Prison Drugs Strategy.

HM Prison and Probation Service.
HM Prison and Probation Service, 2019

National agency responsible for prison and probation services in England and Wales announces three-point plan for tackling the presence of drugs and drug use problems, based on the principles of restricting supply, reducing demand, and building recovery.

SUMMARY

The availability of illicit drugs in prisons is a threat to safety and security, obstructing recovery for prisoners with drug use problems and leading others to develop problems while in prison. The *Prison Drugs Strategy* creates a pathway for real and positive change across the prison estate – reducing or eliminating activities that cause serious harm, enabling prisoners to live law-abiding lives, and supporting them to overcome addiction.

Complementing the themes of the *2017 Drug Strategy*, the strategy is split into three sections, supporting the aims of (1) restricting supply, (2) reducing demand, and (3) building recovery. Underneath each aim, the strategy identifies actions relating to five domains that impact the levels of drug use in prisons:

> ***People*** *– that prisons have the right staff, with appropriate skills and support.*
>
> ***Procedural*** *– that prison processes are clear, fair and effective.*
>
> ***Physical*** *– that prison conditions are safe, clean, decent and promote well-being and recovery.*
>
> ***Population*** *– that prisoners have positive relationships and engage in constructive activities.*
>
> ***Partnership*** *– that all the organisations contributing to achieving our aims work together effectively.*

Delivery of the strategy's aims and objectives requires commitment from stakeholders at a national, regional and local level. All prisons are expected to implement their own drugs strategy by September 2019, tailored to their specific needs and challenges.

Restricting supply

Drugs enter prison in a variety of ways, including coming through the front gate, being thrown over the perimeter, through visits and post, and deliveries by drones. Often drug smuggling into prisons forms part of a complex illicit economy, driven in part by sophisticated and organised criminals.

Prisons should aim to reduce the proportion of 'positive' random mandatory drug tests by March 2020.

Actions that will contribute to this across the five domains (described above) are:
• Providing guidance and advice to all prisons on security measures including searching, prison reception, visits, and new methods for smuggling drugs by April 2019; and sharing the drug diagnostic toolkit (to help prisons understand their drug issues and improve processes and procedures) with all prisons by April 2019, alongside guidance to assist each prison in identifying improvements in their practice.
• Reviewing the approach to drug testing to ensure it is comprehensive and balanced; and launching a restructured counter-corruption unit to tackle types of corruption including drug trafficking by spring 2019.
• Extending the use of enhanced gate and perimeter security across the prison estate, particularly in local prisons; and increasing the searching of all entrants to prisons, including prisoners, visitors and staff.
• Developing a digital categorisation service [which can identify prisoners who pose a threat while in custody], including those who may have the means to smuggle drugs into prison. Closed male prisons have particularly challenging issues with substance use.
• Building national and regional intelligence units to develop intelligence on those offenders who pose the greatest threat to prison security; and working with law enforcement to prevent and disrupt offending by implementing the *Serious and Organised Crime Strategy 2018* for lifetime offender management of priority organised criminals in prison.

Reducing demand

Criminals seek to exploit the demand for drugs in prisons, and unless demand is reduced, any efforts to restrict drug supply will lead to increased prices and potential profits for these criminals.

Prisoners should understand the consequences of drug use within prison, as well as the wider risks to themselves and their families. Furthermore, prisons should offer opportunities that give purpose and direction – progressively increasing the time that prisoners spend outside their cells engaged in productive activity (work, education or treatment).

Actions that will contribute to this are:
• Refreshing the substance use and mental health training provided to new prison officers, and ensuring updated training is available for existing staff.
• Creating a single, evidence-based adjudications and crime-in-prison policy framework and a refreshed incentives and earned privileges policy framework.
• Supporting prisons to establish incentivised substance-free living, sharing learning and best practice from the '10 prisons project' by summer 2019.
• Fully implementing the offender management in custody model in all prisons by December 2019.
• Continuing to implement the recommendations of Lord Farmer's review to ensure that engagement with families is key to prisons' approaches to tackling substance use.

Building recovery

Prisons must have a culture that recognises the relationship between substance use problems and the crimes that lead people to prison, and which seeks to support long-lasting rehabilitation by addressing the root causes of addiction.

Prisons should aim to reduce the number of drug-related deaths in custody, and by December 2020 increase the proportion of those prisoners who complete treatment (and do not return within six months) and the proportion of prisoners with substance use treatment needs who are successfully engaged in community-based treatment within 21 days of release from prison.

Actions that will contribute to this are:
• Working with Public Health England to promote their audit toolkit and guidance on continuity of care, and encouraging prisons to reflect on their current arrangements and how liaison with community healthcare providers and GPs could be improved.
• Re-establishing single points of contact for substance use treatment services in custody in England by December 2019 to improve the sharing of health information, including between treatment providers in prisons and the community.
• Ensuring the safe and secure dispensing of pharmacy and prescription medication, including the use of medicine safes where necessary.
• Publishing statistics on the number of drug-related deaths in custody by July 2019.
• Continuing to work closely with NHS England, Public Health England, the Welsh Government, devolved health bodies, and other partners to ensure effective, joined-up healthcare and treatment for prisoners.

FINDINGS **COMMENTARY** In the same vein as the *2017 Drug Strategy*, the *Prison Drugs Strategy* aims to restrict the supply of drugs, reduce demand, and build recovery. While the strategy targets the presence of drugs and drug use problems in prisons, it acknowledges that the problems do not end there – substance use problems also impact people who leave the prison system and return to the community (and in many cases cycle back to prison), as well as their friends and family.

Commenting on the strategy, Russell Webster who has over 30 years' experience in the fields of substance use and criminal justice, said that "the new prison drug strategy appears, at first look, to be a coherent and well thought out approach" and "on the whole, identifies the right aims and objectives". However, he identified a number of weaknesses or gaps in the strategy, for example:
• The reliance on mandatory drug testing for evaluating the impact of the strategy: Firstly, he explained there is doubt that the small samples of people tested for illicit drug use can provide an accurate measure of the actual levels of drug use within custodial settings; and secondly, the use of mandatory drug testing has inadvertently led to people changing their drug use patterns, for instance turning to 'spice' (a synthetic form of cannabis) which went undetected, or using heroin and other opiates inside which remain detectable in the body for much shorter periods of time than cannabis. [Note: According to the featured strategy, drug testing revealed the presence of new psychoactive substances (once known as 'legal highs' for the first time in the year 2017/18, thought it did not state whether this included spice.]
• The chasm between aspirations to reduce demand and the current reality of prison life: In 2016, the User Voice survey of prisoners investigated the nature and extent of spice use and problems inside prison. One of the main causes of the thriving spice market in custody was reported to be prisoners' desire for 'mind-numbing' experiences, bringing relief from boredom and bad feelings like anxiety and depression. However, prisoners were also open about its harmful consequences such as addiction, debt, violence, bullying, mental health problems, physical health problems, and self-harm. Acknowledging this juxtaposition, it was spoken about in the following way: "it's a bird killer", "a shit feeling is better than no feeling". Reducing the demand for this drug in particular is critical, says Russell Webster, though it was neglected in the strategy. [Note: New psychoactive substances were considered as part of the totality of the drug use problem in prisons and referred to under the pillars of restricting supply and building recovery, though without particular attention to spice, and again,

not under the pillar of reducing demand.]

In 2015, the prison inspectorate for England and Wales raised concerns about the rise in the use of new psychoactive substances in prisons, in particular synthetic cannabis.

> *"The health consequences of synthetic cannabis use have been particularly severe because of its inconsistent composition and unknown effects. Some prisons have required so many ambulance attendances that community resources were depleted. In at least one prison, ambulances are known as 'mambulances' [after 'mamba', another name for synthetic cannabis]. The Prisons and Probation Ombudsman found that, in 19 deaths in prison between April 2012 and September 2014, the prisoner was known, or strongly suspected, to have been using [new psychoactive substance]-type drugs before their deaths. We have had credible accounts of prisoners being used as so-called 'spice-pigs' to test new batches of drugs. In some cases, this was in return for free samples; in others, vulnerable prisoners were tricked or coerced into sampling the batch. Debt associated with synthetic cannabis use sometimes leads to violence and prisoners seeking refuge in the segregation unit or refusing to leave their cells. Debts are sometimes enforced on prisoners' friends or cell mates in prison, or their friends and families outside. Drug misuse damages rehabilitation and, if efforts to reduce reoffending are unsuccessful, creates more victims. Profits from drug supply may be used to fund organised criminal activity in the community."*

A study set in an English adult male prison found that the nature of the market was posing significant challenges to the management of offenders. There, the primary motivation for consumption was being able to take a substance without it being detected. Given this motivation, and the greater likelihood of harms from synthetic versus natural cannabis, the researchers concluded that it was imperative for mandatory drug-testing policies to be revised, and instead rooted in harm reduction – something which would also be relevant to people on probation subject to mandatory drug-testing.

Much like the UK drug strategy before it, harm reduction was all but absent in the text of the *Prison Drugs Strategy*. For example, despite one of the aims of the strategy being to reduce the number of drug-related deaths in custody, this was not linked to evidence-based harm reduction measures such as opioid maintenance prescribing and naloxone. Internationally the evidence is strong that being in treatment – and especially for opiate users, being in a substitute prescribing programme – helps prevent overdose deaths. This effect has also recently been explored in relation to drug poisoning deaths in the UK (1 2 3 4), providing further evidence of the protective effect of being in treatment and the heightened risk of overdose death while not in treatment and after leaving.

Problem drug users are particularly likely to suffer drug-related death after periods of relative abstinence, most notably after being discharged from hospital and released from prison when they may have lost their tolerance for large doses (acquired after regular use) and may be particularly vulnerable due to the nature of the transition. Naloxone is an opioid antagonist which blocks the effects of opiate-type drugs, and can be used to prevent fatal overdoses. In 2011 Scotland became the first country to fund a national policy of distributing naloxone to prevent deaths involving opiate-type drugs, and an evaluation found it did prevent deaths where the effect was most likely to be seen – in the weeks after release from prison.

The third pillar of the strategy – building recovery – was framed as a process of "overcoming addiction" and "long-lasting rehabilitation". Although the strategy avoided narrowly defining recovery, it did arguably pose medication-assisted treatment as a problem in achieving recovery rather than an asset, for example through:
• opioid substitution therapies (eg, methadone and buprenorphine) only being mentioned in the context of the *misuse* of prescribed medicines;
• the *use* (not just the misuse) of prescribed medicines being described as "presenting considerable challenges to safety".

Prisons undoubtedly present a challenging environment for the management of health conditions, including the safe prescribing of medication and use of these by the intended patients. Therefore one could expect the strategy to address how prescribing practices need to be tailored to the prison context, but without the treatments themselves being undermined.

As well as overdose deaths, the *Prison Drugs Strategy* neglected to mention harm reduction in the context of preventing injecting-related infections and viruses such as hepatitis C and HIV. This is notable as prisons represent high-risk environments for the transmission of blood-borne diseases, for example due to overcrowding, poor sanitation, inadequate health care and a greater likelihood of sharing injecting equipment (and with more people). Presumably in a custodial setting, run on principles of punishment, sanctions, and security, the prevailing belief is that prisons cannot accept (and be seen to accept) anything other than being totally drug-free, so consequently harm reduction is not given a platform in the overarching strategy for the prison sector.

The *European Union Drugs Strategy 2013–2020* advocates "[scaling] up the development, availability and coverage of drug demand reduction measures in prison settings, as

appropriate and based on a proper assessment of the health situation and the needs of prisoners, with the aim of achieving a quality of care equivalent to that provided in the community and in accordance with the right to health care and human dignity as enshrined in the European Convention on Human Rights and the EU Charter of Fundamental Rights". Under their definition, this would include "a range of equally important and mutually reinforcing measures, including prevention (environmental, universal, selective and indicated), early detection and intervention, risk and harm reduction, treatment, rehabilitation, social reintegration and recovery".

An overview of harm reduction in prisons in seven European countries (not including the UK) found that the provision of harm reduction in prisons continues to be largely inadequate compared to the progress achieved outside prisons. All of the countries reviewed provide a wide range of harm reduction services in the broader community, but most failed to provide these same services, or the same quality of these services, in prison settings, in clear violation of international human rights law and minimum standards on the treatment of prisoners. Where harm reduction services have been available and easily accessible in prison settings for some time, better health outcomes were observed, including significantly reduced prevalence and incidence of both HIV and hepatitis C.

In 2015, the Scottish Prison Service published a framework for the management of substance use in custody. This included a pledge to "take all reasonable measures to reduce the availability of illicit substances and provide services broadly equivalent to those available in the community, whilst recognising that prisoners require different routes to recovery". Ensuring parity of services with the community echoes the *European drug strategy* as well as UK treatment guidelines, and in Scotland includes "offering a range of harm reduction measures to reduce the transmission of blood borne viruses".

The *Prison Drugs Strategy* applies only to England and Wales where criminal justice is the overall responsibility of the UK Government. However, achieving its aims rests on joint working with agencies that are the devolved responsibilities of individual nations such as healthcare, education, and social services.

Drug recovery wings

An Effectiveness Bank hot topic examines the political mood towards recovery (and move away from harm reduction). In 2010, drug recovery wings were an important element in the Conservative-led coalition government's turn towards abstinence-based recovery and a more 'challenging' treatment regimen:

> *"We believe that, given the substantial investment in drug services, and the strong association between drug use and reoffending, we should be more ambitious in our aims to improve efficiency and effectiveness. We will therefore focus on recovery outcomes, challenging offenders to come off drugs."*

The drug recovery wing model was piloted in 11 prisons, including prisons for women and young offenders, and its evaluation completed in 2014, with the final report in 2017 noting considerable reductions in drinking, drug use and offending. However, evaluation data came from the one-third of prisoners living in the community who remained in contact – there was no way of knowing about the extent to which the other two-thirds of the sample were using drugs, drinking excessively, or engaging in criminality.

Drug recovery wings were also found to have limited impact on 'recovery capital': the "internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems". People who entered prison with robust access to resources left in a similar position, and those who were imprisoned with nothing returned to nothing (ie, precarious housing, marginalisation from employment, and unstructured lives filled with the temptation of illicit earnings). Relatively positive findings from a few of the wings suggested that the concept in itself may not have been flawed, but that perhaps under-resourcing (£30,000 made available to each prison) and strain in prisons (the drug recovery wing pilots happened at a time of substantial decline in prison officer numbers), plus misguided implementation models, undermined its potential.

Thanks for their comments on this entry in draft to Russell Webster. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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