal justice

system £3. (Section 6.1)

- (o) Current sentencing policy ties up vast amounts of resource in the criminal justice system, far in excess of spending on preventative and treatment facilities. (Section 6.2)
- (p) The practice of compulsory detoxification of prisoners on remand at La Moye is not medically or ethically acceptable. (Section 6.3.2)
- (q) There is evidence that some prisoners may have contracted blood-borne infections through injecting drug use while in custody at La Moye. (Section 6.3.10)
- (r) Harm reduction measures within the prison system, such as the Needle Exchange programme, have been shown to be safe and effective in other jurisdictions, such as Spain. (Section 6.3.12)
- (s) The prison service is responding to the recommendations of the Wool Report 2004 into health needs at La Moye. Current problems with overcrowding limit what can be achieved. (Section 6.3.13 - 6.3.17)
- (t) Jersey is the only British jurisdiction which has no statutory provision for post-custodial supervision on release from prison. (Section 6.3.4)
- (u) Former prisoners are very vulnerable in the early weeks after release - appropriate support at this stage is essential to prevent many drifting back into drug use when they return to their previous environment. (Section 6.5)

General

- (v) Short-term financial thinking within the States resource allocation process can prevent proper investment in the development of services which would have long-term benefits for individuals and real financial savings for the community. (Section 7)
- (w) There is currently no collaborative forum to monitor and promote initiatives across different

agencies. (Section 9)

10.2 Key recommendations

10.2.1 HEALTH AND SOCIAL SERVICES

Alcohol and Drugs Service	
1.	The Needle Exchange scheme should be further developed to build on its initial success. (Section 3.1)
2.	A review of the opiate substitution programme should be carried out by an appropriate external medical body. (Section 3.3)
3.	Current detoxification practice should be reviewed within the context of the introduction of the proposed integrated care pathway system of assessment, treatment and aftercare. (Section 3.4)
4.	The Alcohol and Drugs Service should seek to promote a more rapid and sensitive response to requests for assistance. (Section 3.5)
5.	Substance misusers wishing to access treatment should be made fully aware of the comprehensive range of options available in the Island, including abstinence-based approaches, and the support available through Narcotics Anonymous and other agencies. (Section 3.5)
6.	The integrated care pathways approach should be developed as soon as possible following appropriate consultation. (Section 3.6)
7.	Further research should be carried out into the operation of supervised injecting centres in Europe and reported in due course to the Health and Social Services Committee, with recommendations as to whether or not this practice might be implemented in Jersey. (Section 3.8)

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Strengthening the Evidence base: HIV and Hepatitis C:

8. A pilot scheme, based on randomised anonymous testing, designed to monitor the spread/prevalence of blood-borne viruses should be instigated as soon as possible. (Section 4)
9. Whenever a Committee commissions a major report, such as the Imperial College Study of Drug and Alcohol Use in Jersey, the implementation of its recommendations should be earmarked for an update report to the Committee on a regular basis. (Section 4)

Medical care for substance misusers

10. Further opportunities should be offered to GPs to raise awareness of the impact they might have on the health of substance misusers. (Section 3.7)
11. A strategy should be developed, as a matter of urgency, to promote the provision of good quality, accessible primary medical care and treatment in the community for substance-misusers, with particular emphasis on targeting vulnerable young people. (Section 5)

Partnership with voluntary agencies.

12. Clear partnership funding arrangements should be established with voluntary bodies providing proven and effective rehabilitation and aftercare support for substance misusers. (Section 7)
13. Any well-founded new initiative to establish additional community support for substance misusers should be supported by the States with partnership funding. (Section 8)
14. A collaborative forum should be established, bringing together both statutory and voluntary agencies to monitor and promote service initiatives for substances misusers. (Section 9)

10.2.2 HOME AFFAIRS

Sentencing policy

15. The Panel supports a review of sentencing policy for drug-related offences, particularly in relation to young people. (Section 6.2)

Health Needs in H.M. La Moye

16. The practice of compulsory detoxification of prisoners on remand should be reviewed. (Section 6.3)
17. The policy on harm reduction measures available to prisoners should be reviewed, in the light of best practice elsewhere. As a first stage, further research should be carried out into the introduction of a needle exchange scheme into H.M.P La Moye. (Section 6.3)
18. The implementation of the Wool Report on Health Needs in the H.M.P. La Moye should be the subject of a review by a Scrutiny Panel once the full Scrutiny function has been established after the elections in 2005. (Section 6.3)

Aftercare of prisoners

19. Funding should be made available for the establishment of a comprehensive statutory system of post-custodial supervision as soon as possible. (Section 6.4)

- 20 A feasibility study should be carried out into the establishment of a half-way house for prisoners close to release. (Section 6.5)
21. A pilot scheme should be established, in conjunction with Silkworth Lodge, for selected prisoners who wish to access residential treatment and rehabilitation as part of an early release programme. (Section 6.5)

11. CONCLUSION

- 11.1 The Panel acknowledges the co-operation and assistance received in the course of this review from the range of agencies providing services to substance misusers.
- 11.2 The Panel believes that the **Scrutiny process** is designed to allow the public to give their views on the services as they experience them and to hear professionals and politicians explain their policies, in public evidence sessions.
- 11.3 This review has identified both strengths and weaknesses in the service provision for substance misusers. The Panel is conscious that many of these weaknesses have already been recognised by professionals within the organisations as long-standing concerns and are being addressed.
- 11.4
The Panel was impressed by the number of witnesses among the professionals who gave evidence, who were striving to improve and broaden the scope of current services for substance misusers and who presented the Panel with their plans and aspirations for future improvements and expansion of their operations.
- 11.5 The Panel has always hoped that the Scrutiny process could add weight to these pressures for further development.
- 11.6 The Panel presents the recommendations arising from its review for consideration and comment by the Health and Social Services and Home Affairs Committees and requests that they respond **within a period of three months**, in accordance with the guidelines for Shadow Scrutiny, as set out in the Appendix to P.186/2003.
- 11.7 The Panel also advises these Committees that it will seek to review the implementation and outcome of its recommendations in a year's time.

12. REFERENCES

1. Community Safety and Substance Misuse Strategy 2005-2009 'Building a Safer Society" (P.17/2004, adopted by the States on 16th March 2004)
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3. Health Needs Analysis HM Prison La Moye, 2004, confidential report carried out for the Home Affairs Committee by Dr R. Wool
4. De La Haye, May 2004, Study to measure risk taking behaviour among injecting drug users in Jersey
5. Arrest Referral: Emerging Findings from the national monitoring and evaluation programme - DPAS Paper 18 DPAS/P18, 16 July 2002.
6. Substance Misuse Treatment: Service Specification - confidential draft proposal, dated November 2003, under consideration by Health and Social Services Committee
7. Home Affairs Select Committee (Third Report, session 2001-02) The Government's Drug Policy: Is it working?, (HC 318) published 22nd May 2002, and 'The Government's Drug Policy: Is it working? The Government Reply', published July 2002 (Cm 5573)
8. 'Supervised Injecting Centres', Nat M.J. Wright, Charlotte N.E. Tompkins, British Medical Journal, Volume 328, 10th January 2004
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10. Review of Criminal Justice Policy in Jersey, report carried out for Home Affairs Committee by Dr A Rutherford in 2002
- 'Needle Exchange Programs in Prisons in Spain', C. Menoyo, D. Zulaica, F. Parras - Canadian HIV/AIDS Policy and Law Review, Volume 5, Number 4, 2000
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[1] Details of publications referred to in the text of this report may be found in Section 12