Thematic report by HM Inspectorate of Prisons

Changing patterns of substance misuse in adult prisons and service responses

A thematic review

by HM Inspectorate of Prisons

December 2015

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With special thanks to the prisoners and staff who agreed to be interviewed as part of this thematic inspection.

Introduction

Drug misuse is a serious threat to the security of the prison system, the health of individual prisoners and the safety of prisoners and staff. Its effects ripple outwards to harm prisoners' friends and families and the wider community of which they are a part. An increasing number of reports of the misuse of medication in prison and concerns that traditional supply reduction and treatment strategies were ineffective were the initial driver for this thematic inspection. However, the availability of new psychoactive substances (NPS), particularly synthetic cannabis known as 'Spice' or 'Mamba', became highly prevalent during the preparation for this report. NPS have created significant additional harm and are now the most serious threat to the safety and security of the prison system that our inspections identify.

This thematic inspection examined the changing extent and patterns of drug misuse in adult prisons and assessed the effectiveness of the response to it. The inspection's remit did not include tobacco and alcohol use by prisoners, which are important issues in their own right and raise significant operational and policy challenges. Of course, there are wider questions to be asked about the legal status of drugs in the community and the historical inconsistency of legal responses to various harmful substances. This report does not address those issues. There is no prospect of any relaxation of the rules governing the substances that are permitted in prisons and so there is an urgent requirement to address the harm that substance misuse causes in prisons in that realistic context.

The report draws on the evidence of 61 adult prison inspections published between April 2014 and August 2015, the 10,702 survey responses from individual prisoners that were collected as part of those inspections, and detailed field work that was conducted in eight prisons between June and November 2014. We spoke to prisoners, prison staff and managers, drugs and health workers, and other experts. We reviewed a wide range of research undertaken by other bodies. We also considered some earlier inspection findings, where relevant. The inspection was carried out by the inspectorate's research team and specialist health and drugs inspectors.

Changing patterns of drug use in the community provide a useful context for understanding drug misuse in prisons. It is impossible to know for certain the extent and type of drug misuse in the community or in prisons. Nevertheless, there is a wealth of evidence to suggest that patterns of drug use are changing in the community, with drug use appearing to be reducing. The 2014–15 Crime Survey for England and Wales found that 8–9% of adults reported illicit drug use over the previous year, down from 12% in 2003–04. Cannabis remains the most widely used drug and there has been a well-evidenced decline in illicit opiate use. The reported use of prescribed medication and NPS in the community is at a relatively low level. Patterns of dug misuse vary with age, gender, geography and lifestyle.

There are important differences between drug misuse in prisons and the community. A declining number of prisoners needing treatment for opiate misuse reflects trends in the community, although many of those requiring opiate treatment in prison have complex dependence, social, physical and mental health issues. Prisoners are more likely to use depressants than stimulants to counter the boredom and stress of prison life. The use of synthetic cannabis and diverted medication reflects a response to comparative weaknesses in security measures. Often, the price of drugs is higher and the quality poorer in prison, reflecting greater difficulty of supply. The combination of community influences, prisoner demographics and individual prison contexts means that the patterns of drug use will differ from prison to prison. As this report was being prepared, there was an acceleration in the use and availability of NPS. It is important to understand, however, that success in combating current challenges in prisons, such as the availability of NPS or specific medications, will lead to an increased demand for other drugs, and to be prepared for this.

At the present time, some synthetic cannabis is legal (depending on its exact composition) to possess in the community but all forms are banned in prisons. This has four consequences. First, it is cheap to buy or manufacture in large quantities in the community. Second, the difference between the price in the community and that in prison is much greater than for drugs such as opiates or cannabis, which are illegal in both settings. Third, despite the high mark-up, it is still relatively cheap in prisons. Fourth, current testing methods cannot detect synthetic cannabis, and its composition may change from batch to batch. New tests are being developed and special drug dogs are being trained to identify it, but neither of these measures are yet available in most prisons. This means that the risks involved in supply are low and large profits can be made by supplying it in bulk. The low 'wholesale' price, high profit margin and ready supply means that profits can be maintained even if considerable amounts are intercepted. Low risks, high profits and large-scale supply mean that distribution to and within prisons may be linked to organised crime. Payments can be made and collected, and debts enforced in the community. Banning harmful NPS in the community would reduce the price differentials, and hence profits. Changes to the legal status of NPS, the urgent development and implementation of better testing and detection methods, effective joint work with law enforcement agencies, and the imposition of clearer disciplinary and categorisation consequences would increase the risks of supply, and hence decrease its attractiveness.

Diverted medication is popular among adult prisoners and can come from medication prescribed in the prison or be smuggled in. Prisoners may sell or misuse medication because they feel they cannot legitimately get the medication they need, to mimic the effects of illegal drugs or to trade. Effective prescribing practice and drug administration are necessary to prevent this, along with the development of less harmful therapeutic alternatives for legitimate health concerns.

No one should be in any doubt about the harm that drug misuse does in prisons. It damages prisoners' health and sometimes causes deaths. 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'. 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 NPS-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.

Illegal drugs, NPS and illicit medications may get into prisons in a number of ways. The nature of the issue means that it is not possible to quantify this, and supply routes are likely to differ from prison to prison. In large training prisons, with long perimeters and relatively free prisoner movement, drugs may be thrown into the prison in small packages (in a tennis ball, for instance), in larger packages fired by catapults or, in some recent cases, dropped by drones. Easy access to illicit mobile telephones makes it possible to plan the drops carefully. In a busy local prison, drugs may come in with prisoners moving back and forth to court. Some prisoners may get themselves recalled, for a price, and smuggle in drugs hidden in body cavities. The wide variety of staff working in prisons – officers, medical professionals, trainers and suppliers, for instance – may bring drugs in or facilitate other forms of access. Drugs come in with visitors – sometimes willingly and sometimes under pressure. Drugs may also come in with prison goods or prisoner packages and correspondence. Synthetic cannabis can be sprayed onto paper and smoked, making it extremely difficult to detect.

The needs of security should be balanced with the needs to allow prisoners to undertake the activities, and have the family relationships, necessary to reduce the risk that they reoffend. Nevertheless, testing and searching processes should be carried out rigorously to reduce the supply

of traditional drugs. Mandatory drug testing (MDT) is traditionally used as a measure of a prison's performance in reducing drug supply; however, MDT will not detect synthetic cannabis or most illicit medication and is no longer a useful performance indicator.

Reducing supply is only one part of a successful strategy to respond to drug misuse in prison. Individual prisons need a whole-prison response to drug misuse based on a thorough needs analysis. A whole-prison approach will include measures to reduce supply and measures to reduce demand through effective treatment, psychosocial support and education. Strategies should coordinate the activities of different departments and services in the prison and in the community. The strategy needs to go beyond specific drug services to reducing demands for drugs by offering attractive purposeful alternatives, reducing prison violence and creating positive staff–prisoner relationships.

The strategy should include effective treatment and psychosocial support. The development of evidence-based treatment and support strategies has been significant and provides a model for policy development that should inform responses to current needs. Individualised treatment and the growth of peer-led support processes have been successful, although implementation is sometimes inconsistent. New approaches should be used to engage prisoners misusing synthetic cannabis who may not see a need to work with drug services in the same way as users of more traditional drugs. Risks of inconsistent treatment between England and Wales of prisoners who are dependent on illicit opiates need to be addressed. Prisoners in Wales who are opiate dependent do not receive first night opiate substitution treatment, unlike their counterparts in English prisons, which creates considerable risk and means that prisoners moving between prisons in the two nations will not have consistent treatment or support.

Education and information from credible sources have an important role to play in reducing drug misuse, particularly use of synthetic cannabis. The National Offender Management Service (NOMS) and individual prisons have produced a wide range of good education and information material. We have seen examples in some prisons of reported synthetic cannabis use reducing after the introduction of prisoner-led sessions using effective resources in the induction of new arrivals. Prisoners' families may be a source of supply, a resource or themselves victims of the consequences of drug misuse. Education and information should be directed at them and, where appropriate, the prison should work with families to address prisoners' drug misuse. Confidential assistance should be available to friends and family members who may be pressured to supply drugs or pay drug debts, or who may be worried about the misuse of drugs by a family member or friend in prison.

NOMS has made considerable efforts to reduce the supply of and demand for drugs in prisons. New legislation is being introduced; detection of NPS is being improved by the introduction of new tests and the training of drug dogs. The variable composition of each batch of NPS has made the development of an effective test extremely complex and challenging. Joint work with health commissioners and providers is being undertaken to extend access to recovery services as part of prisoners' rehabilitation and improve continuity of treatment and support on release. Despite these efforts, the Prison Service and other relevant national bodies have found it difficult to keep pace with and respond to the unprecedented and rapid growth of NPS use in adult male prisons. It has sometimes been difficult to make best use of the information available from individual establishments and other sources to identify changing needs and modify the strategy accordingly. In part, this reflects a too-willing acceptance in some establishments that drug misuse is an inevitable part of prison life and cannot be reduced. It has taken time to develop new drug tests, change legislation and develop new resources. These measures are still not in place and their effectiveness has not yet been fully tested on a national scale. This report proposes the establishment of a national committee, chaired by the Prisons Minister, so that it has the authority to bring together cross-government and cross-sector expertise, to assess changing needs and ensure that the national strategy adapts and responds accordingly.

The emergence of NPS as the main drug of choice in adult male prisons is just the most recent change in a long history of drug misuse in prisons. As responses to this new challenge become more effective, new substances or types of use will emerge to replace it. Drug misuse, of whatever type,

does serious harm in prisons and in the wider community. Lessons should be learnt from the emergence of NPS at a national and local level to ensure that a dynamic, responsive and well-coordinated whole-system and whole-prison strategy is in place, both to reduce the harm of current use and respond effectively to future needs.

Nick Hardwick December 2015
HM Chief Inspector of Prisons

Section 1. Summary

The issue

1.1 This thematic inspection examined drug misuse in prisons. Tackling drug misuse is a key priority for the Prison Service. Drug misuse in prisons damages the health of individual prisoners, undermines the security and safety of prisons, and hampers rehabilitation. Prisoners are more likely than the general population to have histories of drug misuse, and in some cases this misuse continues in prison. When work on this inspection began, there had been a recognised shift away from the use of opiates and Class A drugs towards the misuse of medication in prisons. During the course of this work, patterns of substance misuse in prison changed again and the use of new psychoactive substances (NPS), and in particular synthetic cannabis, has emerged as a major problem. This thematic inspection aimed to examine changing patterns of substance misuse in adult prisons, assess the effectiveness of current policy and operational responses, and suggest how they might be improved.

Methodology

1.2 This report drew on 61 HM Inspectorate of Prisons (HMI Prisons) inspection reports published between April 2014 and August 2015. A total of 10,702 survey responses were included in the analysis. These inspection findings were supplemented with findings from additional fieldwork conducted in eight prisons between June and November 2014.

1.3 The additional fieldwork comprised a confidential survey which asked prisoners about their drug use before going into custody, and also within their current prison, and a total of 1,218 surveys were completed by prisoners in these eight prisons. Qualitative interviews were also undertaken with prisoners, to explore further their drug use both before and during custody. Interviews also explored their experiences of prison-based drug treatment. Within the eight prisons, interviews were also conducted with staff involved in supply reduction and treatment, concerning trends of, and motivation for, drug misuse in the community and in the prison, and the support available. In addition, interviews were conducted with commissioners of community and prison drug treatment services in England. Further detail about HMI Prisons' inspection processes and the specific methodology used for this fieldwork can be found in Appendix I.

1.4 Third-party research was used to provide background and context for the report. Sources are acknowledged in the text.

1.5 The inspection was undertaken by HMI Prisons, with support and advice where required from other inspectorates: HMI Probation, HMI Constabulary, the Care Quality Commission (CQC) and Healthcare Inspectorate Wales (HIW). We are grateful for their assistance.

Key findings

1.6 **Substance misuse is a serious threat to the security of individual prisons, the health of prisoners and the safety of prisoners and staff. Crime associated with the supply of drugs to prisons and the negative impact of drug use on measures to reduce reoffending adversely affects the community as a whole.**

Throughout this report, we describe the adverse consequences of substance misuse in prisons. Crime and disorder associated with the supply and distribution of illicit substances in prisons undermines effective security in individual prisons. Substance misuse damages the health of prisoners and in some cases leads to death. Violence and disorder associated with substance misuse affects the safety of prisoners and staff. The involvement of organised crime in the supply of drugs to prisons may lead to pressure on prisoners' families and friends, and have wider effects on the community as a whole. Some prisoners report that they have developed a drug problem in prison, and drug use undermines measures to rehabilitate them and reduce reoffending (see paragraphs 2.28 to 2.30 and 3.34 to 3.54).

1.7 Patterns of drug use are changing in the community and, although this will be reflected in patterns of drug use by prisoners both before and, to some extent, within custody, there are some important differences between drug misuse in the community and in prison.

It is impossible to be certain about the extent and nature of drug misuse in either the community or prisons. The 2014–15 Crime Survey for England and Wales found that, for each of the last five years, between 8% and 9% of adults reported using an illegal drug in the previous year, down from 12% in 2003–04. Cannabis is the most common drug used in the community. There has been a long-term decline in illicit opiate use. Reported use of new psychoactive substances and misuse of prescribed medication are low. Patterns of drug use in the community vary by age, gender, region and lifestyle. Offenders are more likely than the general population to misuse drugs and prisoners report high use of illegal drugs before their imprisonment. Drug use in prisons will, to some extent, reflect use in the community but there are some important differences. There is a preference for depressants, rather than stimulants, in prisons. Security measures affect the choice and quality of what is available. The misuse of opiates in prisons appears to be declining but remains an important issue. There has been an increase in the use of diverted medication. Large numbers of prisoners present with chronic pain, and some come into prison taking, or are started in prison on, inappropriately prescribed drugs. In recent years, the use of NPS – in particular, synthetic cannabis, known as 'Spice' or 'Mamba' – has grown significantly (see paragraphs 2.2 to 2.22 and 3.1 to 3.47).

1.8 NPS – specifically, synthetic cannabis – are a problem in many prisons and a very serious threat to the safety and security of some.

Synthetic cannabis use has spread to most prisons and has destabilised the safety and security of some we have inspected. Synthetic cannabis has caused or is still causing wide-ranging problems, including medical emergencies, deaths, bullying, violence and debt. The extent of the problems and level of use appears most severe in category C establishments. There is the potential for large profits to be made from synthetic cannabis, and this has led to gangs and organised crime becoming involved in the distribution in some prisons (see paragraphs 3.26 to 3.32 and 3.48 to 3.54).

1.9 Every prison does not have the same drug problem(s), and patterns of use may change quickly. Policy and operational responses should be flexible and dynamic to meet changing patterns of use.

The extent and the nature of illicit drug misuse vary between individual establishments and can even be different in different parts of the same establishment. Synthetic cannabis is not the only drug issue facing prisons in England and Wales, and its use varies in different prisons. Patterns of use change rapidly at both a national and individual level. The problems associated with synthetic cannabis can be very obvious and have a clear adverse effect on some prisons, but most prisons have wider-ranging drug issues, including illicitly brewed alcohol, traditional drugs (including cannabis and opiates) and illicit medication. Successful measures to reduce the supply of synthetic cannabis are likely to increase demand for other substances. Policy

and operational responses have not been sufficiently flexible and dynamic to meet these changing and varied patterns of use (see paragraphs 3.1 to 3.54, 4.1 to 4.36 and 4.51 to 4.56).

1.10 The development of a coordinated response to synthetic cannabis has not kept pace with the rapidly increasing use of synthetic cannabis in adult male prisons.

The prevalence of NPS has been increasing in the UK since 2008. We first identified synthetic cannabis as an issue in a prison in 2011, but in our annual report for 2013–14 we were already reporting that its use had become widespread in adult male prisons. National developments, such as new legislation, new drug tests and dogs trained to detect synthetic cannabis, are now being established. We observed pockets of good practice develop within individual prisons and by specific treatment providers, but national prison guidance only emerged in 2015, which has resulted in some inconsistent and inadequate approaches across the estate (see paragraphs 3.26 to 3.32, 4.3 and 4.26 to 4.28).

1.11 Current testing methods are inadequate to discourage use or provide an accurate assessment of use on which local and national responses can be based.

There are no effective testing methods for synthetic cannabis available nationally at present, although some are in development. Assessments of local needs are currently hindered by inadequacies in the present mandatory drug testing (MDT) system. MDT is a useful supply reduction strategy but some illicit drugs, such as synthetic cannabis, are popular in prisons simply because they do not show up in current drug tests. This makes MDT results an inaccurate measure of drug misuse in prisons and an inappropriate measure of prison performance (see paragraphs 4.3, 4.18 and 4.29 to 4.31).

1.12 Few establishments have the necessary 'whole-prison' approach to addressing illicit drug use.

Drugs have the potential to affect all areas of prison life and, similarly, all aspects of prison life have the potential to influence the demand for dugs. A 'whole-prison' approach is necessary which tackles:

- Supply reduction: stopping drugs getting into the prison.
- Demand reduction: reducing the demand for drugs by addressing wider issues that may lead to drug use in prison and on release.
- Effective treatment for drug and alcohol issues, including harm reduction.

A prison's drugs and alcohol strategy needs to be embedded into every department, with effective structures to coordinate activity across the prison. Strategies and treatment should not just focus on drugs. Effective drug treatment also needs to address the wider issues that affect drug use, including adequate purposeful activity, and to include joint working between agencies and prison departments to address all the wider issues, including housing, employment, physical health and mental health. Poor performance in these areas in some prisons undermines effective treatment (see paragraphs 4.1 to 4.103).

1.13 Efforts to reduce the supply of drugs are too variable across the prison estate. In some cases, this is exacerbated by a shortage of suitable resources.

The strategies to detect illicit NPS and medication distribution and misuse are broadly the same as for other drugs. Some prisons are more effective than others at reducing supply, and in some cases a lack of suitable resources, such as a lack of trained drug dogs or sufficient staffing to carry out necessary testing or searches, contributes to inadequate responses (see paragraphs 4.19 to 4.28).

1.14 Prison-based drug treatment services have improved dramatically in England over the past 10 years.

The introduction of evidence-based and individualised treatment and support services, such as counselling, assessment, referral, advice and throughcare (CARAT) and the integrated drug treatment system (IDTS), and the subsequent developments in commissioning and provision have greatly improved drug treatment in English prisons and the community for offenders with opiate dependence. However, prisoner outcomes are adversely affected in some prisons by various factors, including poor prescribing; infrequent reviews; an insufficient range, quantity or quality of psychosocial support; and inadequate integration between services and departments. Community and prison drug services need to be innovative to make their services attractive to, and relevant for, people who use drugs other than opiates (see paragraphs 4.57 to 4.103).

1.15 The lack of IDTS in Wales leads to poorer outcomes for some prisoners and creates inconsistency in substance misuse treatment between prisons in England and Wales.

IDTS is not available in Welsh prisons. Our inspection findings have demonstrated that large numbers of prisoners in Wales have drug and alcohol problems on arrival in prison. Unlike their counterparts in English prisons, prisoners in Wales who are dependent on illicit opiates do not receive first night opiate substitution treatment. Instead, they are generally offered symptom relief only, which increases the risk of physical and mental distress in prison and of accidental overdose on release if they return to illicit drug use. In our inspections of Welsh prisons, we have found that those who arrive in prison on confirmed prescribing of opiate substitution treatment in the community will have this prescribing continued in prison, although the length of time for which the prescribing will be continued and the level of psychosocial support available vary between the prisons. This lack of consistent, coordinated, evidence-based treatment, including access to opiate substitution prescribing on arrival, has led to poorer outcomes for some prisoners. Many Welsh residents are held in English prisons and receive IDTS treatment which would not be available if they moved to Welsh prisons. The new North Wales prison which is being built in Wrexham, will hold large numbers of English prisoners. The drug treatment system in prisons needs to be the same across the estate and equivalent to that in the community (see 'Drug misuse and treatment in Wales' section on page 61).

1.16 Insufficient use is made of prisoners' families, friends and prisoner peer supporters to reduce supply and demand for illicit substances.

Well-trained and supervised peer supporters contribute to improved outcomes for prisoners. High-quality, properly supervised peer-led social, emotional and information support is key to effective drug treatment. Too many prisons do not do this effectively. Family and friends are also a largely untapped but key resource for substance misuse recovery in prisons. Research, our recent resettlement thematic report and interviews with prisoners for this thematic inspection confirm that an offender's family and friends are critical to their successful rehabilitation, including from addiction and into recovery. Families and friends may also be a negative factor and, willingly or through coercion, be a source of supply. Targeting families and friends for education and support is essential to improving outcomes for individual prisoners and to reducing supply. Too few prison drug treatment services do this effectively (see paragraphs 4.28 to 4.86).

Recommendation — To Ministers

1.17 The Prison Service should improve its response to current levels and types of drug misuse in prisons and ensure that its structures enable it to respond quickly and flexibly to the next trend. A national committee should be established, chaired by the Prisons Minister, with a membership of relevant operational experts from the public and private prison sectors, health services, law enforcement, substance misuse services and other relevant experts. The committee should be tasked to produce and publish an annual assessment of all aspects of drug use in prisons, based on all the available evidence and intelligence, and produce and keep under review a national prison drugs strategy.

Recommendations — To NOMS

1.18 Individual prisons should have an up-to-date drug and alcohol strategy and action plan which includes supply reduction, demand reduction and treatment based on a comprehensive local assessment of need, overseen by a committee which includes consistent attendance from all departments and relevant community representation. Resources should be allocated to ensure that the required actions, including training, drug testing and searching, occur promptly.

1.19 Work should be carried out to:

- **Provide education and information for families and visitors about synthetic cannabis and other forms of illicit drug use**
- **Develop clear protocols for the involvement of families, where appropriate, in work with individual prisoners to reduce the harm caused by substance misuse**
- **Provide and widely advertise a national, independent hotline that enables family members to report and seek assistance with threats related to the supply of illicit drugs and concerns about a prisoner's use.**

1.20 It should be ensured that protocols with the police at national and local level establish effective actions to disrupt the supply of illicit substances by visitors, prisoners, staff and other sources.

1.21 Mandatory drug testing results should not be used as a measure of prison performance.

1.22 Prisoners should have a consistent range of purposeful activity throughout the week and at weekends.

Recommendation — To Ministers and NOMS

1.23 Urgent action should be taken to reduce the harm caused by new psychoactive substances (NPS), particularly synthetic cannabis. This should include:

a) Measures to reduce the attractiveness and profits of supply by:

- **Quickly introducing legislation that takes due account of the advice from the Advisory Council on the Misuse of Drugs, bans harmful psychoactive substances and so reduces the attractiveness of supply**
- **Urgently developing and rolling out more effective testing methods**
- **Regarding the persistent or large-scale supply of NPS as a security threat and recategorising the prisoners involved accordingly.**

b) The development by every prison of a peer-led programme of substance misuse education, with effective resources to educate prisoners, particularly new arrivals, about the dangers and other consequences of synthetic cannabis use.

c) The development and delivery of national resources to ensure that all staff in prisoner contact roles are trained to understand the symptoms and consequences of synthetic cannabis use and that they are aware of how to deal with it.

Recommendation To Welsh Assembly Ministers and NOMS

1.24 Prisoners in England and Wales should have consistent access to equivalent substance misuse treatment.

Recommendation To NHS England

1.25 Commissioning arrangement should ensure that drug treatment and psychosocial services provide a comprehensive range of interventions that consistently meet current standards but encourage and develop innovative practice. Services should be individualised; well integrated with the prison, health services and community support; appropriate to the needs of the population; and include effective peer support, family support and services for NPS and illicit medication.

Recommendation To NHS England and Public Health England

1.26 A cohesive national strategy to reduce the misuse of prescription and over-the-counter medication should be developed which includes:

a) Monitoring of prescribing trends in the community and prisons, challenging prescribing that is outside normal ranges and the sharing of information on emerging trends locally and nationally.

b) Prompt access for prisoners to cohesive pain management services which include appropriate non-pharmacological and pharmacological options.

c) Evidence-based clinical and psychosocial treatment for dependence on illicit medication.

Section 2. Background to the report

2.1 The focus of this thematic study is substance misuse in adult prisons in England and Wales. However, it is necessary to place this in the context of substance misuse and treatment within the wider community as prisoners come from, and will return to, the community on release.

Changing patterns of substance misuse within the general population

2.2 Illicit drug misuse is a largely hidden or secret activity, which means that accurate information about its prevalence is difficult to obtain. Data about illicit drug use among the general population can be obtained from several sources, each with its own limitations, including drug treatment statistics, crime statistics, drug-related deaths and research. For example, the Crime Survey for England and Wales (CSEW)[1] relies on self-reported drug use, which cannot be verified objectively, and it does not cover those living in group residences (including university halls of residence) or the homeless, where there is a higher level of drug use. In addition, the time lag between data collection and the publication of research[2] means that it is impossible to maintain a completely accurate picture of a rapidly changing situation, and much available research is dated. However, the CSEW gives useful information on crime trends, including drug misuse, which can be compared over time.

Drug use in England and Wales

2.3 According to the latest CSEW (Home Office, 2015), covering the period April 2014 to March 2015, over a third of adults (34.7%; 11.3 million) have used an illicit drug at some point in their life (lifetime use). For each of the last five years, 8–9% of adults have reported using an illicit drug in the previous year, following a gradual reduction from a peak of 12% in 2003–04. Of those who reported illicit drug use in the previous year, over a third of adults (38%) said that they had taken drugs only once or twice in that year, but 36% reported having used drugs more than once a month and 8% of the total reported daily use. Those who reported taking drugs daily were most likely to be taking illicit tranquilisers (13%) or cannabis (9%).

2.4 Cannabis is by far the most used illicit drug in England and Wales. CSEW findings suggest that the proportion of adults reporting cannabis use in the previous year has remained stable, at between 6% and 7%, since 2009–10. Powder cocaine was the next most used drug in 2014–15 among adults (2.3%), followed by ecstasy (1.7%). Only 3.2% of adults (just over a million) had taken a Class A drug in the previous year, which has also been broadly stable in recent years.

2.5 There has been a long-term decline in illicit opiate use, attributed to several factors, including criminal justice initiatives to disrupt supply chains, changing demographics and fashions, and the positive impact of an investment in treatment. An increase in the use of injected image- and performance-enhancing drugs such as steroids has been reported recently, although the

[1] The CSEW (previously known as the British Crime Survey) is an annual survey which has been running since 1982. It asks around 35,000 adults and 3,000 children aged 10–15 years, resident in households in England and Wales, about their experience of a range of crimes during the last year.
[2] The fieldwork for the CSEW takes place over a 12-month period, which means that some data are a minimum of 12 months 'out of date' at the point of publication.

full extent of the problem is unknown. Since 2003–04, the percentage of primary cannabis presentations at drug treatment services has steadily increased, from 10.7% of all presentations to 26.8% in 2013 (UK Focal Point, 2014).

2.6 Opiate users are over-represented in drug treatment, primarily because opiate substitute prescribing encourages them into treatment; however, the numbers presenting for, and in, treatment for heroin use have been reducing over recent years. Drug treatment figures for England and Wales (National Treatment Agency for Substance Misuse (NTA), 2014) show that the total number presenting for treatment fell by 16% between 2008–09 and 2013–14 (from 84,520 to 70,930); the number presenting specifically for opiate or crack cocaine use fell by 20% (from 58,016 to 46,001) in the same period. However, it is estimated that only one in eight high-risk drug users (heroin and crack) in the UK (excluding Northern Ireland) is actually in treatment (UK Focal Point, 2014). The over-40s now make up almost a third of the entire drug treatment population in England, and 90% of those are for heroin and/or crack. These older users tend to be more entrenched in their drug problems and more vulnerable to all the associated health and social problems, and they find it more difficult to recover from their dependency.

Demographic and geographical variations according to the CSEW

2.7 The CSEW showed that the overall use of illicit drugs has been in general decline over the last 20 years, and that much of the drop can be attributed to falling rates of drug use among young people (16–24-year-olds). It highlighted that patterns of illicit drug use are not evenly distributed across the population, with young people still being more likely to use illicit drugs, and to use them more frequently, than older people. It showed that 19.4% (1.2 million) of young adults had used illicit drugs in the previous year and that 5.1% had used them at least monthly. Men are more likely than women to take drugs. Around one in eight adult men (11.9%) compared with one in 18 adult women (5.4%) reported taking an illicit drug in the previous year.

2.8 People with a long-standing illness or disability were more likely than those without such an illness or disability to have misused prescription-only painkillers or to have used an illicit drug in the previous year. Cannabis use was a large contributor to these proportions, as 9.4% of people with a long-standing illness had used cannabis in the previous year, compared with 6.3% of those without.

2.9 Adults who reported drinking alcohol three or more days per week in the previous month were around twice as likely to have used an illicit drug and seven times more likely to have used a Class A drug in the previous year than those who reported drinking less than once a month.

2.10 The level and type of drug use also vary markedly across England. For example, the highest rates of opioid and combined opioid and crack use were in Humber and the lowest rates in the East of England. The North-East had the highest injecting rate and London had twice as much crack use as in the lowest-use areas (Hay et al., 2014). The CSEW showed that people living in urban areas reported higher levels of drug use than those living in rural areas. The poorest local authorities tend to have the highest prevalence of problematic drug users (Marmot et al., 2010). A high proportion of problem drug users[3] have been socially excluded as children and young people; many are poorly educated and a high proportion live in poor housing (Seddon, 2006).

[3] The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines problem drug use as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines'.

Polydrug use

2.11 The CSEW has looked at polydrug use,[4] including alcohol, since 2010–11. Polydrug use carries a higher risk of overdose and adverse consequences. In the combined 2013–14 and 2014–15 surveys,[5] 9% of respondents who had used drugs in the previous year said that they had used more than one drug simultaneously the last time they had used drugs. More than half (56%) of polydrug use involved drinking alcohol along with taking other drugs. Over a quarter of respondents (27%) said that they took the particular combination of drugs as they wanted the combined effect of more than one drug to enhance or extend the effect; others reported that they used one drug to cancel the effects of the other (24%) – for example, to 'come up' or 'come down' – or that they just took whatever drugs were available or offered to them at the time (26%); and one in six (18%) gave no particular reason for their reported polydrug use.

New psychoactive substances (NPS) in England and Wales

2.12 There has been a reported rise in the use of NPS since 2008–09 in the UK and internationally (DrugScope, 2015a). The latest CSEW data indicate that the current prevalence of NPS use among adults is low compared with more established drugs such as cannabis, powder cocaine and ecstasy. Fewer than a million adults (937,000 people; 2.9%) had used an NPS in their lifetime and fewer than one in 100 adults (0.9%) had taken NPS in the previous year.[6] Young male adults (aged 16–24 years) accounted for almost half of all the NPS users in the previous year. Herbal smoking mixtures were most commonly used, reported by 61% of adults who had used NPS in the previous year.

What are NPS?

NPS are predominantly, but not always, synthetic versions of existing drugs developed to avoid legal sanction and detection, and are easily available through retail outlets and the internet. The term 'legal highs' was previously commonly used but has been replaced with the term 'NPS' as it gave a false impression of safety, and laboratory testing of alleged legal highs has shown that many contain illegal compounds. NPS appear and disappear rapidly under multiple brands, and users are not always aware of what they are taking. This makes it difficult to capture the full level of use, assess the health and substance misuse need, and put credible, timely information into the public domain.

According to DrugScope (2014), NPS can be broadly divided into:

- Synthetic cannabis (Black Mamba, Spice),
- Stimulant-type drugs (BZP, mephedrone, Benzo Fury)
- Hallucinogenics (methoxetamine, Bromo-Dragonfly).

Mephedrone-style drugs and synthetic cannabis appear to be the most prevalent NPS in the UK (DrugScope, 2015a). Synthetic cannabis drugs are liquid chemicals that are usually sprayed onto herbs to indicate that they are intended to be smoked, even when sold as incense. They do not have a unique smell. They are stronger than traditional cannabis, with potency varying between preparations, and users may experience severe reactions from using too much. The liquid form is increasing in popularity, partly because of e-cigarettes, but it can also be sprayed onto paper (and used to roll cigarettes), making it more difficult to detect than herbal matter, which would raise suspicion even if it does not smell like cannabis (see Annex).

[4] Polydrug use is more than one type of drug being taken either at the same time or within the same period.
[5] As numbers of polydrug and polysubstance users are small, two years of survey data have been combined for this analysis.
[6] We do not have useful trend data yet as these substances are new, as are research activities to monitor them. For example, the 2014–15 CSEW asked questions on the use of *all* NPS in the previous year, whereas previous studies had asked about specific NPS only.

The key harms associated with NPS are not completely understood as little is known about the pharmacology, toxicology and safety profile of these compounds in humans (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2009). The potential for physical and psychological dependence is unclear but is assumed to be at least equivalent to that of the drugs they are based on.

According to the Scottish Drugs Forum (2013), the key harms currently associated with NPS use include:

- Overdose and temporary psychotic states and unpredictable behaviour
- Hallucination and vomiting
- Confusion leading to aggression and violence
- Intense comedown that can cause users to feel suicidal
- Increase in mental health issues, including psychosis, paranoia, anxiety, 'psychiatric complications'
- Depression
- Physical and psychological dependency
- Temporary psychotic states and unpredictable behaviour
- Drug-related overdose and death.

2.13 CSEW data indicated that NPS use is strongly associated with the misuse of other illicit drugs (Home Office, 2015); 83% of adults who had taken another illicit drug in the previous year also reported that they had used NPS. People who had visited a pub or a nightclub or who had consumed alcohol in the previous month were significantly more likely to have used NPS in the previous year than those who had not.

2.14 DrugScope[7] undertook snapshot surveys of drug use in a number of towns and cities across the UK in 2013 and 2014. The 2014 survey reported a continuing rise in NPS – particularly synthetic cannabis – in most areas by opiate users, the street homeless, socially excluded teenagers and people in prison. The report quoted a Birmingham homeless charity, which stated that a large number of their opiate-using clients and street drinkers were smoking synthetic cannabis, leading to health emergencies:

> *'…They are using it because it's cheap, it's strong and because those who are out on licence will not go back to jail if they are caught taking them because they're legal'* (Daly, 2014).

2.15 It has been suggested that NPS use by groups, including prisoners, professionals, military personnel and younger users, may be driven by the wish to avoid detection or criminal sanction and some may use NPS as they are easier to access than preferred alternatives (Home Office, 2014).

2.16 Few NPS users have accessed drug treatment services to date. NPS were recorded as the main drugs declared by less than 1% (144) of those accessing treatment in England in 2013–14 (NAT, 2014). The stimulant NPS drug, mephedrone, appears to have had a greater prevalence in Wales than in England since 2009, particularly among those aged 15–29 (Smith and Emmerson, 2014), although it remains a very small proportion of overall presentations (1.4%). Synthetic cannabis referrals were not reported specifically in treatment data for Wales but may have been included in the 1% of referrals for 'other' drugs (Smith and Emerson, 2014).

[7] DrugScope was a charitable organisation that was the national voice of the drug and alcohol treatment sector and was a prominent independent centre of expertise on drugs and drug misuse. It went into liquidation in March 2015.

2.17 National Drug Treatment Monitoring System (NDTMS) monitoring data revealed only a tiny number of prisoners receiving treatment for NPS, reflecting the similarly low rates in the community. For the period April to September 2014, across all prisons in England, only 121 of the 56,000 adults treated for substance misuse issues were for NPS, with a further 119 having NPS as a secondary drug (NTA, 2015); overall, this represents less than 1% of all those accessing treatment. The two most cited primary drugs that prisoners received treatment for were heroin (20,717) and cannabis (7,787); crack cocaine was the most cited secondary drug.

2.18 Although the overall level of NPS use and the numbers coming forward to drug treatment services with NPS as a primary substance of concern are low, the European data available suggest that, as a group, NPS now constitute an important component of the overall drug problem, in terms of both prevalence and the health-related problems associated with drug use (Home Office, 2014).

Misuse of medication in England and Wales

2.19 Commonly misused prescription-only and over-the-counter (PO/OTC) medication includes painkillers, benzodiazepines[8] and sedatives (NTA, 2011), and opioid substitution treatment medications such as methadone and buprenorphine. The risks associated with misuse of medication are similar to those of other illicit drugs, including adverse drug interactions and accidental overdose.

2.20 The DrugScope 2014 street survey identified significant misuse of the prescription drugs pregabalin (which treats nerve pain and epilepsy) and gabapentin (which treats epilepsy), chiefly among Britain's opiate-using and prison populations (Daly, 2014). Pregabalin enhances the desired effects of heroin while also reducing the undesirable effects of withdrawal symptoms (Wakeman and Seddon, 2013), making it more sought after for misuse than gabapentin, with a growing illicit market (Public Health England (PHE) and NHS England, 2014). National guidance on the safer prescribing of these drugs, issued in December 2014, highlighted that both have a depressant effect on the central nervous system which is exacerbated when they are taken with other depressant drugs, including alcohol; this can lead to drowsiness, sedation, respiratory depression and, at the extreme, death. This means that extreme care needs to be taken when prescribing more than one depressant drug (PHE and NHS England, 2014).

2.21 Questions on the misuse of prescription-only painkillers (but no other types of prescription drugs) were added to the CSEW in 2014–15. In this survey, 5.4% of adults reported misusing a prescription-only painkiller not prescribed to them in the previous year, and a quarter of adults who reported the misuse of prescription-only painkillers said that they had also taken another drug in the previous year (Home Office, 2015). A significant minority had taken them for reasons other than pain relief.

2.22 The numbers presenting at community treatment services for PO/OTC medication are relatively low; 2% of new presentations to specialist drug services in 2009–10 (3,735) were for PO/OTC medication, with a further 14% (28,775) reporting it as a secondary drug (NTA, 2011). More recent figures from Public Health England and NHS Wales indicated that the number of people presenting to specialist drug services remains low (NTA, 2014; Smith and Emmerson, 2014). A large proportion of those who present for drug treatment for heroin (NTA, 2011) and those on opiate substitution prescribing (Dale-Perera et al., 2014) report taking other medications concurrently, often procured from friends, street dealers or the

[8] Benzodiazepines are a tranquilizer used to treat anxiety, agitation and restlessness, epilepsy, mania, alcohol withdrawal and sleeping problems.

internet. However, many people who have issues with PO/OTC medication may not self-refer, may not be identified or may be managed by their GP, with only the most complex cases presenting to specialist services. This makes it difficult to assess prevalence accurately (NTA, 2011; Reay, 2009).

Addressing substance misuse: policy and treatment responses

2.23 The reduction in drug-induced deaths, infectious diseases, other health consequences and offending are key policy issues. Drug strategies for England and Wales focus on supply reduction (by HM Revenue and Customs, police and courts), prevention (including communication programmes, such as Talk to Frank in England and DAN 24/7 in Wales plus focused support for vulnerable groups) and treatment through local multi-agency partnerships (EMCDDA, 2014).

Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS)

WEDINOS, started in 2009, is a local initiative in Wales testing samples of unknown/unidentified drugs provided by patients. The drugs were profiled and a process of mapping trends and harms was initiated. Since 2013, Public Health Wales and the Welsh Government have funded WEDINOS as a robust mechanism for the collection and testing of unknown/unidentified or new psychoactive substances and the production and dissemination of pragmatic harm reduction advice. Samples may be submitted by anyone in Wales, and participating organisations include hostels, nightclubs, mental health community teams, the Ambulance Service and the Police.

2.24 Recent UK drug treatment strategies emphasise the importance of reintegration to sustaining recovery from substance misuse, including coordinated working between physical and mental health, housing, employment, criminal justice and drug treatment services to address the breadth of a user's needs, including, but not exclusively, the physical symptoms of drug misuse (UK Focal Point, 2014).

2.25 Since April 2011, the Department of Health has had responsibility for funding both clinical and non-clinical drug and alcohol treatment in all prisons and in the community in England. In Wales, health services are the responsibility of the Welsh Government, with responsibility for commissioning devolved to local health boards.

2.26 2013 saw major changes to substance misuse treatment, with:

- The functions of the NTA[9] transferred to Public Health England
- The absorption of a 'ring fenced' drug treatment budget into the wider public health funding pot
- Increased discretion for new local decision makers and bodies, in line with the key *Patel Report* (2010) recommendation that integrated and needs-led treatment services are best commissioned at a local level.

2.27 All communities in England and Wales have support services for those with a drug problem. Drug treatment incorporates a range of services, including advice and information, relapse

[9] The NTA was created as a special health authority in 2001 to improve the availability, capacity and effectiveness of drug treatment in England.

prevention, aftercare programmes, needle exchange, blood-borne virus testing, opiate substitute prescribing, one-to-one and group-based psychosocial interventions, inpatient treatment, day programmes and residential rehabilitation. Most drug treatment is voluntary and referral can be by self or by other professionals such as probation officers, social workers or GPs. Some treatment can be mandated from police custody or by a court when offending is linked to drug misuse. Substitute prescribing for opiate dependence is provided for stabilisation, planned reduction, maintenance and relapse prevention but should always occur within a wider treatment package (UK Focal Point, 2014) of psychosocial interventions. As noted above, opiate users are over-represented in drug treatment.

Drugs and crime

2.28 Drug misuse and crime are strongly linked but the relationship is complex. Levels of drug use are high among offenders, with the highest levels of use reported among the most prolific offenders (Morgan, 2014). Some people are criminalised directly through their drug use. The police recorded 186,657 drug offences in the year ending September 2014, a decrease of 7% compared with the previous year, but 30% higher than in 2003–04. Some of these increases are linked with national targets, including penalty notices for disorder for possession of cannabis (Office for National Statistics (ONS), 2015). Cannabis possession has accounted for around two-thirds of all recorded drug offences every year since 2005–06 (ONS, 2015).

2.29 Opiate and crack users are more likely to commit crime such as shoplifting and burglary to secure funds for drug use (Morgan, 2014; Bennett et al., 2008). Although a small minority of opiate and crack users commit a large number of offences, many of those who offend at high rates began their criminal careers before opiate/crack initiation (Morgan, 2014) and many opiate and crack users commit little or no crime. For some opiate and crack users, their drug use was a catalyst for offending but for others it accelerated and extended their criminal career (Morgan, 2014).

2.30 The limited data available from the Probation Service suggest that the numbers being identified as having a drug misuse-related need are reducing. Between 2008–09 and 2011–12, the number of full offender assessment system (OASys) assessments completed for the start of a community sentence, suspended sentence or period on licence supervised by the Probation Service for which an offending-related need linked to drug misuse was identified fell by 55%, from 55,165 to 24,881. Of the 76,500 offenders assessed for and starting a community order between October 2009 and December 2010 as part of the Offender Management Community Cohort Study (OMCCS), 32% were identified as having an offending-related need linked to their misuse of drugs (including prescribed medication) (Wood et al., 2013).

Treatment for those in the criminal justice system

Community-based services

Drug interventions programme (DIP)

The DIP operated in most local areas in England and Wales, from 2003 to March 2013, to tackle Class A drug-misusing offenders. The service included actively offering treatment to those in police and court custody and 'through-the-gate' support to prisoners. In April 2013, Home Office funding for DIP was devolved to Police and Crime Commissioners (PCCs), and it is no longer a nationally regulated programme.

Funding continued in 2014–15 but from 2015–16 it is unclear what will be funded and commissioned, and there is likely to be considerable variation between police and local authority areas (UK Focal

Point, 2014). Our police and court inspections in 2014 and 2015 indicated that police, court and through-the-gate prison services exist in different forms, with a significant variation in provision between commissioning areas. It is too early to comment on whether this has had an impact on the quality of provision.

Drug testing on arrest

Drug testing on arrest was introduced as part of DIP in 2003, to help to tackle drug-related offending, whereby police could request a drug test for heroin or crack for all those arrested. Not all forces drug test on arrest and some forces just test those arrested for an offence known to be linked to drug use – for example, acquisitive crimes. Those testing positive are required by law to undergo an assessment of their drug misuse, possibly leading to treatment. The positive rate between 2004–05 and 2009–10 peaked at 47% in 2004–05 and fell to a low of 29% in 2009–10, the latest dates for which figures are available (Malik, 2010).

Prison-based services

Counselling, assessment, referral, advice and throughcare (CARAT)

Psychosocial drug services were introduced into prisons in 1999 as the 'CARAT' service. This created increased consistency in psychosocial provision and included a welcome focus on resettlement activity following release from prison. Initially, the service was primarily staffed by prison officers. Since the transfer of commissioning to NHS England in 2013, these services have been provided primarily by specialist civilian drug treatment providers.

The integrated drug treatment system (IDTS)
Before 2006, there had been a large variation in the clinical treatment of prisoners who were withdrawing from opiates and alcohol. Around this time, a number of prisoners and ex-prisoners successfully sued the Prison Service for subjecting them to enforced unassisted opiate withdrawal.

IDTS was phased in from 2006 in England to:

- increase the volume and quality of drug and alcohol treatment available to prisoners, with a particular focus on early days in custody, including the consistent and timely stabilisation of opiate, alcohol and hypnotic withdrawals
- improve integration between psychosocial and clinical services
- reinforce the continuity of care between prisons and those released into the community.

A key driver for the implementation of IDTS in English prisons was to reduce the number of incidences of relapse and death by drug overdose on release from prison.

Prison inspections have found that IDTS has reduced the demand for heroin in prison and improved outcomes for prisoners, although formal evaluation findings for the programme are not yet available.

Substance misuse services in prison are generally no longer referred to as 'CARAT' and 'IDTS'. They are sometimes referred to as substance misuse services but many prisons have chosen names that promote recovery, for example the Drug and Alcohol Recovery Team (DART) at HMP Littlehey or the Substance Treatment and Recovery (STAR) team at HMP Manchester.

Addressing NPS misuse

2.31 In 2012, the UK Government recognised that the use and availability of NPS were changing the UK drugs market, and published an action plan to tackle them (HM Government, 2012),

to reduce demand and supply and ensure that effective treatment and support were available. The Government has continued to develop new strategies to address NPS, including new legislation proposed in the Queen's speech in May 2015 to ban the new generation of psychoactive drugs. Organisations including HMI Prisons and the Advisory Council on the Misuse of Drugs (ACMD) have broadly supported this legislation but have recommended some revisions (ACMD, 2015; House of Commons Home Affairs Committee, 2015). Particular concern, for example, has been raised about the breadth of the term 'psychoactive substances' used in the Bill. It includes any substance that affects the physiological and/or psychological functioning of the brain and does not discriminate between benign/potentially beneficial and potentially harmful effects.

2.32 Community commissioners that we interviewed for this thematic inspection report said that, although there was an increasing issue with NPS in their locality, they lacked any clear data on prevalence. They also reported low levels of engagement with services by primary NPS users. Although they were able to support people with NPS issues, most did not offer a dedicated NPS service. NPS were a key strategic priority for some commissioners and some were trying to increase understanding of the issues and service needs of NPS users. For example, Brighton and Hove commissioners have identified NPS as an increasing issue and formed a working group looking at need; they have improved the accessibility of treatment by running a clinic specifically for NPS. In 2014, Public Health England issued guidance on commissioning NPS services in the community which included brief references to prisons (PHE, 2014a).

Addressing the misuse of medication

2.33 The NTA review on addiction to medicine (NTA, 2011) noted a large variation in provision, the need for greater national clarity on the best approach to use, and the importance of understanding the local problem. The review also recommended a range of strategies to address dependency on PO/OTC medicine, including:

- Strict guidelines to prevent diversion
- Appropriate evidence-based prescribing and reviews
- Effective medicine management committees
- Auditing of prescribing
- Providing warnings about the risks of dependence
- Training staff.

2.34 Commissioners interviewed for this thematic inspection reported a hidden population who misused PO/OTC medication and who were not engaging with their services. Some reported an increase in medicine misuse in the community and in those released from prison; this was reportedly being addressed by educating prescribers.

Section 3. Substance misuse in prisons

3.1 Patterns of substance misuse in prisons have never directly reflected those found in the community. In prisons, there has traditionally been a preference for using depressants such as heroin and cannabis, which will help prisoners to 'kill time', over stimulants such as cocaine, crack cocaine and ecstasy, which many associate with a 'club' or party scene in the community. This thematic study set out to explore recent changing patterns of substance misuse in prisons, such as the move towards medications and new psychoactive substances (NPS), and away from Class A drugs and cannabis.

3.2 While drugs are available in prison, there is generally less choice, a lower purity and less availability, but at a higher price than in the community. Additionally, an emphasis in prison on supply reduction, including drug testing and searches, makes detection more likely than in the community, and the consequences for individuals of using small amounts of drugs are potentially greater in prison than in the community. Sanctions can include loss of privileges, return from open to closed conditions and time added on to sentence. Nevertheless, substantial numbers of prisoners misuse drugs and medications, and factors such as the availability of drugs and potential for sanctions if caught using them drive some of the changes in drug use patterns in prison compared with the community.

Substance misuse before arrival in prison

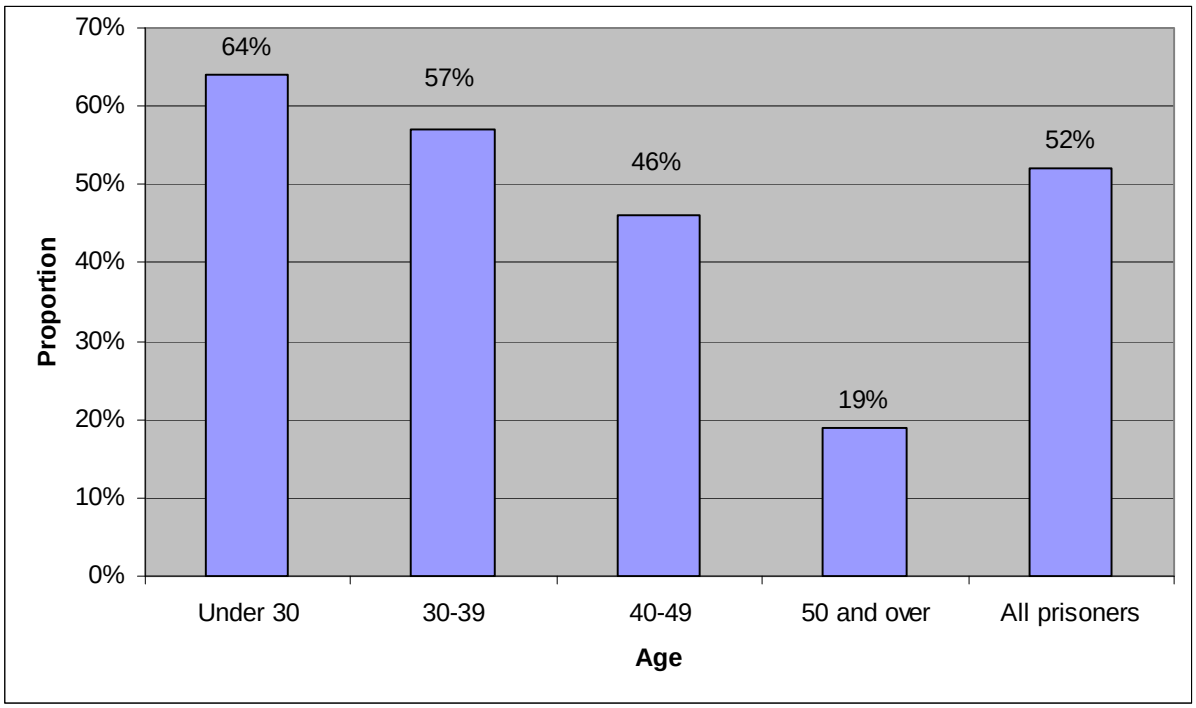
3.3 As described earlier, offenders have higher rates of substance misuse than the population as a whole, so a high number of entrants to prison will have a history of drug-taking and some will report problems related to their use, including dependence. However, much of the available research on prevalence is dated, meaning that recent changes are not reflected owing to the fast pace with which drug use in prisons is evolving.

3.4 The 2013 Surveying Prisoner Crime Reduction (SPCR) longitudinal study (Light et al., 2013) provides some useful information on prisoners' drug use but predates the changes in community drug use described in the previous chapter, the advent of NPS and the full rollout of the integrated drug treatment system. The SPCR study followed 3,849 adult prisoners from 2005–06, sentenced to between one month and four years in prison in England and Wales, looking at reported drug history and reoffending. Key findings included:

- Rates of illegal drug use were higher among prisoners than offenders on community orders and the general population.
- 81% reported having taken an illicit drug at some point in the past and 64% reported having taken drugs in the four weeks before their imprisonment.
- Prevalence rates for lifetime illicit drug use were highest for cannabis (71%), followed by powder cocaine (45%), crack cocaine (43%), ecstasy (42%), amphetamines (41%) and heroin (40%).
- 27% of males and 36% of females reported using unprescribed tranquillisers, while 20% of males and 27% of females reported using unprescribed methadone.
- Female prisoners reported more Class A drug use in the four weeks before custody than male prisoners, and were also more likely to report that their offending was to support someone else's (as well as their own) drug use.

3.5 In our survey for this thematic inspection, 52% of respondents said that they had used illicit drugs or medication in the two months before going into prison. This is much higher than the general community prevalence reported in the CSEW, but lower than that suggested by the older SPCR study (Light et al., 2013), which may reflect the overall trend of reducing illicit drug use highlighted by the CSEW. Reported prior drug use in the community was much higher among younger prisoners than those aged 50 and over (see Figure 1).

Figure 1: Reported drug use in the two months before going into prison, by age (N=1,376[10]) (HMI Prisons thematic survey)

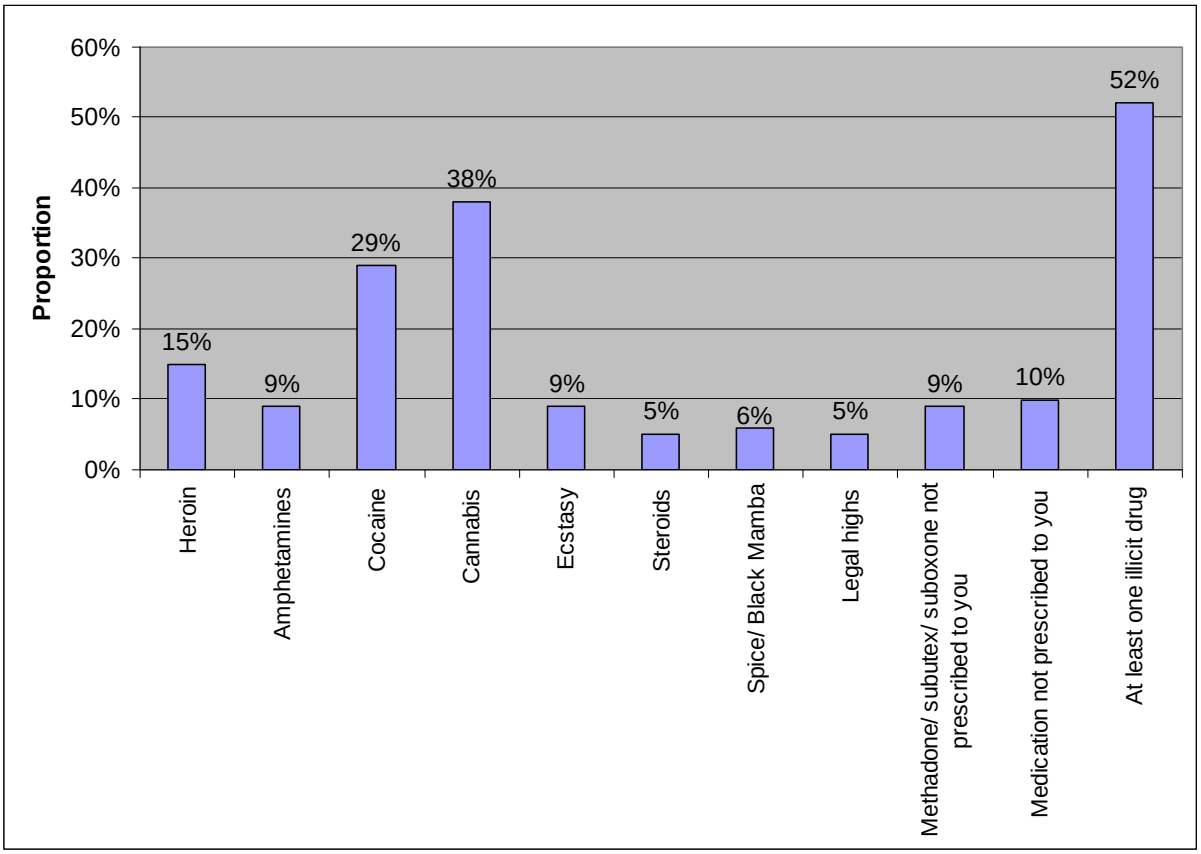


3.6 Cannabis was the most commonly reported drug used before going into prison (38%), followed by cocaine (29%). Our survey findings showed that the level of NPS use before going into prison was low relative to other substances, at 6% for Spice/Black Mamba and 5% for legal highs (Figure 2).[11] When interviewed, prisoners who said that they had used NPS in the community before going into prison had generally used it with other drugs or with illicit medication. The primary drugs that they said they had taken along with NPS were heroin and cannabis. The reported prior use of NPS and legal highs was lowest in open prisons, which may reflect the fact that NPS may have emerged in the community only after some respondents had entered prison.

3.7 One in 10 prisoners said that they had used either opiate substitute medication (9%) or other medication not prescribed to them (10%), and this had only been used in combination with other primary drugs, mainly heroin.

[10] The N number refers to the number of valid responses.
[11] The terms 'Spice/Black Mamba' and 'legal highs' were used in the prisoner survey as they were more widely recognised by prisoners than 'synthetic cannabis' and 'NPS'.

Figure 2: Reported drug use in the two months before going to prison by type of drug* (N=1,384) (HMI Prisons thematic survey)



* The total of all types of drug is greater than 100% as prisoners could report having taken more than one drug.

Substance misuse on arrival in prison

3.8 A high proportion of prisoners enter prisons with drug and alcohol problems. National treatment data showed that between April and September 2014, a quarter (25%) of all new entrants into prisons in England began treatment for substance misuse (including alcohol) within three weeks of their arrival.

3.9 In published HMI Prisons inspection surveys between April 2014 and August 2015, 28% of respondents (N=10,702) reported having a problem with drugs on arrival in prison. Women are under-represented in drug treatment services and report less drug use in the community than men, but levels of drug dependence among female prisoners have been found consistently to be higher than among male prisoners (Fazel et al., 2006; Singleton et al., 2003). This is reflected in the HMI Prisons inspection survey findings for the afore-mentioned period, which showed that a significantly higher proportion of female than male prisoners had a problem with drugs on arrival in prison (41% versus 27%). Those with mental health problems were also significantly more likely to say they had a problem with drugs when they went into prison.

Substance misuse in prisons

3.10 Although there are no concrete data, it is clear from inspections of prisons, including interviews with staff and prisoners, that the use of Class A drugs and cannabis, as evidenced by mandatory drug testing (MDT) finds and prisoner and staff reports, has reduced but not ceased in the past 4–5 years.

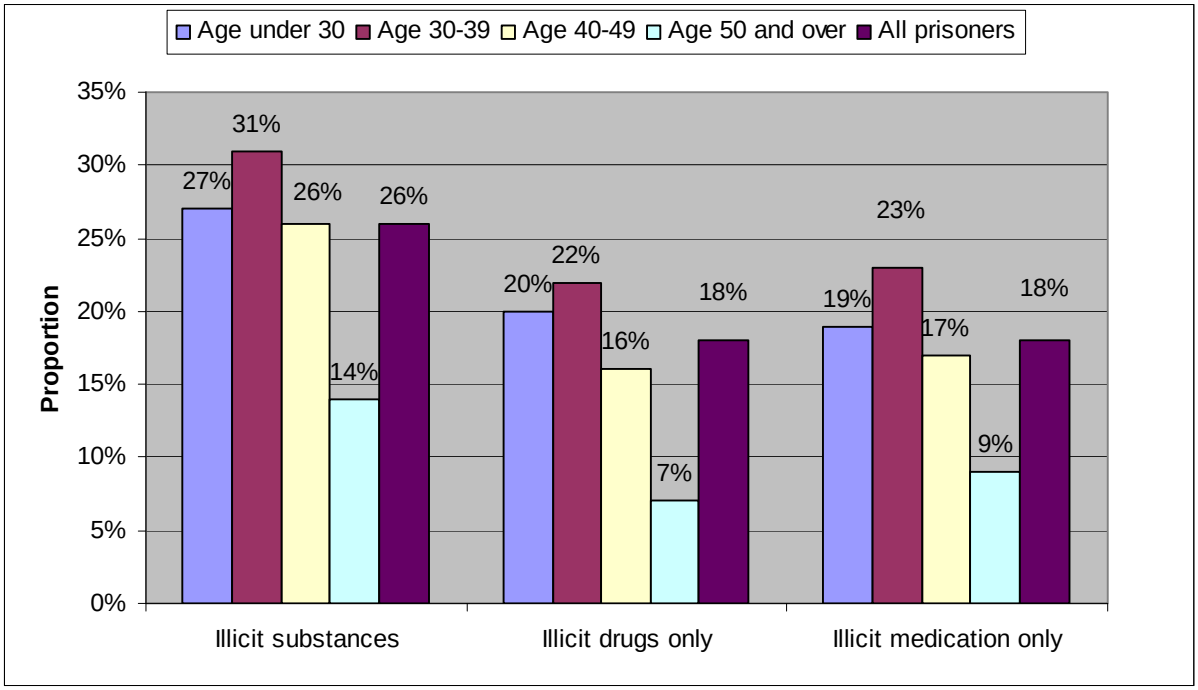
3.11 In our additional survey in eight prisons (N=1,376), more than a quarter of respondents (26%) said that they had taken either illicit drugs or medication in their current prison. There was significant variation in the reported level of use by age. The highest level of use of any illicit substance was reported by those aged 30–39 (31%) and the lowest was in those aged 50 and over (14%).

3.12 A lower proportion of women than men said that they had used illicit substances in the prison (19% versus 26%). There was only one women's establishment in our sample of eight but this finding is consistent with findings from our wider inspections. Generally, finds, MDT results and reports from staff and prisoners in women's prisons indicate that illicit drug misuse, including NPS, is less common among women than men. Medication, including diverted medication, is typically more sought after by women; however, synthetic cannabis was reported to us as an emerging issue in an inspection of a women's prison in 2015 for the first time.

The diversion of medication continued to be an issue but appropriate steps were being taken to monitor and address it, although some aspects of supervision around medication queues needed to improve. Intelligence reports and finds had indicated that in the months prior to the inspection new psychoactive substances… had emerged as a further concern. **HMP New Hall 2015**

3.13 Similar levels and patterns of use were reported for illicit drugs only compared with illicit medication only, as shown in Figure 3 (overall, 18% in each case).

Figure 3: Illicit substance misuse in current prison, by age (N=1,376) (HMI Prisons thematic survey)



3.14 Patterns of drug use in prisons change and, in the same way that use of synthetic cannabis overshadowed the misuse of diverted medication during and since the fieldwork for this study in 2014, it is likely that the prevalent drugs of misuse may change again as disruption to the supply of synthetic cannabis improves. This may vary between prisons and within a prison over time, based on multiple factors, including prevalent drug trends in the surrounding community and the effectiveness of supply reduction strategies. In prisons where there are fewer drugs coming in, medication diverted within the prison or the seeking of clinically inappropriate prescribing will be in greater demand. Anecdotal evidence in some prisons suggests spikes in illicitly brewed alcohol in the immediate aftermath of large finds which reduced the availability of synthetic cannabis.

3.15 We have not looked specifically at tobacco in this thematic inspection report but the future implementation of the smoking ban in prison is likely to be a driver to change patterns of drug misuse in prison again. Most prisoners smoke and this has health consequences, not only for those who actually smoke, but also for other prisoners and staff who live and work in the same environment. In establishments where smoking is currently banned, such as those holding young people, we consistently observe that this creates a market for illicit tobacco. We inspected HMP Isle of Man in March 2011 and found that a smoking ban had led to large-scale trading in illicit tobacco, prisoners being bullied for nicotine replacement therapy, and dangerous practices to light home-made cigarettes.

The total prison ban on smoking tobacco had resulted in a large number of negative outcomes. Staff had stepped up efforts to detect illicit tobacco and its substitutes, evidenced by the 63 smoking material-related finds in the six months from September 2010 to February 2011, compared with nine drug and six hooch finds. The widespread demand for scarce tobacco or its alternatives had also resulted in some prisoners being bullied for nicotine patches on arrival at the prison or when they obtained their patches from the health care department. … Prisoners showed us how they rendered and extracted nicotine from the patches for addition to 'alternative' smoking materials, which included dried fruit peel and tea. Some fruit was subsequently banned but prisoners also used lint from tumble driers and even pubic hair. The full extent of the risks to health posed by smoking such substances are largely unknown, although nurses told us that many prisoners presented with sore throats. ***HMP Isle of Man 2011***

3.16 The potential health benefits of the smoking ban for staff and prisoners are clear and, although it may also lead to a reduction in the smoking of NPS, and synthetic cannabis in particular, it may also lead to more use of other NPS. The ban will need to be managed carefully, to ensure that it does not lead to an increased illicit market for other harmful substances, with the associated adverse effects on safety and security.

Specific substances used in prison

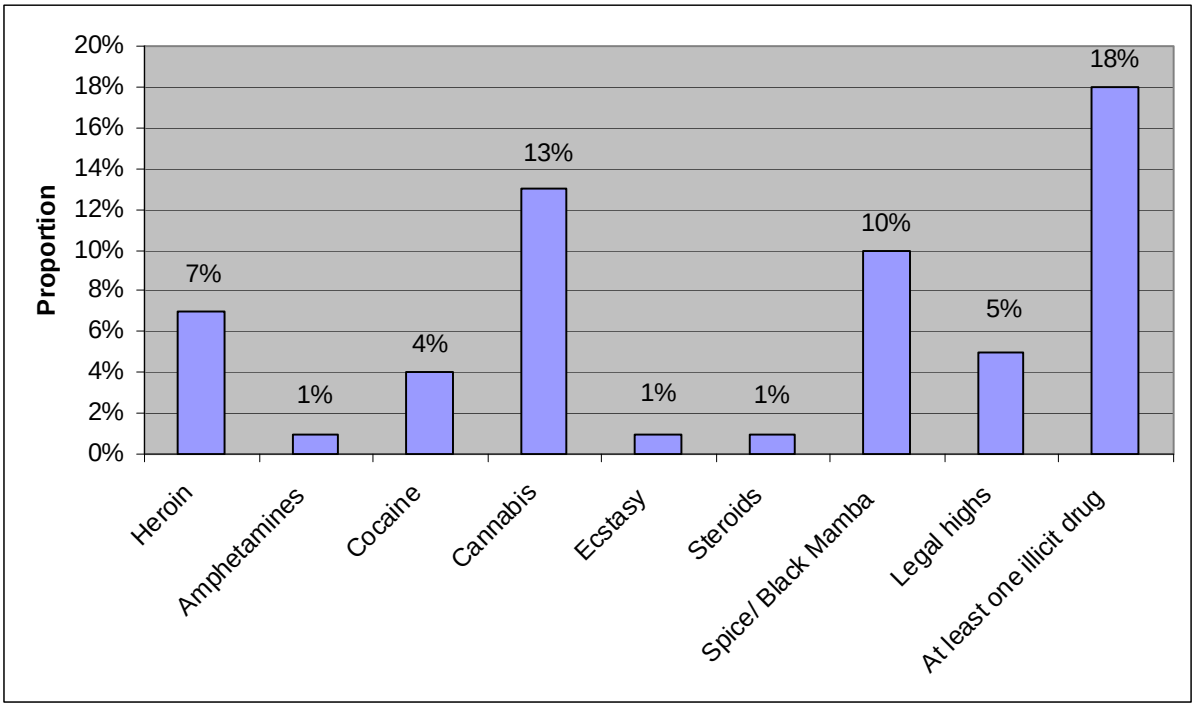
3.17 Drug availability and use varies across different prisons and between regions. Previous research has shown that prisoners have a high prevalence of polydrug use and dual diagnosis (both substance misuse and mental health problems) (Patel, 2010). This was confirmed by our fieldwork for this thematic inspection.

3.18 Different drugs are typically available in the community than in prisons; therefore, when offenders enter prison, their substance misuse may change. Prisoners we interviewed reported that their drug use altered in prison according to the substances that were available. This could include multiple drugs at the same time or different drugs on different days, both of which practices carry a significant risk of harm, including drug interactions and accidental overdose.

3.19 Figure 4 shows the illicit drugs that prisoners reported using in their current prison. Cannabis (13%) and synthetic cannabis (Spice/Black Mamba; 10%) were more frequently

reported as having been used than other drugs. Reported use of Spice or Black Mamba was also higher in prisons than in the community, with only 6% of those surveyed saying that they had used one of these drugs in the two months before going into custody. Our inspection findings, including MDT results, also demonstrate that cannabis remains a popular drug in prisons, as it is in the community, and this may also be a significant additional factor in the popularity of synthetic cannabis, as it is similar in effect, with lower risks of detection.

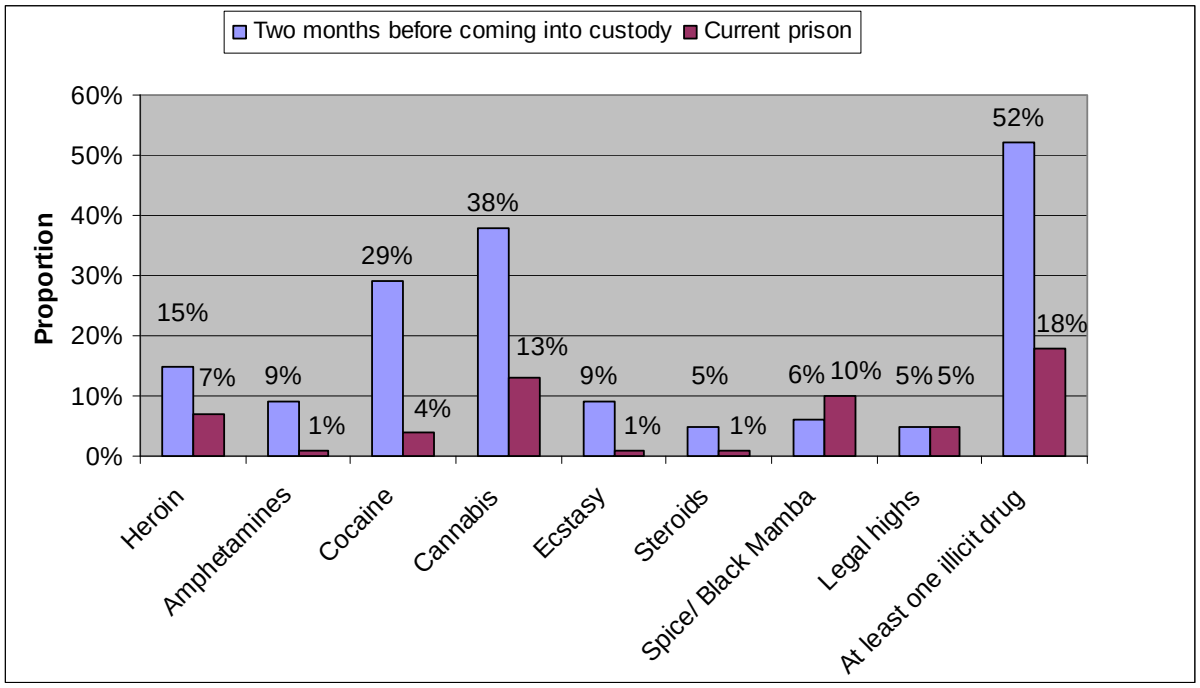
Figure 4: Reported drug use in current prison by type of drug* (N=1,384) (HMI Prisons thematic survey)



* The total of all types of drug is greater than 100% as prisoners could report having taken more than one drug.

3.20 Figure 5 shows how use in the two months before going into prison differed from use in their current prison.

Figure 5: Reported drug use in the two months before going into custody and in current prison, by drug (N=1,384)



3.21 Women and older prisoners were less likely than men and younger prisoners to say that they had used synthetic cannabis, reflecting patterns of use in the community. For example, just 3% of prisoners in the women's prison said that they had taken Spice specifically, compared with 11% of prisoners in the seven male establishments (N=1,384). In addition, only 2% of those aged 50 and over reported taking Spice or Black Mamba, compared with 13% of under-30s (N=1,376).

Diverted medicines

3.22 The diversion of medications is a serious problem in prisons. The most commonly diverted medications in prison are those that have a depressant effect on the nervous system, reflecting a desire to blunt emotions (Bullock, 2003). Buprenorphine has been a drug of misuse in prison for several years – even in establishments that do not prescribe it (Ministry of Justice (MOJ), 2007) – and prisoners have reported snorting it rather than taking it under the tongue (as it should be taken), to achieve an increased effect (Tompkins et al., 2009). Some prisoners we spoke to confirmed that they snorted buprenorphine; one prisoner described it as being 'for a head buzz'. Other medications, including benzodiazepines, anti-depressants and painkillers, have been reported by staff and prisoners as being popular because of their low cost, availability, perceived undetectability and guaranteed effect (Penfold et al., 2005; Plugge et al., 2009).

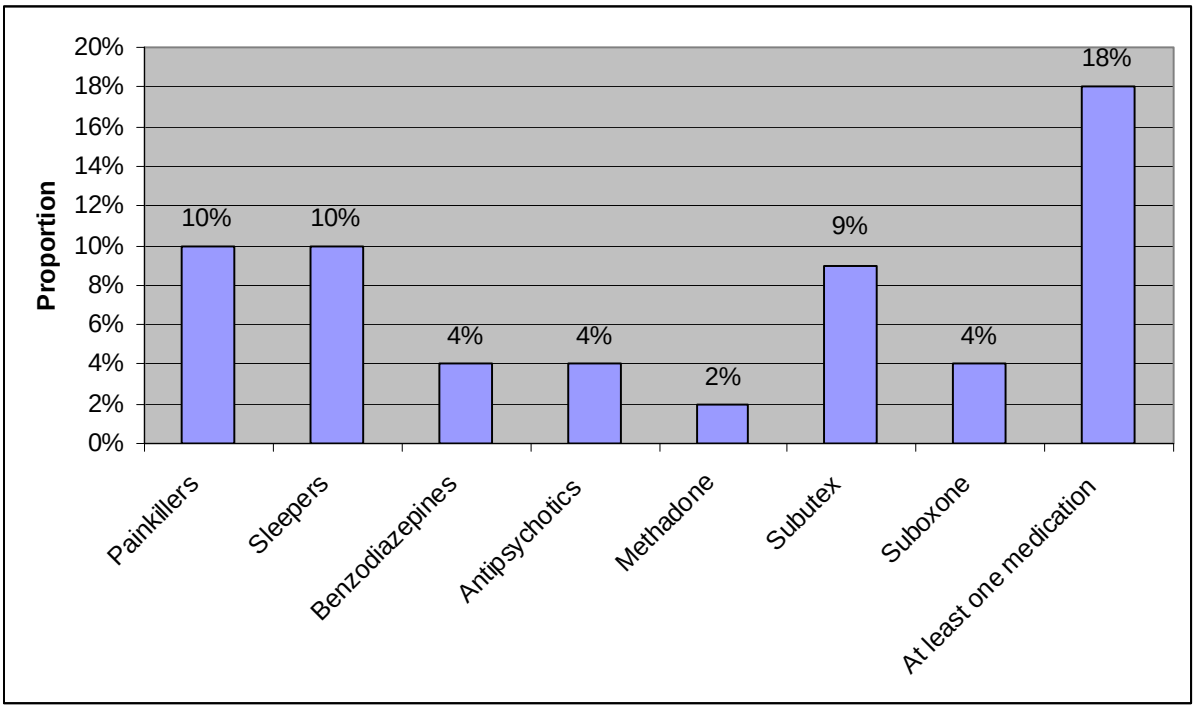
3.23 We first reported on the widespread misuse of diverted medication (see Annex) in high security prisons and vulnerable prisoner populations inspected in 2010–2011 (HM Chief Inspector of Prisons for England and Wales, 2011). By 2012–13, this had spread to mainstream prison populations (HM Chief Inspector of Prisons for England and Wales, 2013).

… There has been a steady increase in the reported abuse of prescribed medication, where medication is 'diverted' by someone for whom it was not prescribed. Prisoners might sell their own medication or have it taken from them through theft or bullying. The risks of diverted medication include bullying, drug debts, unexpected drug interactions and overdose. Medication commonly diverted includes certain painkillers, sedatives and psychiatric medication. Many of these medications cannot be detected by mandatory drug testing (MDT), or there are no legal powers to do so, and consequently, as highlighted in our 2010–11 report, MDT is no longer an accurate measure of drug use in British prisons. We also found that suspicion drug testing – which could detect some diverted medication – was not adequately completed at a third of the prisons we visited. **HM Chief Inspector of Prisons Annual Report 2012–13**

3.24 Varied guidance on prescribing has been published as patterns of misuse have emerged (PHE and NHS England, 2014; Royal College of General Practitioners Secure Environments Group, 2011). For example, Buscopan (hyoscine butylbromide), a medication which is used for stomach cramps, particularly during opiate reduction in prison settings, emerged as a drug that is being misused by prisoners as it can give some euphoric effects, and prescribing guidance was issued in 2015. In June 2014, tramadol (a painkiller for moderate-to-severe pain) was reclassified as a controlled drug, prompting a reduction in prescribing and more tightly controlled administration in most establishments. We have observed a large reduction in the number of prisoners being prescribed tramadol since then, but the prescribing of other pain killers has increased, creating an alternate market.

3.25 In our survey of eight establishments for this thematic inspection, prisoners were asked which illicit medications they had taken in their current prison. The findings are shown in Figure 6. The most commonly used illicit medications were painkillers and medication to assist sleep. In addition, 6% of respondents who said that they had used illicit medications while in prison reported that they had come to rely on medication while in prison.

Figure 6: Illicit medication use in current prison, by type of medication (excluding over-the-counter medication) (N=1,384)*[12]



* The total for all types of medication is greater than the figure for at least one illicit medication as prisoners could have taken more than one type of medication.

[12] The terms 'sleepers' and 'subutex' were used in the questionnaire as they were viewed as being more recognised by prisoners than the formal names.

NPS use

3.26 Synthetic cannabis (more specifically, Spice) was first identified to HMI Prisons as a serious problem in December 2011 at the inspection of HMP Standford Hill, but was not identified as a widespread issue until 2013 onwards. In the 2013–14 annual report (HM Chief Inspector of Prisons for England and Wales, 2014), synthetic cannabis was identified as a concern by HMI Prisons in a third (37%) of male prisons inspected, and this increased to 64% in 2014–15 (HM Chief Inspector of Prisons for England and Wales, 2015).

In this reporting year, diverted medication (that taken by someone other than for whom it was prescribed) was reported as an issue in 19 (50%) adult male prisons fully inspected. NPS, specifically 'Spice' and 'Black Mamba', were cited as causes for concern at 14 (37%) of the adult male establishments inspected, particularly local and category D jails. Although many prisons had taken steps to promote awareness of this problem, we highlighted the need for some to give prisoners and staff accurate and up-to-date information on the acute health dangers associated with NPS. **HM Chief Inspector of Prisons for England and Wales Annual Report 2013–14**

Last year, we warned that the development of new and largely non-detectable psychoactive substances (NPS) – such as 'Spice' and 'Black Mamba' – was a dangerous new trend in prisons, and our findings this year confirmed that their use had grown, leading to problems such as bullying, debt and medical emergencies requiring hospitalisation. National measures to combat this were still in development throughout most of 2014-15: MOJ policy guidance to prison governors was distributed in February 2015, and changes to legislation had not yet come into effect. **HM Chief Inspector of Prisons for England and Wales Annual Report 2014–15**

The extent of the problem identified on inspection varied across prisons and regions. Inspections have found that synthetic cannabis has become the most prominent substance misuse issue in the previous 18 months in most prisons, with many staff and prisoners reporting high levels of use and associated problems, but the extent of use is not quantifiable. Synthetic cannabis under various names was identified as a problem in every inspection report published between January and August 2015. However, synthetic cannabis was rarely the only issue; it was generally part of wider patterns of misuse that also included diverted medication and illicit drugs, including cannabis. In some prisons we inspected, we observed that their focus on synthetic cannabis alone was leading to an increase in the misuse of other drugs that was going largely unchallenged. Prisons need to have a whole-prison approach to the misuse of all drugs, to prevent alternatives emerging and becoming problematic.

3.27 Staff and prisoners we spoke to as part of this thematic inspection told us that synthetic cannabis is popular in prison because it is undetectable and cheap, and has a guaranteed effect. It is attractive to supply because there are no penalties for its possession in the community. It is cheap to buy or manufacture and, although, in prison, prices are lower than for other substances, the difference between the community and prison price is much greater than for substances that are illegal in both environments and so profits are greater. Low costs, low risks of detection or penalties, and large profits make it attractive to supply in large quantities. Research undertaken for this thematic study confirmed Spice to be a significant issue in prisons currently, and prisoners suggested that it is a new drug of choice in prisons in England.

3.28 Many prisoners we interviewed referred to having witnessed the ill-effects of synthetic cannabis. For example, one prisoner said that he had seen prison officers and his cell mate attacked because someone was 'out of control' on Mamba. Prisoners who said they had tried Spice said that it made them variously paranoid, hypersensitive, 'feel guilty about things', depressed and easily wound up. Staff and prisoners told us that prisoners could not recall what they had done while under the influence of synthetic cannabis once the effects had worn off. Some prisoners we spoke to had been warned about the dangers of using synthetic

cannabis, or showed some awareness of the varied and sometimes unknown substances it could contain, and the associated risks. Staff we interviewed admitted that they needed to know more about synthetic cannabis and NPS and their effects, in order to detect use and to deal better with the associated problems.

3.29 As noted above, NPS, including synthetic cannabis, cover a range of substances that may contain different active ingredients. Therefore, prisoners do not necessarily know what exactly they are using or the effect it will have on them.

3.30 A large proportion of adult male establishments inspected since 2013 reported incidents when emergency medical assistance had been required for prisoners as a result of synthetic cannabis use.

3.31 Recent inspections have found that the number of medical emergencies has decreased in establishments with long histories of synthetic cannabis use but remains high in establishments where the use of synthetic cannabis is a more recent phenomenon. This may reflect reduced use because of both increased awareness by prisoners of the potential risks involved, and the effectiveness of measures to limit supply. However, it may instead mask continued use as prisoners become more adept at looking after each other when overdosing, to avoid receiving sanctions for NPS use. This not only increases the risk of serious health consequences for prisoners, but also reduces the likelihood of prison staff being aware of such incidents. Most prisons do not keep accurate records of suspected medical emergencies or bizarre behaviour attributed to illicit drugs (including synthetic cannabis), which means that opportunities for individual establishments and the Prison Service to monitor and learn from these are limited.

3.32 In addition, new products are being tested by prisoners before being circulated within prisons. Some prisoners may choose to be the tester in return for free drugs. We have been given credible accounts of prisoners, referred to as 'spice pigs', who are forced or tricked into testing new strands of Spice before they are used more widely in the establishment, to find out what quantities are safe, and what effects can be marketed. We were told that spice pigs tended to be more vulnerable prisoners or those who were in debt. Interviewees also told us that this could be a source of entertainment for other prisoners or a means to encourage an addiction in the hope that they became buyers in the future.

Developing substance misuse problems while in prison

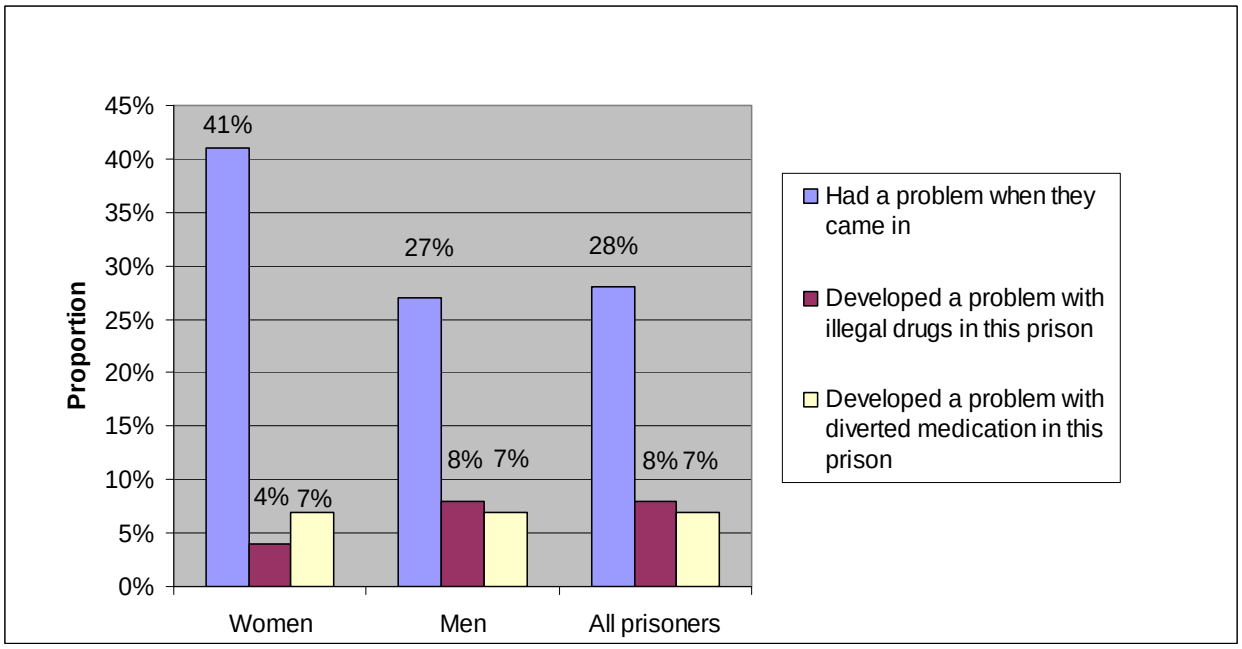
3.33 In published inspection reports between April 2014 and August 2015 (N=10,702), 8% of male and 4% of female prisoners who took part in our confidential survey said that they had developed a problem with illegal drugs since they had been in the prison. What prisoners define as a problem is unclear; it could be a dependency, bullying or debt related to either their own or others' substance misuse. We also have no way of ascertaining what proportion of these initiated drug use in prison for the first time in their lives or who had previous drug issues. Among all prisoners, the proportion who had developed a problem with illegal drugs varied from 3% in open prisons to 10% in category C training prisons. Only 1% of those aged 50 and over said that they had developed a problem with drugs.

3.34 Since 2012, we have included a question on diverted medication in our survey in all of the prisons we inspect. The proportion of prisoners surveyed reporting that they had developed a problem with diverted medication has remained reasonably constant, at 7–8%, over the previous three years. In our inspection surveys published between April 2014 and August 2015 (N=10,702), 7% of male and 7% of female prisoners said that they had developed a problem with diverted medication. The lowest rate was 2%, in open male prisons, compared with a high of 8% in male local, and in category B training prisons. Consistent with other

findings, the proportion was lower among older prisoners, with only 4% of those aged 50 and over reporting that they had developed a problem.

3.35 Figure 7 shows the proportion of prisoners who had developed a problem with illegal drugs or illicit medication (or both), alongside the proportion who said that they had had a problem before entering prison, in reports published between April 2014 and August 2015. It shows clearly that women were more likely to report a problem with illicit drugs on entry but less likely to report developing a problem while in prison. Similar proportions of men and women reported developing a problem with diverted medication. There are fewer women's prisons but, in the previous two years, we have reported much more positively on the flexibility of prescribing and the support provided in women's establishments, which may have had an impact on drug misuse in these prisons.

Figure 7: Problems with illicit substances, by gender (N=10,702)



Reported reasons for substance misuse in prisons

3.36 As noted above, a high proportion of prisoners report using drugs before imprisonment and may then be more predisposed to use drugs in prison. In our interviews, prisoners reported various reasons for using drugs in prison, as set out below.

Boredom and stress

3.37 Relieving boredom appears to be an important factor in the use of drugs in prison. Depressants result in decreased awareness of surroundings, decreased alertness and blunted emotions, which prisoners reported to be desirable within a prison environment (Bullock, 2003). For example, in the interviews, prisoners described using drugs in prison as a means 'to get out of the cell' and that using drugs helped the sentence to pass more quickly:

'People take it [drugs] to pass the time. It's hard being in one room for 24 hours'.

'Here, everyone is always looking for something to take; no work going on, so take something and get a bit of a lift'.

'Being "out of it" makes the time pass quicker; at weekends it is worse than weekdays. I take drugs first thing in the morning and then the day passes without dragging'.

3.38 Within the thematic survey, prisoners who said that they had a job in the prison were significantly less likely than those who had no job to say that they had taken drugs in their prison (17% compared with 20%), and those who reported spending more than 10 hours out of their cells on a weekday were also significantly less likely than those who did not to report illicit substance misuse (13% compared with 19%) (N=1,161).

3.39 The HMI Prisons 2014–2015 annual report (HM Chief Inspector of Prisons for England and Wales, 2015) highlighted that we had judged outcomes for purposeful activity to be good or very good in only 25% of the adult male prisons we inspected in that period,[13] the worst outcome since we started measuring them in 2005–06. We also reported that one in five prisoners said that they spent less than two hours a day out of their cells during the week and only one in seven spent 10 hours or more out of their cell each day. A lack of sufficient purposeful activity is likely to make the misuse of substances more attractive.

Self-medication for physical and/or mental health issues

3.40 There can be differences between what is prescribed in the community and what individual prisons prescribe, and this can result in changes in medication or dose. In our interviews for this thematic inspection, some prisoners said that differences in prison prescribing had prompted them to seek illicit substances or medications to compensate for or to mask any ill-effects from the change:

'They [health services staff] don't give you the meds you were prescribed on the outside, so people look to trade them illegally to fill the gap'.

'When I first came in, I was self-medicating; there was such a delay getting on to a script that I had to use in the meantime. The prison is very strict with prescriptions – I was offered methadone at first but did not want to take it as you can still use on top'.[14]

3.41 Other prisoners said that they took drugs to help them sleep, which, as the prisoner below described, could be a problem during planned reduction from either medication or illicit drugs:

'I started taking subbies [subutex] when doing diazepam detox. Helped me sleep and deal with diazepam withdrawals'.

Physical or psychological dependence

3.42 During interviews for this thematic inspection, some prisoners told us that they continued to use illicit drugs in prison as they were addicted to them, and their use within prison was a continuation of what they would have been using in the community. Continued use was also a habit for some prisoners we spoke to:

'[Cannabis] is "normality" – been using it most of life anyway'.

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[13] The Chief Inspector of Prisons' Annual Report for 2014–15 covers all reports published by HMI Prisons between April 2014 and March 2015.

[14] 'Use on top' refers to being able to take and feel the effects of illicit drugs alongside prescribed opioid substitution treatment, something that is possible with methadone but not with higher doses of buprenorphine.

'Comfortable using it [buprenorphine] – keeps me away from heroin. I would rather use subutex than heroin'.

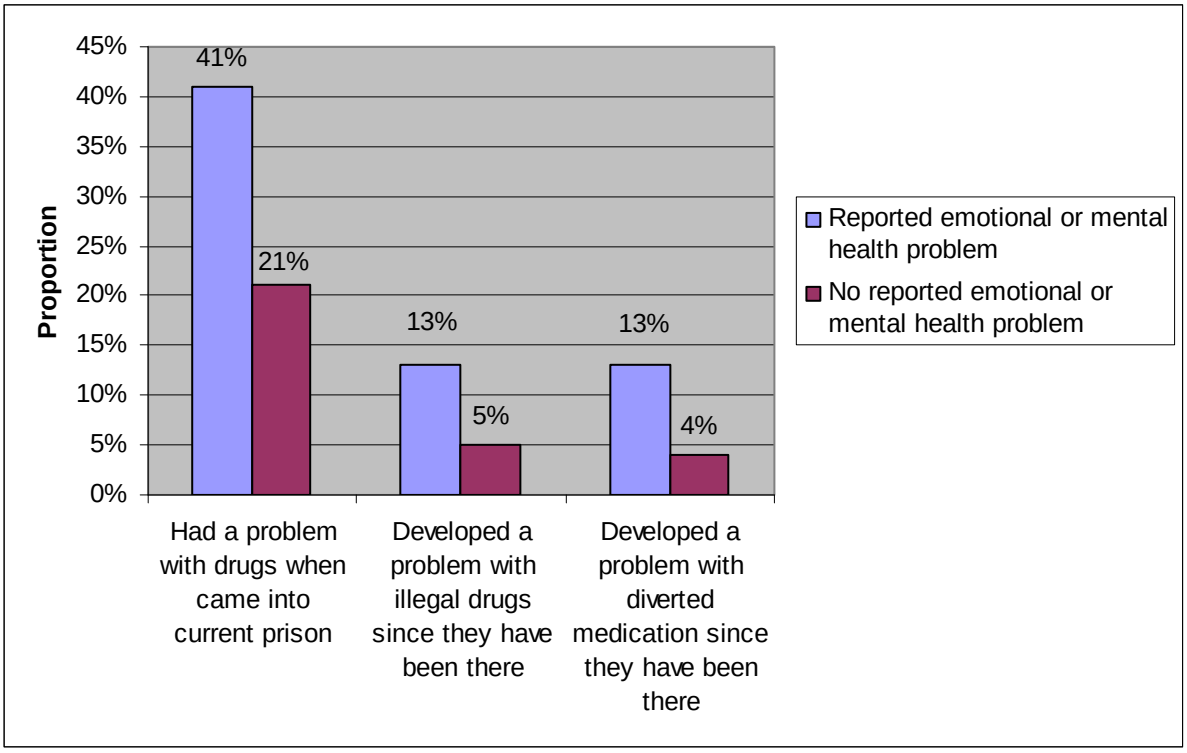
3.43 Additionally, imprisonment can bring many stresses, deprivations and triggers for drug misuse which may also create demand for depressants. Alcohol, which may be used as a prop or create dependence in the community, is also prohibited in prisons, and this might increase the demand for alternative illicit substances.

Drug use and mental health problems

3.44 The co-existence of mental health and substance misuse problems is widely recognised and was highlighted in the Patel Report (2010), the Bradley Report (2009) and our mental health thematic report (HMI Prisons, 2007). The Chief Medical Officer annual report 2014 highlighted the importance of integrating wider mental health care with addiction care provision (Strang et al., 2014).

3.45 In our general surveys of prisons, we ask prisoners if they have any emotional well-being or mental health problems. We compared the answers of those who answered 'yes' against those who answered 'no' to this in our adult prison inspections published in 2014–15. Figure 8 presents these findings.

Figure 8: Reported drug use, by emotional or mental health problem (N=10,173)



Reported reasons for not using illicit substances in prisons

3.46 Prison provides an opportunity to achieve abstinence. In our prisoner interviews for this thematic inspection, some prisoners said that the relative lack of substances available in prison compared with the community meant that they were less tempted, and better able to stop taking drugs in the prison:

'Cannabis is expensive and I cannot justify spending that much tobacco on drugs to myself'.

'I don't really use drugs [heroin, crack] in the prison; I don't have the money for it – especially not enough money for the quantity of drugs that I would want to take. I also prefer injecting drugs and would not do that in a prison. I also prefer stimulants, which are not really available in the prison – not really a prison thing'.

3.47 Some prisoners also reported that sanctions and negative repercussions for them prevented them from using illicit drugs and medications while in prison:

'Never been tempted, as a lifer, and all it takes is me taking a drug once and I would be targeted for testing, which would delay my release date'.

'I don't smoke weed because there is no point – I want to get out of jail. It makes me paranoid in case I fail an MDT, which would make me lose my enhanced status'.

'I have too much to lose; I'm a cleaner and work on the servery and would lose that if I was caught using drugs again'.

Problems associated with substance misuse in prisons

3.48 Illicit drug use in prison leads to most of the same negative outcomes for users as for those in the community, including overdose, dependence and debt; however, these problems may be more pronounced in prison. The adverse consequences arising from the availability of synthetic cannabis in prison applies to a lesser or greater degree to all drugs. The drugs available are generally of a lower purity and a higher price than those in the community, which often leads to polydrug use of varied medicines and drugs to get an effect; this increases the risk of physical harm and exacerbates debt problems.

3.49 Many prisoners have very low incomes in prison (particularly if they are not receiving additional funds from family or friends outside) – often under £10 a week. Debts spiral quickly owing to the informal credit terms in many prisons, whereby prisoners may have to pay back double the amount borrowed. It is not just drug users who get into debt; debts may be passed on to friends or cellmates if they have not been paid in full before a prisoner is released. Debts may be enforced by placing pressure on family members and friends in the community, either by threatening them directly or threatening to harm the prisoner if the debt is not paid. We were told that large sums of money may pass through supply chains, with profits used to fund other criminal activity. Prisoners explained that they sometimes sold their own prescribed medication to pay their debts or to pay for other drugs. Others we interviewed said that prisoners had to sell or transport drugs to repay their debt, while others gambled to try to pay off debts (playing dominoes, for example), which increased the risk of their debts increasing.

3.50 Illicit drug use in prison also contributes negatively to many aspects of prison life, including violence, indiscipline and bullying. Some instances of violence can be directly linked to drug use – for example, aggression as a side effect of use or violence/threats of violence to procure medication/drugs or related to drug debts.

The availability of drugs, particularly new psychoactive substances (… such as 'Spice' and 'Black Mamba'), were a significant factor in much of the violence and these had also been the cause of regular hospital admissions. ***HMP Altcourse 2014***

Levels of violence were high and many incidents were serious… The presence of new psychoactive substances (NPS), the pressure to obtain them and associated debt were among the causes, along with gang affiliations and an increasing number of category B prisoners. ***HMP Dovegate 2015***

3.51 The HMI Prisons 2014–15 annual report highlighted increasing levels of violence in adult male prisons over the previous five years, including serious assaults by prisoners on other prisoners and by prisoners on staff (HM Chief Inspector of Prisons for England and Wales, 2015). A number of potential contributory factors were identified, including the rapid increase in the availability of synthetic cannabis, and particularly its impact on debt and associated violence. The National Offender Management Service (NOMS) has also highlighted NPS and their links to prison violence as a significant issue and a key priority for 2015–16 (NOMS, 2015a). Illicit drug use, alongside the associated debt and violence, can have a destabilising effect on prisons, as we found at HMP Guys Marsh (2014).

Levels of violence in the prison were very high and many prisoners were frightened. Almost a quarter of prisoners told us that they did not feel safe at the time of the inspection. In the six months before the inspection, there had been 17 assaults on staff, 53 assaults on prisoners and 19 fights – three times the level at our previous inspection. The violence was driven by the supply of drugs, particularly synthetic cannabinoids such as 'Spice'. Subutex, diverted prescribed medication and illicitly brewed alcohol were also problems. Sixty-five per cent of prisoners told us that it was easy to get drugs in the prison and 50% alcohol. We were told that much of this trade was led by gangs and by organised crime operating outside the prison. Although the price of the drugs on the streets was low, it was very high in prison, so there were attempts to get large quantities in – even if there were significant interceptions, big profits could be made. Most of the drugs were legal outside the prison and there was no effective way to test for them, so the risks of supply were low. There had been a number of medical emergencies and hospital admissions associated with the consumption of Spice. The supply of drugs led to debt, and debts were enforced by violence or threats of violence to prisoners or their family and associates outside the prison. Gangs operated openly in the prison. ***HMP Guys Marsh 2014***

3.52 Some prisoners surveyed in inspections published between April 2014 and March 2015 reported being victimised by other prisoners for reasons related to drugs (4%) or medication (5%). In addition, 9% of prisoners who completed the thematic survey said that they had been pressured to give away their medication. Prisoners we interviewed for this thematic inspection said that violence was sometimes related to heightened emotions when drugs were not available, and to some prisoners retaliating because they had not had the opportunity to buy an illicit substance or had not received a promised illicit substance. They also said that if they were involved in a fight over drugs, they would not admit this to officers. Staff interviewed for this thematic inspection acknowledged that violence related to drugs was a problem and was one of the reasons for developing improved strategies to prevent substance misuse.

3.53 As noted above, a large proportion of adult male establishments inspected since 2013 reported incidents where emergency medical assistance had been required for prisoners because of synthetic cannabis use. Emergency ambulances had been called to attend to prisoners having fits, blackouts and other adverse symptoms, and in some instances multiple ambulances had been required when several prisoners had needed assistance at the same time. This not only put individual prisoners at risk, but also placed an excessive demand on resources that were required for the local community too. Prisoners and staff in more than one establishment used the term 'mambulance' to refer to ambulances called specifically to deal with people who had used 'Mamba'.

3.54 Illicit drug use is also linked to deaths in custody. The Prisons and Probation Ombudsman (PPO) reported in 2011–12 that 6% of all fatal incidents[15] that he investigated were due to drug toxicity. Recurring factors in these deaths included trading in prescribed or smuggled drugs, the hoarding of drugs for later use and the combined effects of prescribed medication and illicit drug use (PPO, 2012a). The PPO highlighted in July 2015 that in 19 deaths in prison between April 2012 and September 2014, the prisoner was known, or strongly suspected, to have been using NPS-type drugs before their deaths (PPO, 2015). The report noted that there was a link between the use of NPS and both mental and physical health problems. The PPO has reported that NPS have altered prisoners' behaviour, and highlighted the health risks, along with debt and bullying, resulting from their use, creating the potential to increase self-harm and suicide among vulnerable prisoners.

[15] The total of 229 includes four deaths in immigration removal centres and 15 in probation approved premises, the remainder being in prisons.

Section 4. Service responses

A whole-prison approach

4.1 All prisons have to hold prisoners securely, reduce the risk of reoffending and provide safe and well-ordered establishments in which prisoners are treated humanely, decently and lawfully. There is therefore a continuous challenge to maintain the right balance between security, care and rehabilitation.

4.2 The need for a whole-prison approach to drug and alcohol issues is clear from the Prisons and Probation Ombudsman (PPO) 2011–12 annual report (PPO, 2012a) conclusions that the following improvements were required to reduce prison drug fatalities:

- Reviewing the medications prescribed to prisoners with known drug habits
- Improving information sharing between prison prescribers, to ensure that prisoners are not prescribed medication which can be fatal when taken together
- Reducing the supply and use of illicit drugs within prison.

What is a whole-prison approach to substance misuse?

A 'whole-prison' approach requires coordinated activity across prison departments to tackle three broad areas:

- Supply reduction: stopping drugs getting into the prison
- Demand reduction: reducing the demand for drugs by addressing wider issues that may lead to drug use. For example:
  i. Action to reduce violence and bullying – when prisoners feel safe in custody they experience lower levels of stress, and the desire to self-medicate will be reduced
  ii. Provision of adequate purposeful activity to reduce boredom and promote better sleep patterns
  iii. Provide timely access to health services, including effective pain management, dental care and external hospital appointments, reducing the demand for self-medication
- Treatment for drug and alcohol issues – this should include timely individualised substitute prescribing integrated with evidence-based psychosocial interventions. This should include harm reduction measures, including accurate and effective drugs awareness and education that equips staff and prisoners to deal with situations and make informed choices in their own behaviour.

This should be supported by broader prison characteristics, including a rehabilitative culture, effective staff–prisoner relationships, a decent environment and proportionate security measures.

4.3 Effectiveness begins with establishing the level of need efficiently and promptly, to ensure that the prison devotes sufficient and appropriate resources to meeting that need – be it drug testing, searching, training or treatment, or the appropriate combination of all of these. Initially, many prisons were slow to respond to the rapidly changing landscape in relation to synthetic cannabis. Some prisons responded well to the challenge but others did not, and this was exacerbated by an initial lack of national guidance to prisons to help them to manage this problem and share good practice. The National Offender Management Service (NOMS) published guidance in February 2015, which reminded governors of the existing powers that they had, such as imposing sanctions for finds of alleged new psychoactive substances (NPS)

as an 'unauthorised article' rather than waiting to get it tested. Public Health England is preparing a toolkit on NPS for use in prisons which is due for publication in Autumn 2015. Joint guidance from NOMS and Public Health England earlier would have helped to establish the coordinated approaches required.

4.4 The Blakey report (2008) on supply reduction in prisons reported on inconsistent integration between operations, security and treatment, and said:

> *'I would have liked to have found in every prison a clear and consistent arrangement for running the drug strategy covering both treatment and trafficking and headed by a senior governor'.*

4.5 In inspection reports published between April 2014 and August 2015, we identified several prisons which had an excellent strategic, whole-prison approach to drug and alcohol issues. However, in too many adult prisons the strategy was out of date, had no accompanying action plan or lacked a current underpinning needs assessment.

The prison's strategic approach to drug and alcohol treatment was among the best we have seen. The drug strategy governor and partnership manager worked closely together to oversee delivery of what was called the prisoner's 'recovery journey'. This could include clinical care and a wide range of low-, medium- and high-intensity psychosocial interventions and aftercare. The combined treatment and supply reduction strategy was delivered through a very comprehensive action plan, which was monitored by a well-attended drug strategy committee. ***HMP Northumberland 2014***

4.6 Some prisons we inspected used out-of-date or insufficient information for their needs assessment – for example, only using data from drug services and ignoring potentially rich data from other sources, including health reception screens, prescribing trends, prisoner feedback, offender assessment system (OASys) data, drug finds and mandatory drug testing (MDT) testing results. Patterns of drug use can change quickly and regular systematic review of local prisoner needs is essential for an effective strategy.

4.7 An effective substance misuse committee is integral to the successful implementation and monitoring of a prison's drug and alcohol strategy. However, in several prisons we inspected in 2014–15, poor attendance by representatives of key departments, such as security, health services, offender management unit and residential managers, or an insufficient strategic focus reduced its effectiveness. This was further exacerbated in some prisons when substance misuse was subsumed into other committees, such as resettlement, without ensuring that an adequate strategic focus on substance misuse was maintained.

How drugs get into prison?

4.8 It is not possible to estimate accurately the extent of drug trafficking into prisons. However, drugs are clearly getting into prisons, and medications that are prescribed within prisons are being diverted, as evidenced by intelligence reports, positive drug testing and drug finds. Supply arrangements are often sophisticated and supply routes are likely to reflect the nature of the prison and the physical attributes of the drug itself. In any prison, illicit mobile telephones can be used to organise supply.

4.9 The Blakey report (2008) highlighted that visitors, 'over the wall', post, prisoners and staff were the primary sources of illicit drugs.

Visitors

4.10 Prisons are busy environments that, by necessity, have large numbers of visitors. This includes social visits for prisoners from family and friends; professional visits, including solicitors, health professionals, probation officers and community drug workers; prisoner transport vehicles; and assorted contractors, food deliveries and so on. There are mechanisms in place to search people and vehicles visiting prisons and to oversee activity to reduce opportunities to smuggle contraband in and out. However, manual searches cannot detect substances that have been swallowed or concealed internally. Table 1 shows the number of incidents where visitors were arrested by the police on suspicion of conveying drugs into prisons in England between April 2011 and March 2014.

Table 1: Number of incidents where visitors were arrested by the police on suspicion of conveying drugs into prisons in England, April 2011 to March 2014 (Hansard, 2015)

	2010–11	2011–12	2012–13	2013–14
Total	268	229	248	296

'Over the wall'

4.11 Some prisons are vulnerable to throwovers (items coming over the wall). This may be due to having a long perimeter that cannot be monitored effectively at all times or being located on a main road or in a housing estate where people outside the prison can access it easily. Items thrown over have included tennis balls, dead birds or small animals stuffed with drugs, which can then be picked up by prisoners (see Figure 9). Prisons have also reported arrows being shot into the prison with a line attached to pass items, and large catapults to carry drugs over perimeter walls (see Figure 10); drones have also been captured in some prisons. Category C training prisons, which have large perimeters and relatively free prisoner movement as they go to and from work, are most susceptible to drugs coming over the wall.

Figure 9: Drugs found in one prison which had been projected over the fence in tennis balls and packages weighted with coins

Figure 10: Catapult found outside a prison fence, used to project contraband into the prison

Post

4.12 Drugs may be secreted in items posted to the prison, including trainers and children's artwork. Synthetic cannabis is very versatile and can be sprayed onto paper – letters or documents posted to a prisoner, for instance – and then smoked as part of a roll-up cigarette. There were 349 reported incidents in which drugs were discovered in prison post in England and Wales in 2013–14 (Centre for Social Justice, 2015).

Prisoners

4.13 New arrivals into prison may arrive with drugs secreted on or in their person for personal use or wider distribution, or as couriers for others; this is most likely to happen in local prisons, which have a high prisoner throughput. We have been told of offenders breaching their licence deliberately to be returned to prison for a short period so that they can take drugs in; they may be paid large amounts of money to do this. All prisoners are given a rub down search on arrival in prison, and they may be scanned or strip-searched by officers, based on identified risk. However, some drugs that are secreted internally cannot be detected, so drugs are able to enter the prison in this way.

Staff

4.14 People who work in prisons, and particularly those who have keys, have high levels of freedom around the establishment. Staff may agree to bring in contraband for profit or because they have been coerced or threatened. In prisons with high levels of security, staff may also facilitate smuggling by drug couriers such as visitors, by helping them to avoid security checks. Strategies to address staff corruption include stringent security checks on

staff before they start work at the establishment, targeted and random staff searches, and training to avoid conditioning, although this does not prevent corruption (see Table 2).

Table 2: Number of staff convicted, dismissed and excluded in relation to conveying drugs into prisons in England, April 2011 to March 2014 (Hansard, 2015)

	2010–11	2011–12	2012–13	2013–14
Total	11	16	9	25

4.15 Any of the above-named routes, and more, may be used in any prison and there are no reliable data to show which is most prevalent. Nevertheless, it is clear that supply routes will respond quickly to weaknesses in defences and changes in profit factors, which means that security measures should be equally responsive.

4.16 In HMI Prisons inspection reports published between April 2014 and August 2015, 35% of male and 28% of female prisoners surveyed said that it was easy or very easy to get illegal drugs in the prison they were in. There was wide variation between different types of prison, ranging from a low of 18% in high secure establishments to a high of 41% in category C training prisons. This finding is, of course, an indication of perceived rather than actual availability; however, we have consistently found the most prominent reported issues relating to drug supply and misuse to be at category C training prisons.

4.17 The number of incidents in which drugs have been found in a prisoner's possession in prisons in England has increased over the past four years (see Table 3).

Table 3: Number of incidents in which drugs were found in a prisoner's possession in prisons in England, April 2011 to March 2014 (Hansard, 2015)

	2010–11	2011–12	2012–13	2013–14
Total	1,163	1,211	1,545	1,694

4.18 NOMS is working with the Home Office on legislation to tackle drug supply across the UK. Work is also under way on developing new drug tests for NPS, strengthening perimeter defences, producing a new generation of body scanners and training drug dogs to detect NPS, along with working with the police and Crown Prosecution Service. A clause has been included in the Serious Crime Bill which, if agreed, will create an offence of throwing or projecting any item over a prison perimeter so that it lands in a prison. NOMS is also working with NHS England on updated clinical guidance on the management of substance misuse in adult prisons and providing an NPS toolkit for prisons.

Supply reduction

4.19 The Blakey report (2008) highlighted that the way to disrupt supply routes into prisons was to:

- Use good practice
- Disrupt the use of mobile telephones
- Use searching
- Use search dogs
- Use legislation
- Develop and use technology
- Develop partnership working with the police
- Use intelligence.

4.20 All of the above remain central to effective drug supply reduction in prisons. NOMS further highlighted the challenge (NOMS, 2009):

> *'There is growing evidence of carefully organised attempts to traffic drugs into prisons, with great efforts made by criminals to overcome improved security measures in order to exploit the potential profits to be made in doing so. Reducing prison drug supply is a constant battle. As one route is closed, it does not take long for another to open'.*

4.21 There is certainly no evidence to suggest that the threat has diminished – and the rapid increase in the availability of synthetic cannabis may indicate that it has increased.

Strategy

4.22 Supply reduction is a key component of prison activity to maintain safety and security, and starts with an effective strategy. The HMI Prisons 2014–15 annual report noted that too many prisons had an inadequate supply reduction strategy; many were out of date, lacked clear actions, were not regularly reviewed and did not adequately reflect key issues (including NPS and medication), and frontline staff were often not aware of the key priorities (HM Inspectorate of Prisons, 2015). This will inevitably lead to an inadequate response.

4.23 Supply reduction in prisons requires coordinated, integrated working between all prison departments, including security, residential units and health care, as each have an interlinking role to play in supply reduction. We have seen effective multi-departmental approaches to reducing drug and alcohol supply at several prisons. However, strategies in some prisons were weakened by ineffective communication of key priorities to operational staff, which meant that the strategy was not translated into action. Despite the number of problems associated with synthetic cannabis, we are still finding that most prisons do not have an explicit NPS supply reduction strategy, although some prisons do have good strategies.

Key departments were represented at the monthly security meeting and relevant longer-term objectives were set to reflect threats relating to drugs, mobile telephones and items that were being thrown over the fence. A weekly intelligence meeting with security and other relevant staff reviewed all incidents and identified actions, which were followed up. A daily security briefing was distributed among all staff and we observed wing managers carrying out detailed briefings on the wings. The prison received good support from local police and there were adequate anti-corruption procedures in place. ***HMP Dovegate 2015***

There had been several serious incidents over the previous few months, many of which had been attributed to NPS. The security department was sighted on the threats and issues of NPS supply, and had introduced several specific initiatives, a committee and an action plan to address these … However, since the absorption of the drug strategy committee into the quarterly reducing reoffending meeting, a whole-prison approach to drugs had only been achieved with the recent introduction of an NPS committee. Only one such meeting had been held but a dynamic action plan was emerging and there was a renewed strategic approach involving all relevant departments. ***HMP Stocken 2015***

Key departments were represented at the monthly security meeting and relevant longer-term objectives were set to reflect the current threats around drugs, gang issues and mobile telephones. There were good relationships with other departments, particularly safer custody, with effective exchange of information between these departments. The prison received some support from the local police and also from the North-West region Titan team, which provided police support for security and anti-corruption matters. … There had been increasingly regular and large finds of NPS, coupled with several reported instances of prisoners presenting with the effects of having taken these, some of which had been reported as being Spice... The prison was dealing with the issue robustly through a specific strategy which included the education of prisoners and staff, and a clear protocol for dealing with prisoners suspected of taking these substances. ***HMP Liverpool 2015***

Searching and finds

4.24 As discussed above, drugs can enter prisons in many ways, so supply reduction approaches need to address all these routes in a proportionate way. Searching, both routine and intelligence led, is an important supply reduction tool. Searches may be made of prisoners, staff, visitors, prisoner property and the prison itself, and can be random or intelligence led.

4.25 Finds may be of drugs and associated paraphernalia (such as foil or syringes), medication or mobile telephones, which may be used to set up drug deals. The level of drug finds alone does not accurately reflect the level of use as it is unlikely that all illicit drugs will be found; however, in combination with other measures, including MDT rates, levels of violence and intelligence, it may indicate the effectiveness of supply reduction measures. We have repeatedly found on inspection that intelligence-led searching was either very delayed or did not occur, often because of reduced staffing levels.

In the previous six months, 2,099 intelligence reports had been submitted and processed efficiently, but some necessary actions, including target searching, were not always completed within acceptable timescales. Despite this, there had been some good finds, including 'hooch' (illicitly brewed alcohol), drugs, mobile telephones and weapons (mostly in communal areas), but prisoners and staff indicated that such items continued to be available. The main challenge was the prevention of unauthorised items, including mobile telephones, illegal drugs and new psychoactive substances (NPS). The security department worked well with other departments and external agencies, including the police, and was focused primarily on drug- and debt-related issues. The prison was active in trying to address these issues in a measured and proportionate way, but more was required as prisoners continued to be exposed to the associated violence. ***HMP Stoke Heath 2015***

4.26 Synthetic cannabis has no distinctive odour and is therefore harder to detect than non-synthetic cannabis, making it more attractive to smuggle in and use. The penalties for a prisoner caught with synthetic cannabis or other NPS will usually be limited to 'possession of an unauthorised article' as they have not been identified officially by drug testing The penalty will be lower than for 'possession of a controlled drug', increasing the attractiveness of synthetic cannabis to users and dealers. However, the supply reduction policy at HMP Stocken (2015) appropriately included enhanced penalties for possession of NPS, to act as a deterrent.

4.27 Dogs trained to detect the smell of various substances, including drugs and mobile telephones, are deployed in some prisons and can be useful both in increasing finds and acting as a deterrent to use. Some staff interviewed for this thematic inspection said that drug dogs were a valuable resource, but there were not enough of them and they were not trained to detect new drugs such as Spice or other NPS. Currently, few prisons have access to dogs trained to detect Spice, although more are now being trained (NOMS, 2015b).

4.28 Figures from the Ministry of Justice[16] show that the number of Spice finds in prison increased markedly, from 15 in 2010 to 262 in 2013, and then again to 430 (an increase of 60%) in only the first seven months of 2014, the latest year for which information is available. It is unclear from this if these finds were all confirmed as Spice by drug analysis. Our inspectors are often told about finds of unidentified tablets or herbal matter. It is essential that finds are analysed to establish what drugs are being found, to inform an effective local drug strategy.

[16] www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison [accessed 7 December 2015].

MDT

4.29 Prison MDT identifies how many of those who have been targeted for a test used one of the substances on the testing panel in the days preceding the test. However, prisoners may have used substances that are not tested for, or used substances that are tested for but not in the days immediately before the test, so MDT is not an accurate reflection of drug use in prison.

MDT

The MDT programme has been in place since 1996 to supply information on patterns of drugs misuse, deter prisoners from misusing drugs, identify those in need of referral to drug treatment, contribute to drug supply reduction, and contribute to prisoner safety, violence reduction, order and control (Ministry of Justice (MOJ), 2015). There is clear guidance on how MDT is to be conducted (MOJ, 2005). Currently, MDT can only test for drugs that are controlled substances under the Misuse of Drugs Act (1971), so cannot test for many medications or NPS.[17]

There are five types of MDT:

Random testing: This involves prisoners being selected for testing on a strictly random basis. Establishments with an average population of 400 or more in the previous 12 months must test at least 5% of their population, and those with fewer than 400 at least 10% monthly. At least 14% of random tests must be carried out at weekends. All prisoners appearing on the main random list must be tested, unless they have been discharged or are excused by health services staff. Each prison has its own random MDT target, agreed with the area manager. Testing should be unpredictable and spread evenly across the month.

Suspicion testing: This involves prisoners being tested because staff have reason to believe that they have misused drugs. A decision to authorise the test should be made on the basis of analysis of the intelligence received and should be completed within 72 hours of the intelligence being submitted.

Frequent testing: All prisoners found guilty on adjudication of taking a Class A drug, such as cocaine, must be placed on a programme of frequent testing, although the number, frequency and period of frequent testing is at the governor's discretion. Frequent testing can be considered for other drug offences, and appropriate support for drug misuse should also be offered.

Reception testing: This may be completed on reception to a prison, either as a transfer between prisons or on first arrival to prison from the community, on a routine or occasional basis

Risk assessment: This involves testing because a prisoner is being considered for a privilege, a job or a situation where a high level of trust is to be granted. This may include release on temporary licence or reclassification. The testing should be completed without prior warning and be as unpredictable as possible. Once selected, prisoners are required to provide a urine sample, which is sent to a laboratory for testing. Prisoners who either test positive for a drug that has not been prescribed legitimately or refuse to be tested are punished under the prison discipline (adjudication) system. Prisoners who test positive are automatically referred to prison drug treatment services.

Drug detection time in the urine

The length of time for which different drugs can be detected in urine varies by drug and individual factors, such as level of use and metabolism; for example, detection times for cannabis vary from three days for a single use to 36 days for heavy daily use, and for heroin are around 24 hours.

[17] Processes are under way to insert a clause into the Prisons Act 1952 to allow prisons to be tested for drugs that are not controlled under the 1971 Act in England and Wales.

4.30 Figures from NOMS show that positive random MDT rates have reduced, from a mean of 24.4% across all prisons in 1996–97 to 6.9% in 2014–15. They have been steady over the past three years, at around 7% (NOMS, 2014a). The positive random MDT rate between April 2014 and March 2015 dropped overall, from 7.4% in the previous year to 6.9%, but increased in some establishments, including women's closed and women's local prisons (NOMS, 2015c). Men's local prisons had the highest positive rates. The results for individual prisons ranged from a low of 0.2% at HMP Ashfield to a high of 19.1% at HMP Pentonville (NOMS, 2015d).

4.31 MDT can be a useful indicator and deterrent, if used effectively. However, the past two HMI Prisons annual reports highlighted that some prisons do not meet their random MDT targets, and that in a large proportion of prisons significant numbers of MDT suspicion tests are either not done or completed out of time (HM Chief Inspector of Prisons for England and Wales, 2014, 2015). The value of MDT is further undermined by the increased use of undetectable drugs and medicines that are not on the testing panel, such as most medications and NPS. The Criminal Justice and Courts Act 2015 will, in time, allow prisons to test for a wider range of substances under MDT, which will be a welcome initiative. MDT is a useful aspect of supply reduction but the figures for a prison should not be used as a measure of its current performance, as they may give false assurance or encourage a focus on drugs on the MDT panel, at the expense of other, equally harmful substances.

Mandatory drug testing (MDT) rates were higher than the target (6.8% against 4.5%), and in our survey, more prisoners than the comparator said they had developed a problem with drugs in the prison. Nevertheless, the prison's strategic approach to drug supply reduction was well-sighted on the most common entry routes, and had achieved some good success with drug finds. The prison used drug dogs trained to detect the new psychoactive substances (NPS), and staff and prisoners' knowledge of the dangers of these drugs was improving through an effective awareness raising campaign. Although suspicion drug tests were unable to detect NPS, they were timely. Cannabis was the main drug detected under MDT. ***HMP Brinsford 2015***

The prison had implemented a frequent testing programme and multi-agency case reviews as part of the support and sanctions protocol, and information sharing between security and substance misuse services was good. This strategy combined punitive measures for those found using illicit substances, with a clear support plan. We felt it provided a robust response to the challenges faced, and sent a clear message that the use of illicit drugs would not be tolerated, while still offering appropriate support. ***HMP New Hall 2015***

Sanctions for prisoners found to be involved in illicit substance misuse in prisons

4.32 Prisoners found to have been involved in using or distributing illicit drugs in prison may be sanctioned in a variety of ways, depending on the severity of the offence. A history of negative sanctions will have an impact on sentence management decisions, including recategorisation.

Incentives and earned privileges (IEP)

4.33 In the IEP scheme, which was introduced in 1995, prisoners have the potential to earn privileges through demonstrating positive behaviour, and to lose privileges through negative behaviour, such as the use of illicit substances. Privileges may include association time, additional access to gym facilities or the amount that can be spent in the prison shop.

Adjudication

4.34 When a prisoner breaks a prison rule, he/she can be charged with an offence against the prison rules (NOMS, 2011). The charge has to be laid within 48 hours of the offence and be heard the next day by a governor. If the charge is serious, it could be referred to the police or to the independent adjudicator.[18] There are clear rules governing how this process is to be managed and how the prisoners can defend themselves against the charge. If the charge is proven, a sanction (punishment) will be allocated which must comply with the Prison Rules (1999) and may include exclusion from work, cellular confinement for a specified period or stoppage of pay.

Closed visits

4.35 Social visits from family or friends are an important part of the rehabilitation of prisoners and are essential to maintaining good family ties. However, social visits are a known potential route by which illicit items, including drugs, can be smuggled in. The management of visits is governed by security rules and guidance to maintain prison security. Specific visitors may be banned for a specified period or closed visits may be put in place.

4.36 Closed visits[19] can be an effective and proportionate response to suspected trafficking through preventing direct contact between a prisoner and his or her visitor(s). There is a balance between ensuring that prisoners and their families have good-quality visits, that prisoners' families and children are treated decently and that healthy relationships are encouraged – and ensuring adequate security to prevent trafficking.

Preventing the misuse of diverted medication

4.37 In the HMI Prisons 2012–13 Annual Report (HM Chief Inspector of Prisons for England and Wales, 2013), we stated:

> *In many prisons inspected, several factors contributed to medication diversion – high levels of prescribing of medications liable to abuse; divertible medication inappropriately given to prisoners in possession; poor supervision of medication queues; and a lack of secure in-cell storage for medications. In several prisons, the strategic approach to the problem was poor.* **HM Chief Inspector of Prisons Annual Report 2012–13**

4.38 In high security prisons, a high level of external security may make diverted medication the easiest drug to obtain.

Strategy

4.39 Efforts to address the diversion of medication prescribed in prisons should be included in the prison's strategic approach to drugs and alcohol, and include good prescribing practices, administration and queue supervision; the secure in-cell storage of in-possession medication;[20] and the use of spot checks to assess if prisoners prescribed medication in possession are using them appropriately. A range of general and prison-specific prescribing guidance exists to inform best practice. Inspections over the past two years found that prescribing practice had improved, but it remained an issue in a significant minority of

[18] Independent adjudicators are district judges or deputy district judges approved by the Lord Chancellor for the purpose of enquiring into the charges referred to them.
[19] Closed visits involve a prisoner and visitor(s) being separated by glass and unable to make physical contact. They are usually applied as a result of attempting to smuggle unauthorised articles into the prison through visits.
[20] When a prisoner receives medication 'in possession' they are permitted to keep it in their cell.

establishments, often exacerbated by high use of locum prescribers who did not follow the available guidance. The implementation of a tradable medication strategy based on cross-departmental cooperation had reduced the misuse of tradable prescription medication at HMP Wakefield (2014).

In-possession medication

4.40 In-possession medication increases prisoner autonomy, prepares them to manage their own medication on release and allows them to take their doses at appropriate times. It also reduces the risks – for example, bullying – associated with excessively long medication queues. There are also potential advantages for the establishment in reducing the time required for drug administration – which is even more crucial, given the recent changes to the core day that leave little time for this. However, the decision to give medication in-possession has to be based on an individual current risk assessment that considers the risks associated with both the individual and the drug(s).

4.41 Of the 61 adult prison reports published between April 2014 and August 2015, we highlighted that five establishments had an inadequate in-possession policy, 14 needed to improve their risk assessment processes and seven did not provide prisoners with secure storage for in-possession medication.

Administration

4.42 Prisoners assessed to be at high risk of overdosing are given their medication under supervision. Additionally, medication that is deemed to have a high potential for diversion may be administered under supervision, regardless of the individual's assessed risk. Supervised medication requires prisoners to take their medication in front of a nurse and demonstrate that it has been swallowed by showing that no medication is secreted in their mouth or hands. Medication queues can offer opportunities for bullying of other prisoners, breaches of confidentiality by crowding around the administration area, intimidation of health services staff and diversion of medication. The presence of discipline staff at medication administration queues can prevent these issues and is a key aspect of supply and violence reduction. However, we are finding that it is increasingly common for there to be inconsistent or no observation of medication queues by discipline staff, usually because of reduced staffing levels.

4.43 In our survey for this thematic inspection, 4% of respondents said that they had previously given away or traded their own prescribed medication and 9% that they had been pressured to give it away:

> *'I have been hassled for meds; people come up to me and try to get me to sell, but I won't as I need them. Getting meds at the hatch is a problem as people can see and hear what other prisoners are getting. They could dispense when everyone is locked up instead'.*

4.44 Others we interviewed said that they had chosen not to be prescribed specific medication in order to avoid being pressured to give it away:

> *'As soon as I came to F and A wings, I was asked what medication I was taking. I felt intimidated but not threatened; it was frightening at the time due to my mental health issues but I was too scared to ask for daily meds as they may put me on an ACCT[21] because I overdosed in the past. Getting weekly meds in possession was a contributing factor to coming off my anti-psychotics – avoid the hassle of people asking for meds'.*

[21] Assessment, care in custody and teamwork case management for prisoners at risk of suicide or self-harm.

Some prisoners reported feeling anxious in health care or trying to be last in the queue at the hatch because they were scared of other prisoners knowing what medication they had been prescribed in case it was taken off them. In the previous six months, 60 to 70 patients had been on opiate substitution therapy, with an average of 61% on reducing regimes, which was appropriate. Prescribing and care were robust and recovery focused, with reviews at appropriate intervals. The administration of opiate substitution medication was safe. … officers sited themselves strategically and regulated medicine queues. Patients had confidentiality, were not subject to intimidation, and staff took time and care to check that medications had been ingested. Health care offered 24-hour nursing care for patients undergoing detoxification. There was no drug-free area in the prison, which presented a daily challenge for those preferring abstinence. ***HMP Altcourse 2014***

4.45 Some prisoners will try to take their medication away with them; sometimes, this is because they want to take it later because the timing of administration is inappropriate. In 12 of the 61 HMI Prisons reports published between April 2014 and August 2015, we highlighted concerns that the timing of medication administration was inappropriate, including night sedation being given as early as 4.30pm.

4.46 Prisoners may also want to take their medication away with them to divert or pass it on to others for personal gain or as a result of coercion. This can include regurgitation of medication, both in tablet and liquid form, for other prisoners to take. Supervision of supply is therefore essential for all medication. We observe the administration of medication as part of each inspection, and in some establishments we have seen chaotic, unsupervised and sometimes unhygienic administration practices, which exacerbate the risks of medication being diverted. Of the 61 adult prison inspection reports published between April 2014 and August 2015, inadequate officer supervision of controlled drug administration was highlighted for six prisons, and of general medication in 20 prisons.

Pain management

4.47 Effective pain management is a complex issue as pain can be difficult to assess objectively; this complexity is exacerbated in prisons (Public Health England, 2013a). Many prisoners have a history of injuries, broken bones and chronic back pain. Anxiety related to imprisonment, and aspects of the prison environment such as reduced access to exercise and poor-quality beds, can also intensify symptoms. Accessing treatment for drug misuse can result in a resurgence of pain that was previously masked by the illicit drug as its pain-relieving effect wears off. Additionally, illicit drug use is no longer the focus of every day, so that the individual is able to address other issues they have put off, such as relationships, medical issues and finances. Some prisoners arrive in prison on extensive, complicated prescribing regimes, including medications that have not been prescribed in line with best clinical practice. This creates significant challenges for prescribers to identify those with genuine need and to ensure that prescribing is correct. NHS England is developing a national pain formulary for use across the secure estate which addresses the unique challenges presented by the prison environment; it is due for publication in late 2015 and will supplement the current guidance (Department of Health, 2007; Public Health England, 2013a). The Royal College of Anaesthetists and Public Health England have been running joint training events on pain management in prisons since July 2015.

4.48 Some prisoners have genuine chronic severe pain but others may be motivated to use old injuries to seek prescribed medication to alter their mood or to sell. We spoke to prisoners who confirmed that faking pain was an accepted conventional method of obtaining medication to sell on.

4.49 HMI Prisons reports published between April 2014 and August 2015 identified inconsistent management of pain across the prison estate, with some prisons refusing to prescribe certain medications, such as tramadol and pregabalin because they have a high potential to be

diverted. This may seem to be an easy and desirable solution for managing high-value tradable items. However, it does not give prisoners community-equivalent care, and generates significant physical and mental distress for those who are denied medication; for example, some prisoners interviewed for this thematic inspection described having to endure high levels of pain as a result of being denied pain relief. It also creates additional risks, including an underground market for the drug.

4.50 Pharmacological treatment is only part of the solution for persistent pain, and the support available needs to include broader approaches, including psychologically informed interventions and physical rehabilitation. Some prisons use a multidisciplinary approach including pain specialists to ensure that the management of pain is evidence based and effective, including relevant non-pharmacological strategies, according to best practice.

NPS: Education and awareness-raising

4.51 We observed a mainly poor level of awareness of synthetic cannabis among prisoners and prison staff in HMI Prisons inspections between April 2014 and August 2015. Some staff we interviewed for this thematic inspection said that prisons should do more to train staff in how to deal better with NPS incidents on a local area or national basis. Staff training in some prisons where NPS are a problem has often been difficult to organise as staff shortages have reduced opportunities to release staff from operational duties to attend training sessions.

4.52 Prisoners we interviewed also said that they would have liked to be taught about NPS on arrival into the prison. We have seen effective targeted initiatives at some prisons. HMP Dovegate (2015) prisoner peer workers facilitated an education session for all new receptions, including a DVD on NPS, which we judged to have reduced the number of NPS-related incidents in the prison.

Survey results and an average mandatory drug testing (MDT) rate of 13.6% for the main prison in the previous six months indicated that drugs were widely available, and 41% of prisoners told us it was easy to get drugs in the prison. Finds were mainly for subutex, NPS and hooch. The prison was taking steps to address NPS use, including producing a DVD which showed the negative health effects of using these substances, which was being routinely shown to prisoners. **HMP Dovegate 2015**

The positive random mandatory drug testing (MDT) rate for the six months to May 2014 was relatively low, at 4.8%, against a key performance target of 6.0%. However, this did not accurately reflect drug usage as there were large-scale issues with 'Spice' and diverted medication, which could not be detected by the current MDT testing panel. In the previous six months, there had been 15 acute incidents where prisoners' use of Spice had been suspected, three of which had resulted in prisoners being taken to hospital. In response to this, the drug strategy committee had coordinated a series of well-organised initiatives, including the provision of information on the dangers of Spice to staff, prisoners and visitors. In the same period, staff had requested 173 tests on prisoners suspected of taking drugs, but very few of these (only 30%) had been completed because of the redeployment of testing staff. **HMP Wymott 2014**

The mandatory drug testing (MDT) positive rate was 4.5%, which was lower than target (10%) and than at the time of the previous inspection, but prisoners and staff told us that this was not a true reflection of drug use, owing to the availability of 'Black Mamba' (a new psychoactive substance), which was not detectable. Staff had found 23 packages thrown over the wall in the previous six months, most of which had been believed to contain Black Mamba. In November 2014, the supply reduction strategy had been updated to try to address the availability of Black Mamba, initially through close working with the police and education for prisoners and staff. **HMP Oakwood 2014**

4.53 We have also seen some effective peer-led education, whereby well-trained and well-supervised prisoners provided effective education to other prisoners, such as at HMP High Down (2015).

The security committee set and monitored appropriate objectives focused on maintaining a safe environment. Intelligence was mostly processed efficiently. The average positive mandatory drug testing (MDT) rate was low, at approximately 6%. We were told that new psychoactive substances (highly potent synthetic cannabinoids that are potentially more harmful than cannabis but do not show up in MDTs) had been a problem in the prison but their use appeared to be diminishing. Peer mentors were used well to make prisoners aware of the risks of NPS. **HMP High Down 2015**

4.54 Prisoners' families and friends can be both a source of positive support and a potential route by which drugs can come into prison. We have found little evidence of efforts to educate families and other visitors about the risks they create for prisoners by bringing in drugs (especially synthetic cannabis) for them, or to support family members and visitors who may be under pressure to do so. In addition, little use has been made of supportive family members to work with the prison to encourage prisoners to avoid drug misuse; we have seen this in a small number of recent inspections and it appears to be effective.

4.55 Many prisoners have required emergency medical attention from the ambulance service and the local accident and emergency unit. There is a need for evidence-based joint protocols and associated training between prisons and their local ambulance services and hospitals to ensure that these medical emergencies are managed correctly.

4.56 The Spice awareness project (see below) highlights both the extent of the issue with Spice in that prison and the education work being undertaken to address it.

Spice awareness project[22]

Following a number of overdoses attributed to Spice, a Spice awareness project was undertaken by a charity at a large category C prison in November 2014, with the aim of improving Spice awareness among staff and prisoners, increasing engagement with drug services and determining the level of Spice use within the establishment.

Every prisoner was interviewed individually on a wing-by-wing basis. Eighty-five per cent of them did not know exactly what Spice was, its effects or how to use it safely. Nevertheless, 80% of all prisoners said that they had tried Spice during their current sentence, and on some wings around 65% admitted to using the drug currently. One Spice joint cost £3–4 and gave a day of effect. Regular unreported accidental overdoses were described, where the offender concerned was left by others to ride it out or placed in the recovery position. The use of 'drug pigs' was also common, whereby vulnerable prisoners were forced to test new batches of product.

All wing staff on duty were also interviewed and none of the 50 spoken to knew about Spice, what it looked like or how to identify or support users. Information leaflets were distributed to all prisoners and left for dissemination to staff.

Treatment and support services in prison

4.57 Effective treatment is an important strand of drug supply reduction in prison and is undermined if supply reduction strategies are ineffective. Prison provides an opportunity to address untreated physical and mental health problems, including addiction. However, this

[22] Unpublished report shared with HMIP inspectors.

can be difficult to achieve for prisoners on very short sentences or remand, as the individual is often released before lasting change can be effected. Substitute prescribing to treat opiate addiction can be an important aspect of a wider treatment plan, which should include individually tailored psychosocial support. As only a minority of those who access treatment will successfully achieve lasting recovery following a single episode of treatment (Strang et al., 2014), services need to anticipate repeat treatment episodes and the need for ongoing (maintenance) prescribing for some, while ensuring that this does not generate complacency in treatment provision.

4.58 Motivation for drug users to enter treatment commonly includes to improve health, end their dependence, stop committing crimes, gain employment and take better care of their family. Effective treatment requires ongoing work on motivation, plus regular review and adjustment, ideally sequencing appropriate care and ensuring access to other services as required (Dale-Perera at al., 2014). Public Health England has stressed that, while opiate substitution treatment (OST) is an effective intervention for heroin use and dependence, the medication itself and accompanying psychosocial/recovery interventions need to be optimised to give the user the best chance of recovery and sustained abstinence (PHE, 2014b).We have observed some inflexible prescribing, enforced reduction and poor integration of clinical and psychosocial services in some prisons, contributing to poorer outcomes.

4.59 The services needed in prisons vary between different populations and establishments; for example, new arrivals from the community into local prisons will need rapid assessment and treatment for withdrawal; those on short sentences or remand need short, focused interventions; and those on longer sentences will require longer interventions focused on achieving and maintaining recovery. No one approach will meet the needs of all prisoners. Furthermore, it is important that prisoners identified with, or suspected of, illicit drug use – for example, through finds of unauthorised articles, positive MDT results and behaviour – are supported to access treatment. In most prisons we inspected, prisoners who tested positive in random MDT were automatically referred to drug treatment services for support, but this does not happen consistently when drug misuse is identified in other ways, such as finds, which is a missed opportunity. There is potential to use mandated education in conjunction with reduced or suspended sanctions, to increase prisoner engagement and improve outcomes, in a similar way to drug testing on arrest or the national speed awareness scheme (for drivers caught exceeding the road traffic speed limit).

4.60 In HMI Prisons reports published between April 2014 and August 2015, nearly two-thirds (63%) of respondents who said that they had a drug problem reported that they had received support for this in the prison they were in, and four in five (80%) said that the support had been helpful. Female prisoners were most likely (83%) and men in local prisons least likely (59%) to access support. Women were also significantly more likely to report that the support they received was helpful (88% compared with 79% in men's establishments).

4.61 If prisoners develop a drug problem or continue illicit use in prison, it can have an impact on levels of violence and debt in prison; it is also likely to affect their rehabilitation and increase the likelihood of future offending and further victims after release. The potential for prisoners to develop a drug problem in prison is not new. In the Surveying Prisoner Crime Reduction study (Light et al., 2013), 55% of heroin users (both male and female) reported using heroin in prison, and around 38% of men and 10% of women who reported heroin use said that they had started using it in a prison. Although the improvement in prison drug misuse services has had a positive impact on the level of opiate use in prisons, diverted medication and synthetic cannabis present new challenges. Drug treatment services need to be sensitive to changing patterns of use and offer accessible, responsive services.

4.62 Prison drug treatment services are not seeing large numbers of prisoners accessing support for synthetic cannabis or cannabis, despite our survey of eight establishments for this thematic inspection finding that synthetic cannabis was reported by 10% of respondents and cannabis by 13%. Not all prisoners who use synthetic cannabis will want, or need, treatment but there appears to be a reluctance by prisoners using these substances to engage with treatment services. Some prisoners said that they were reluctant to access support because they feared being targeted for additional MDT or searches. Others appeared to have little knowledge of the drug support services available. Some NPS users expressly stated that they had never experienced adverse effects and therefore saw no need for support or treatment. At HMP Springhill (2014), prisoner peer supporters ran group support sessions relating to NPS, which had led to increased attendance.

Clinical treatment for drug dependency

4.63 Prisoners who are dependent on drugs or alcohol are at high risk of complications related to withdrawal and treatment in the first five days after arrival in prison. In order to confirm use, clinical drug testing is undertaken by health services staff, with the informed consent of the prisoner, and this is used to inform clinical management, such as to confirm the need for opiate substitute prescribing or to establish if drug use is the cause of particular behaviour or symptoms. Clinical testing is also used as part of ongoing opiate substitute treatment, to confirm that the prisoner is taking the medication prescribed and is not using illicitly on top of that prescription. The results of clinical drug tests are confidential and cannot be disclosed outside of the health/substance misuse team without written consent.

4.64 As part of the care brought in under the integrated drug treatment system (IDTS), all new arrivals into local prisons in England are assessed for drug and alcohol withdrawal, and those who are physically dependent on opiates should be offered low-dose OST (usually methadone). The OST is then gradually increased to a stable dose. Those prisoners who arrive already on OST prescribed in the community will usually have it maintained following liaison with the community prescriber and pharmacy. Additional monitoring, including physical observations, review of levels of withdrawal/intoxication and overnight checks, is required during this stabilisation phase.

4.65 In most prisons we inspect, there are satisfactory arrangements, but there was a significant risk of life-threatening consequences at those establishments where monitoring during the first five days was inadequate. First night OST was generally available but was either inconsistent or absent in a small number of establishments, which increased the risk of illicit drug use and adverse physical health consequences.

There was good joint working and information sharing between departments and the integrated substance misuse team (ISMT) contributed to sentence planning meetings, HDC, re-categorisation and parole reports. Two members of the ISMT also covered local courts, where they started initial assessments and confirmed existing treatment regimes. The information was then passed on to the prison-based team to ensure treatment continuation. There was evidence of good-quality release planning. The ISMT held weekly pre-release clinics, where prisoners were provided with harm reduction information; strong links had been developed with community-based drug and alcohol services; and local prison link workers visited every week to arrange post-release support. ***HMP Dovegate 2015***

4.66 The UK Government 2010 drug strategy heralded an enhanced recovery agenda for all drugs that were misused, including medicines and NPS (known then as 'legal highs'). It emphasised the importance of supporting individuals to access and complete drug treatment successfully using both substitute prescribing and other recovery activities (Advisory Council on the Misuse of Drugs (ACMD), 2015) rather than maintaining prisoners for long periods on OST alone. In English prisons, prisoners on remand or serving short sentences can be maintained

on a stable dose of OST if a community service agrees to prescribe and if this is what the patient wants, to reduce the risk of accidental overdose post-release due to reduced tolerance. Prisoners serving long sentences are generally encouraged to reduce in prison, although those with significant mental health or physical health issues may be maintained. Both reduction and maintenance should occur as part of a personalised recovery plan which includes psychosocial interventions and regular reviews.

4.67 The HMI Prisons 2011–12 annual report (HM Chief Inspector of Prisons for England and Wales, 2012), stated that:

> *We welcomed a shift in emphasis from long-term methadone maintenance prescribing towards a recovery-orientated drug treatment approach.* **HM Chief Inspector of Prisons Annual Report 2011–12**

4.68 However, the annual report in 2012–13 (HM Chief Inspector of Prisons for England and Wales, 2013) highlighted that:

> *In several prisons, there was poor clinical management, ranging from long-term maintenance prescribing without regular reviews to forced reduction without sufficient patient involvement, combined with inadequate support.* **HM Chief Inspector of Prisons Annual Report 2012–13**

4.69 Prescribing and psychosocial support need to be optimised to maximise recovery outcomes. Strategies associated with rapid abstinence are associated with poor outcomes (Dale-Perera et al., 2014), and coercive abstinence in prison may be followed by relapse after release, leading to drug emergencies and possibly death (Stover and Michels, 2010).

4.70 In HMI Prisons reports published between April 2014 and August 2015, most clinical services we inspected provided flexible prescribing which included offering both buprenorphine and methadone at an appropriate dose for the individual, tailored reduction plans that were agreed with the patient, and regular reviews with an appropriate individualised recovery focus. Enforced reduction or insufficiently flexible prescribing in some establishments contributed to illicit use. Buprenorphine was unavailable or severely restricted in several prisons as a strategy to reduce illicit drug use, but this contributed to poorer outcomes for some prisoners, particularly those serving short sentences or on remand, who were forced to switch from buprenorphine to methadone.

4.71 Prisoners who achieve abstinence in prison may be vulnerable to relapse, particularly in the first few weeks, as they develop alternative coping strategies. The HMP Wymott (2014) clinical team provided up to six weeks' post-detoxification support, which was highly valued by prisoners.

4.72 Support for prisoners with a dual diagnosis (coexisting substance dependency and mental health issues) was satisfactory in most establishments, and impressive in HMP Thameside (2014), but a few establishments had inadequate provision. In many prisons we inspect, there is a divide between prescribing for opiate addiction and prescribing for general health issues, including mental health and pain, so prescribing can be uncoordinated and sometimes counterproductive. We observed effective joint working at HMP Stocken (2015) between mental health, primary care and substance misuse, which we commended as good practice.

> *The support and care coordination of prisoners with substance use and mental health problems had improved considerably and a designated social worker, together with a mental health nurse, provided a comprehensive new dual diagnosis service … which improved the care of prisoners with substance use and mental health problems.* ***HMP Thameside 2014***

Prisoners of concern were discussed at weekly meetings attended by substance misuse, primary health and mental health service senior staff. The identification of prisoners with complex needs was robust and an identified care coordinator ensured continuity of care. All health services staff knew who was being managed in this way. Case management meetings with other departments were held promptly, to ensure a whole-prison approach. ***HMP Stocken 2015***

Psychosocial support[23] in prisons

4.73 Following the transfer of the commissioning of prison substance misuse services in England to NHS England, we have seen large variations in psychosocial service provision across the different prison-based providers; however, generally, there was an appropriate recovery focus for drugs and alcohol in most prisons, and some impressive innovation.

The teams were co-located at the Iris Centre, which had good facilities and offered the 225 women involved (more than half the population) easy access. Interventions ranged from low key 'recovery café' drop-in sessions and evening complementary therapy groups to structured one-to-one work, substance-specific modules and a Pillars to Recovery course. Lifeline's recovery programme ran four times a year and another agency, Acorn, provided a 12-week reduction and abstinence recovery programme (RAMP), which was offered separately to women with alcohol problems. ***HMP Styal 2015***

4.74 The substance misuse team in HMP/YOI Isis (2014) was working to engage with vulnerable service users, including a new mentoring scheme in relation to gang membership.

4.75 The introduction of counselling, assessment, referral, advice and throughcare (CARAT), and later IDTS, resulted in improved and more consistent support services that were more integrated with clinical prescribing services in many, but not all establishments. Since 2006, this has developed into a comprehensive package of one-to-one sessions with key workers, group-work and self-help fellowships in many English prisons.

4.76 The integration of clinical and psychosocial services means that prisoners should receive a more holistically focused drug treatment service that combines any necessary clinical treatment (either at maintenance levels or as a reducing dose) with psychosocial support that should ultimately encourage them into recovery and a life free from drugs. HMI Prisons Expectations and National Guidelines on the treatment of drug dependence both encourage the delivery of integrated services (Department of Health, 2007; HM Inspectorate of Prisons Expectations, 2012). Successful treatment outcomes for individuals with substance misuse problems are more likely when psychosocial and clinical services work with the client in an integrated way. This has been the case in most, but not all adult prisons we have inspected.

4.77 In several prisons, a shortage of wing staff meant that groups were regularly cancelled and that prisoners' access to valuable peer support was restricted. Prisoners also told us that they were unable to access courses as there were insufficient places available. In some prisons, only group support was available, which excluded those prisoners who would have benefited from one-to-one support.

4.78 Drug-free residential rehabilitation is a useful option for a significant minority of prisoners who need additional support in developing alternative strategies to achieve recovery away from their usual environment. We have inspected some excellent drug therapeutic

[23] Psychosocial support refers to a wide range of interventions that may be offered to help an individual to address physical and psychological dependence in addition to any prescribing support. It may include support at different levels of intensity, reflecting the severity of the disorder or previous experience of treatment. It can be delivered by staff or peers, as one-to-one or group sessions. It also often includes practical support and strategies to address social needs or increase confidence and build a positive social support network.

communities within prisons which offered residents enhanced opportunities to achieve and maintain recovery.

Prisoners could also access a drug-free recovery wing, which was similar to a therapeutic community. The unit was well managed and offered a supportive environment, with structured activities, groups and regular compact-based drug testing. ***HMP Pentonville 2015***

4.79 Drug recovery or drug-free wings exist in many establishments, although we found that many were not actually fulfilling this brief. Outcomes on many units were adversely affected by a poor regime, excessive numbers of residents who were on the unit for operational reasons and not interested in recovery, and inconsistent staffing. In four of the 61 adult prison inspections published between April 2014 and August 2015, we made recommendations that only those in recovery should be housed on these units, and in six that they should be staffed by consistent, specially trained and selected officers. Prisoners we interviewed for this thematic inspection were generally positive about the residential-based support on offer in their prison. They said that the staff there better understood the phenomenon of addiction and the difficulties of managing their problems.

4.80 Compact-based drug testing[24] can be useful evidence of engagement, contribute positively to prisoners' recovery and be an effective motivator for abstinence in drug recovery wings and drug therapeutic communities. However, we have observed, that, although it is a positive tool when it is used, it is not widely available, owing to cost.

4.81 The lack of dedicated drug recovery units impeded outcomes in some establishments, whereby those that achieved abstinence struggled to maintain this in a normal wing environment. Prisoners we interviewed said that there was pressure to take drugs on the main wings as they were more widely available there, and some struggled not to use illicit substances if they had to share a cell with someone who used drugs regularly. Some alleged that individuals who had successfully become drug free were then targeted by dealers because they were most susceptible. In several inspection reports published between April 2014 and August 2015, we recommended that drug recovery wings should be developed to support prisoners in their recovery.

Peer support

4.82 Mutual aid in the form of peer-led social, emotional and informational support is recognised as a key aspect of effective psychosocial drug treatment, both in prison and the community (ACMD, 2013; Public Health England, 2013b). This includes 12-step-based interventions such as Narcotics Anonymous (NA) and self-management and recovery training (SMART) recovery.

4.83 NOMS has identified that a feature common to women who have successfully desisted from crime is that they develop a positive social identity, often as a result of activities that have exposed them to positive pro-social peers and allowed them to do good for the community (NOMS, 2015e). This could include becoming and/or working with a peer supporter, and is likely also to be true for some men.

4.84 HMI Prisons inspections during 2014–15 found that access to mutual aid groups such as NA and to well-trained and supervised peer supporters was good in many adult prisons. Some prisoners interviewed for this thematic inspection said that these services were not available when they wanted them, and in one establishment NA groups had been discontinued and replaced with other support which prisoners considered to be inferior. In prison inspection

[24] Compact-based drug testing is voluntary drug testing carried out with the informed consent of the prisoner within a clear behaviour compact. A positive result may lead to removal from a drug recovery or drug-free community.

reports published between April 2014 and August 2015, we found access to peer support to be either lacking or too limited in a significant minority of establishments. In one, prison peer supporters were not always available because they were not unlocked for long enough – again, owing to problems with staffing and reduced time out of cell under the prison core day. Prisoners valued peer support highly and reported it to be beneficial.

Peer support services were integral to the substance misuse provision. Eight well-trained and supervised peer supporters co-facilitated groups and a daily drop-in session, and also provided ad hoc support on the huts. Following low attendance at Spice and legal high sessions run by DART workers, the group became peer led and engagement increased significantly. DART workers and peer supporters had provided drug awareness sessions for young adult prisoners at Aylesbury prison that had been well received. The peer supporters we spoke to were positive about the impact of their role on their personal recovery as well as the support they gave others. Peer supporters also ran weekly Narcotics Anonymous and Gamblers Anonymous groups, and an external facilitator ran a weekly Alcoholics Anonymous group. ***HMP Springhill 2014***

Each of the 13 peer supporters undertook an Open College Network level 2 qualification in substance awareness and peer mentoring. They had benefited from the effective recovery programmes in place, and could now pass on what they had learned. They received support from a dedicated worker, who ran a weekly mentors' support group and regular one-to-one supervision. ***HMP Belmarsh 2015***

Family involvement in support

4.85 Many prisoners have family and friends in the community, and some prisoners we interviewed for this thematic inspection cited family as sources of support. Evidence suggests that family and social networks are influential both during addiction and in recovery (Copello and Orford, 2002; Lander et al., 2013). Prisoners' family and friends can be targeted for education to harness their effectiveness in supporting the prisoner in recovery, and also to help them to cope with the effects of the prisoner's drug use. This could include training them to use the opiate antidote naloxone, which could help to reduce the number of fatal drug overdoses in the community. It could also be an opportunity to support some visiting family and friends into treatment themselves. Only a few substance misuse services we have inspected offered any structured family support, which was a wasted opportunity to improve outcomes. In some prisons, families are invited to support a prisoner graduating from treatment programmes, which is a positive initiative. Prisoners and staff we interviewed in the women's prison for this thematic inspection spoke positively about the family support offered to those with substance misuse problems.

Support was provided to prisoners and their families by the in-prison family recovery worker. Since the start of the service in November 2013, 70 prisoners and 27 family members had engaged with the service… The family recovery service improved the potential for successful resettlement and family reintegration of prisoners who were substance misusers. ***HMP Bedford 2015***

Prisoners also had access to the national Addaction network of community-based substance use support services, and an in-house support helpline was available for families… The Addaction in-house telephone helpline service offered support and information to friends and families affected by prisoners' drug and alcohol misuse. ***HMP North Sea Camp 2014***

An organisation called Families and Loved ones accessing Mutual and Emotional Support (FLAMES) held bimonthly events, where families of residents in the therapeutic community could attend the establishment for structured visits and link up with mutual aid efforts in their communities. ***HMP Garth 2014***

4.86 However, as already referred to, family and friends can also be a potential route for drug supply and may themselves be pressured into bringing drugs into the prison. Family and friends may be reluctant to report this to the authorities, and we also found little appropriate assistance available for them.

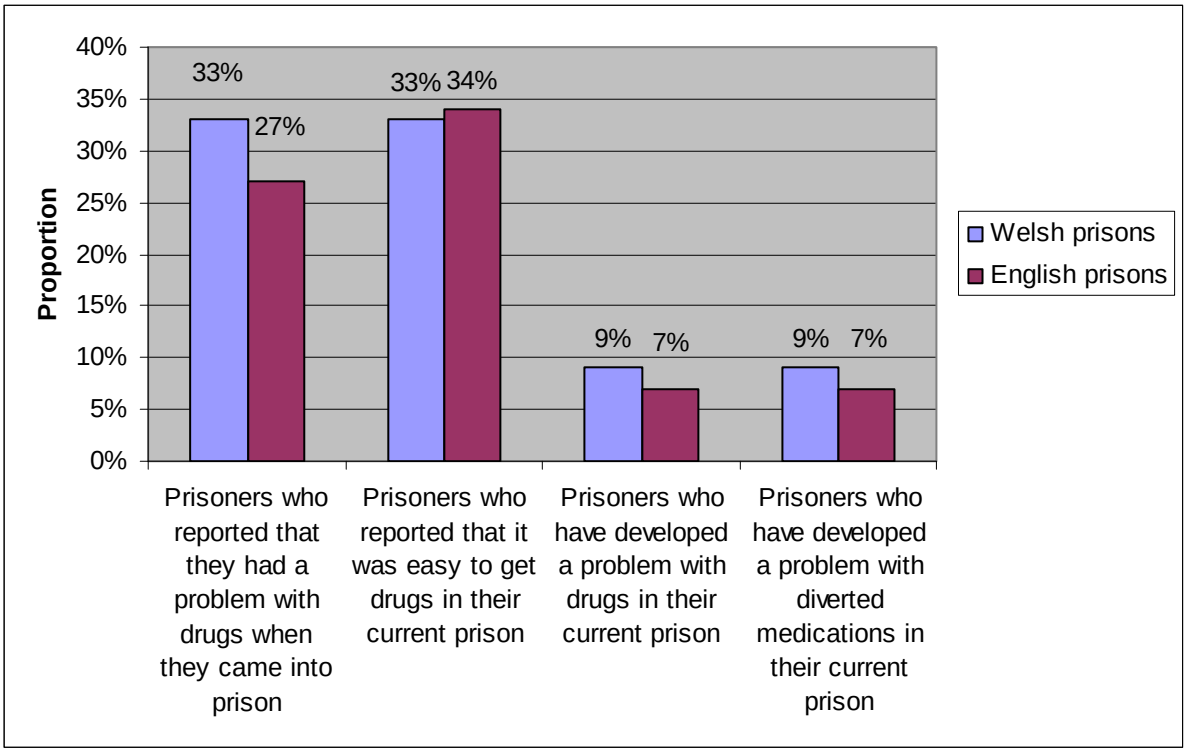
Drug misuse and treatment in Wales

There are recognised variations in drug misuse between England and Wales, along with differences in the treatment systems available. In 2013–14, higher levels of cannabis, amphetamine and hallucinogen use were reported in Wales but lower levels of powder cocaine and ecstasy than in England, according to a profile of Welsh substance misuse (Smith and Emmerson, 2014).

Evidence from HMI Prisons inspections suggested that there was a smaller problem with Spice in Welsh prisons compared with English prisons, although it was beginning to emerge during our inspection of HMP Swansea in 2014. Prisoners in the Welsh prison interviewed for this thematic inspection said that they had either never seen Spice or that they had seen only a few people using it. However, as we reported to the National Assembly for Wales Health and Social Care Committee in October 2014, as the use of NPS gains momentum in Welsh communities, it can be predicted with some confidence that Welsh prisons will see a rise in the incidence of NPS misuse.

There are five prisons in Wales. HMPs Swansea and Cardiff have a local function. HMP Parc is a category C resettlement/training prison, with a small remand function. HMP Usk is a category C prison combined with HMP Prescoed, which has a category D function. A sixth prison is being built at Wrexham in North Wales. We compared the key findings from our most recent inspection surveys at each of these prisons with those from all English men's prisons inspected between April 2013 and August 2015. Figure 11 provides a comparison between prisoners in Welsh prisons and those in English prisons, looking at some key questions from the main inspection survey.

Figure 11: A comparison between the responses of prisoners in Welsh prisons and those in English prisons (N=16,196)



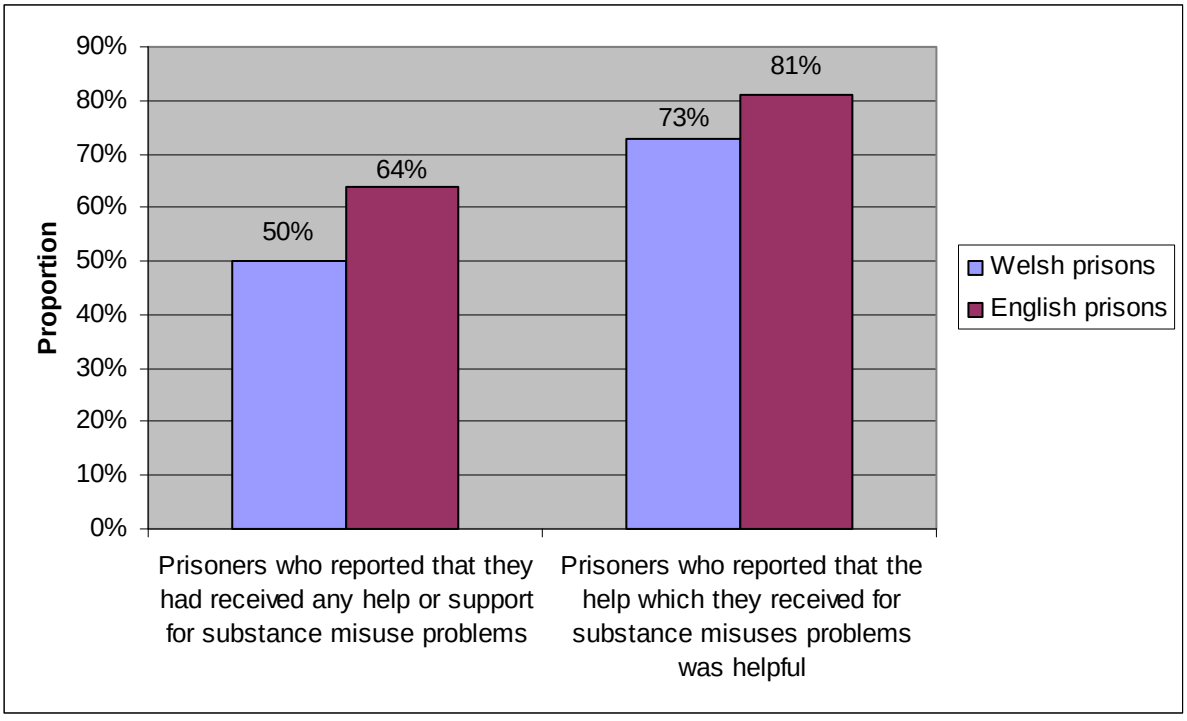
At the time they were inspected, all of the Welsh prisons had random MDT rates that were lower than in comparator prisons in England.

Drug treatment in Wales is organised differently to that in England. IDTS has not been funded and implemented in Wales. Each prison provides psychosocial and clinical support for substance misuse. Prisoners who arrive on a current community prescription of OST are generally maintained,

although, in our most recent inspections, the three prisons with a local function varied in the duration and nature of treatment offered. However, the main difference between English and Welsh prisons is that, in Wales, those arriving from the community who are addicted to opiates but not engaged with community treatment are not automatically offered OST in the form of methadone or buprenorphine on the day of arrival. Instead, a withdrawal programme, using a non-opiate medication, is usually offered to this group. No distinction is made between remand and sentenced prisoners. It is therefore not uncommon for an opiate-dependent prisoner to be remanded for 2–3 weeks, withdrawn from opiates (regardless of their own wishes or intent to stop using drugs), and then returned to court and subsequently released having lost all physical tolerance to the drug. If that prisoner then uses opiates on release, their risk of overdose is extremely high.

OST is a recognised incentive to encourage people dependent on illicit opiates into treatment. In Wales, the incentive for those who arrive dependent on illicit opiates to engage in treatment is reduced and there is an increased market for illicit drugs, as those going to prison know that they will not get OST. In our view, this provides a considerably less safe service for those held in prisons in Wales compared with those held in England, as indicated in Figure 11. The disparity is increased because a large number of offenders from North Wales, and all female offenders, are housed in prisons in England as there are no prison facilities in North Wales and none at all for female prisoners in Wales, and they receive very different treatment. When the new North Wales prison opens, it will accept prisoners from England as well as Wales, which will mean that prisoners from each nation will receive unequal treatment, depending on where they are held. This difference in treatment is also likely to have an impact on the rates of reoffending and return to problematic drug use on release. Figure 12 provides a comparison between the survey responses of prisoners in Welsh prisons and in English prisons concerning the support they received for their drug use.

Figure 12: A comparison between the responses of prisoners in Welsh prisons and those in English prisons concerning the support they received for their drug use (N=16,196)



Although we found some good psychosocial work being conducted in HMP Cardiff (2013), it was poorly integrated with clinical treatment. In HMP Swansea, there was also poor integration of clinical support with psychosocial interventions. The psychosocial team was understaffed and so could do little more than conduct initial assessments and brief interventions. Officers on the drug recovery wing who had been trained to deliver group-work programmes were so frequently redeployed to other duties that they had ceased all programme delivery. In HMP/YOI Parc (2013), the picture was

better, with the psychosocial service providing a similar package of options to those found in English prisons.

As already stated, there are no women's prisons in Wales, and women's prison in England cover very large catchment areas. Women from Wales are held in English prisons, which makes it difficult to put effective resettlement plans in place. Commissioners interviewed for this thematic inspection confirmed that this presented particular problems.

The introduction of the Wales Integrated Offender Intervention Service (IOIS), which has a remit to reduce reoffending, has improved post-release support for prisoners with substance misuse problems.

There were plans to create further integration between the substance misuse service and the OMU through substance misuse offender supervisors. There were strong links with IOIS providers at strategic and operational level (the head of community engagement led the drug strategy and was responsible for community IOISs), and prisoners could access designated prison link workers from South, West and North Wales who regularly attended and were able to meet those due for release at the gate. ***HMP/YOI Parc 2013***

Resettlement and 'through-the-gate' support

4.87 Prisoners are at risk of relapsing into drug use, increasing their drug use and reoffending, on release. Relapse into, or increased levels of, drug use post-release presents serious risks of physical harm to individuals. In 2012, the PPO highlighted an increase in drug-related deaths among newly released prisoners – most of whom were found to be using diverted prescription medicines (PPO, 2012b). It recommended that staff at approved premises be made aware of the dangers of both mixed drug and methadone toxicity and to ensure that medication administration is supervised to reduce the opportunity for the trade in prescription drugs. An average of two deaths a day (765) were registered in England and Wales in 2013, for which heroin or morphine were mentioned on the death certificate, an increase of 32% on 2012 (Office for National Statistics, 2014).

4.88 The reoffending rate for those released from custody between April 2011 and March 2012 was 45.8%, and varied by age and gender, with a higher rate for men and young people. A Ministry of Justice review of evidence on reoffending from 2014 highlighted that reconviction rates were higher among prisoners who had used drugs in the month before going into custody (MOJ, 2013).

4.89 The health risks associated with drug use on exit from custody and high reoffending rates alike carry high costs for society generally, emphasising the key role of effective resettlement activity.

Resettlement

4.90 Effective resettlement from prison to the community involves several strands, including support with:

- Accommodation
- Education, training and employment
- Changing attitudes, thinking and behaviour
- The maintenance of family ties
- Finance, benefit and debt
- Continuity of treatment for all physical, mental and substance misuse issues

- Individualised health promotion advice to reduce the risk of harm, including drug overdose, blood-borne viruses and sexually transmitted infections.

4.91 Considerable changes to resettlement planning and provision were introduced in April 2015 as a result of the Offender Rehabilitation Act 2014. The Act grants powers to community rehabilitation companies (CRCs) to make drug tests of adult offenders released on licence compulsory and require them to attend appointments designed to address their substance misuse. It is too early to comment on the impact of these changes.

Accessing treatment on release

4.92 A DrugScope State of the Sector survey (2015b) revealed the pressures affecting community drug services. Half of those who responded reported a range of challenges, including reduced funding and staffing, difficulties in accessing support services (including housing), support for older clients, mental health services and employment. The constant cycle and churn of local commissioning and recommissioning was also reported to have had an impact. This is likely to affect the ability of services to support their clients, including ex-prisoners. Some commissioners we interviewed for this thematic inspection said that a reduction in budgets was resulting in more innovative and integrated treatment models. Public Health England has stressed the importance of continuing current levels of funding to address drug and alcohol misuse owing to its positive impact on health and social outcomes, including offending (PHE, 2015a).

4.93 Prison substance misuse services are primarily commissioned by NHS England, and community services are commissioned by Public Health England. Our interviews with commissioners indicated that there was little joint working, which could result in a disjointed approach.

4.94 Continuity of, or access to, drug treatment on release is an important aspect of resettlement. Public Health England figures indicate that prisons were responsible for 9% of referrals into community drug treatment in 2013–14 (Public Health England 2014a). National Drug Treatment Monitoring System data indicate that a high proportion of prisoners referred into community opiate substitute prescribing do not attend their appointments post-release, with only 24% of those referred to community drug services attending the treatment service within three weeks of release. Our interviews with prisoners suggested that several factors were responsible for this. Some admitted that attending treatment would not be their first priority on release, and several thought that they would lack the willpower either to make appointments or to turn up. Others did not find service locations practical – for example, if they had employment in a different area. Some prisons make the arrangements for prisoners to attend – either by arranging for the agency to collect prisoners from the prison gate and take them to their appointments or providing transport for them to attend their first appointment, which increases engagement with services post-release.

4.95 Commissioners we spoke to for this thematic inspection said that the number of released prisoners attending community services for support for either NPS or illicit medication issues is low. This may be because released prisoners do not see NPS or illicit medication use as a problem, or their perceptions that community services will be unable to help or that any drug problem will have been resolved on release.

4.96 When interviewed for this thematic inspection, most health care commissioners noted that, while there were occasional issues with sudden releases from court or on bail, overall, liaison from prisons before release was effective..

4.97 Some prisoners who successfully withdraw from opiates in prison and then return to the same social circumstances on release that contributed to their previous drug use are at high risk of relapse. A planned introduction of OST with methadone or buprenorphine before release, in consultation with community services, can be a positive intervention alongside other psychosocial support, as it means that the prisoner will have increased tolerance on release and be at a lower risk of an opiate overdose. This intervention is not appropriate for all and should only occur following multidisciplinary input, including community services.

4.98 While every attempt should be made to reduce the likelihood that released prisoners will use drugs on release, some released prisoners will return to drug use and they are at an increased risk of overdose.

4.99 Take-home naloxone is an important and cost-effective harm-reduction initiative which enables opiate drug users and their families to provide a timely overdose intervention that can save lives, following appropriate training (ACMD, 2012). HMPs Cardiff, Swansea and Parc all participate in the national take-home naloxone programme. Public Health England has published guidance on its use (2015b). In 2005, naloxone was added to the list of injectable medicines that can be used legally by anyone to save a life in an emergency, so can be held by a family member or friend (Medicines for Human Use Order, 2005). To achieve the best impact on overdose rates, as many people as possible should be trained to use naloxone. A change in medicine regulations in October 2015 has allowed naloxone to be issued without a prescription, which may increase its use. Most English prisons we inspect do not currently offer this service; however, training motivated prisoners and their families could be a very valuable harm reduction initiative to reduce opiate overdoses in the community. We highlighted the participation of HMP Bristol in the national pilot scheme in England as an example of good practice.

The prison continued to participate in a national naloxone pilot scheme, training prisoners to treat opiate overdose on release. The 'N-ALIVe' study had been recruiting participants since January 2013 and 340 prisoners had joined in the study. ***HMP Bristol 2014***

4.100 Engagement in community treatment on release can be improved by having continuity of a case worker or services between the prison and the community.

…the same providers were used in prison and in the community; this offered joined-up continuation of care on release. Assessments and recovery plans were shared with drug intervention programme teams, and designated prison link workers were based at the establishment. New developments included a pilot 'through-the-gate' reception scheme based at the community engagement centre next to the prison … and pre-release drug testing. Prisoners could be met at the gate by recovery mentors on release. ***HMP Preston 2014***

Good joint working between departments took place, the drug and alcohol recovery team contributed to sentence planning, release plans were good and women were consistently given harm reduction information. The opiate-blocker naloxone was available pre-release. Throughcare services were also provided to women with alcohol problems. Styal was a pilot site for through-the-gate services… Fifty-six women were actively involved with the service, including 18 who received follow-up in the community. Strong links had been made with community women's centres and the project included peer mentor support. Weekly case management meetings with community partners facilitated ongoing care coordination and files demonstrated good-quality post-release work. ***HMP Styal 2014***

Outcomes for prisoners with drug and alcohol problems were excellent. [The drug treatment service provider] provided drug intervention programme services in the North West region, helping to maintain continuity of care where prisoners needed substance use support on release. The prison was also involved with the Gateways resettlement scheme, which offered a wide range of interventions, including post-release mentoring support and abstinence recovery housing. Gateways, in partnership with the Work Company, a non-profit employment and recruitment organisation, delivered a service preparing substance users to access employment, training and education following a programme of one-to-one mentoring and up to 12 weeks'

community support post-release. Gateways also ran a take-home naloxone scheme that trained prisoners with a history and continued risk of injecting drug use to apply an opiate overdose antidote kit. The kits were issued at the point of release. ***HMP Lancaster Farms 2015***

Resettlement opportunities for prisoners with substance misuse needs who were residents of Hampshire and Dorset were good, mainly because of the recent appointment of a full-time community integration and support worker. A wide range of services was delivered, including arranging gate pick-ups, housing, rehabilitation centre funding, community treatment, arranging recovery champion visits to the prison and developing links with regional drug intervention programme and drug, alcohol and assessment teams. ***HMP Winchester 2014***

Accommodation and training needs

4.101 The effectiveness of the support provided by prisons is increased if all the risk factors are addressed before the prisoner is released, including employment, housing, domestic violence and issues related to prostitution. The North-West 'Through The Gate Substance Misuse Services' pilot provides comprehensive resettlement support for some prisoners with substance misuse issues, and some of the services we inspected that are part of this pilot were very promising.

The North-West 'Through the Gate Substance Misuse Services' pilot

The 'Through the Gate Substance Misuse Services' pilot project at 10 North-West prisons is designed to test a comprehensive end-to-end approach to tackling addiction by improving the identification of drug misusers and increasing access into treatment. This will provide greater levels of self-motivation and engagement with treatment, and continuity of care through the gate for drug misusers entering, transferring between and leaving prisons. It includes anonymous drug testing on arrival into and on leaving the prison, and since December 2014 the testing panel has incorporated anonymous testing of Spice, prescription-only drugs and a wider selection of drugs than MDT as part of public health monitoring on prevalence. All prison drug seizures have also been submitted for analysis as part of the Home Office 'forensic early warning system' (FEWS) (NOMS, 2014b). The pilot is currently being evaluated.

4.102 Prisoners interviewed for this thematic inspection told us how important accommodation and other practical resettlement services were to prevent relapse. Since May 2015, CRCs have taken over most practical resettlement services and need to work closely with substance misuse services to provide the range of support necessary to reduce the likelihood of relapse. It is too early to assess the effectiveness of CRCs.

4.103 At HMP The Mount (2015), we found the following good practice in relation to resettlement planning, which also made good use of peer supporters to support prisoners before release.

The RAPt team also organised a project called 'group aftercare peer support' (GAPS). Peer supporters facilitated GAPS groups for one session a week for 12 weeks for prisoners with substance use issues who were nearing release. Visiting speakers from community agencies gave presentations promoting education, training and employment, housing and recovery-based services for these prisoners. Participants then drew up their own resettlement action plans, which were peer reviewed by the group. The finished action plan was then presented to the OMU with any additional necessary input from the RAPt resettlement worker. ***HMP The Mount 2015***

Section 5. Appendices

Appendix I: Methodology

5.1 This thematic inspection looked at substance misuse within the adult prison estate (including young adults). It drew on a total 61 HMI Prisons inspections of prisons published between April 2014 and August 2015[25] and, where it was helpful, on some earlier inspections. In addition to the information gathered from the inspection reports themselves, the collective survey responses over this period were also analysed. The analysis of inspection reports and survey responses included the following establishment types:

Type of prison	Number of prisons	Number of respondents
Local prisons	25	4,479
Category B training prisons	4	715
Category C training prisons	14	2,458
High secure prisons	3	489
Young adult prisons	5	866
Open prisons	5	717
Women's prisons	7	978
Total	**63**[26]	**10,702**

5.2 Additional fieldwork was conducted in eight prisons, as described below.

5.3 HMI Prisons inspects all aspects of prison life against our expectations (HM Inspectorate of Prisons Expectations 2012, 2014). When inspecting substance misuse services, a specialist inspector specifically looks at:

- Supply reduction strategic approach and practices
- Clinical services, including stabilisation, planned reduction and maintenance, for prisoners with drug addiction
- Prescribing of opiate substitution treatment
- Safety of drug administration, including opportunities for medication diversion
- Psychosocial services, including specialist drug recovery wings
- Mental health support for those with a dual diagnosis
- Continuity of support for prisoners on release and
- How well all the above are integrated.

[25] When more than one inspection had taken place at an establishment, only the most recent inspection report was included.

[26] Two surveys were carried out at two establishments during this period to reflect their dual functions. HMP Hewell has an open function alongside its main local function, and HMP Winchester has a separate category C unit alongside its main local function.

5.4 The substance misuse inspector will also link in with other inspectors where the areas of inspection overlap and have a positive or negative impact on levels of substance misuse and support services, including security, health services, purposeful activity and safer custody.

Additional analysis of Welsh prisons

5.5 In addition to the analysis of survey responses published in inspection reports between April 2014 and August 2015, the responses of prisoners in Welsh prisons were compared with those of prisoners in English prisons. This analysis covers prison inspection reports published between April 2013 and August 2015, drawing on 817 respondents in five Welsh prisons and 15,379 respondents in 93 English prisons.

Additional fieldwork in prisons

5.6 Fieldwork was conducted in a total of eight establishments holding adult offenders between June and November 2014. Additional information collected did not form part of the main inspection judgement.

5.7 Prisons were selected to include a range of the different functional types of establishment and ensure that different regional areas were also included: two local prisons, a category C trainer prison, an open prison, a high secure prison, a young offender institution, a women's prison and a prison in Wales were included.

5.8 Fieldwork in prisons comprised the following steps.

A survey of prisoners

5.9 A short questionnaire was administered to a representative sample of prisoners at the same time as the regular HMI Prisons prisoner survey conducted in advance of every inspection.

5.10 Surveys were carried out to government social research standards. Using a robust statistical formula, we calculated the sample size required to ensure that our survey findings reflected the experiences of the entire population of the establishment. Respondents were then randomly selected from a P-Nomis (electronic case notes) prisoner population printout, using a stratified systematic sampling method. We also ensured that the proportion of black and minority ethnic prisoners in the sample reflected the proportion in the prison as a whole.

5.11 The questionnaire included questions on:

- Drug use in the two months before entering prison
- Drug use within their current prison
- The perceived availability and sources of both illicit drugs and diverted medication.

5.12 The questionnaire also provided prisoners with the opportunity to opt in to speak to a researcher as part of the fieldwork. A total of 1,218 surveys were analysed as part of this report; these were distributed as follows:

Type of prison	Number of prisons	Number of respondents
Local prisons[27]	3	493
Category C training prisons	1	175
High secure prisons	1	139
Young adult prisons	1	137
Open prisons	1	141
Women's prisons	1	133
Total	**8**	**1,218**

Prisoner interviews

5.13 Semi-structured confidential interviews were conducted with a total of 85 prisoners across eight establishments. Prisoners who consented to take part in an interview were sampled to ensure that a variety of experience was captured, including drugs used in the community and those used in prisons.

5.14 Prisoners were asked about:

- Previous misuse of illicit drugs and medication in the community
- Use of illicit drugs and medication in their current prison
- Sources of drugs and perceived availability of illicit drugs and medication within their current prison
- Awareness and experiences of substance misuse services within their current prison, and their future support needs, both in their current prison and on release.

Staff interviews

5.15 Semi-structured interviews were conducted with a total of 34 members of staff across eight establishments. These covered:

- Knowledge of substance misuse outside the prison
- Substance misuse trends in the prison and motivations for use
- Awareness of the sources of drugs and problems arising from substance misuse in prison
- Responses to substance misuse, in terms of both support services and supply reduction measures.

Community fieldwork

5.16 Semi-structured interviews were conducted with 13 local authority commissioners of services in the English prisons where our fieldwork was conducted, five commissioners of services for other prisons, and six NHS England commissioners across England. The aim of

[27] This includes one local prison in Wales.

these interviews was to gain a wider understanding of the presentation and treatment needs of those in prison, and of offenders and ex-offenders in contact with community services. We were unable to speak to a commissioner from Wales. We also spoke to four substance misuse public health leads.

5.17 Interviews covered the following areas:

- The needs of prisoners in prison and on release into the community
- Local substance misuse trends and needs analysis
- Local substance misuse service commissioning
- Connections between commissioned substance misuse services and probation and mental health services.

Appendix II: Terminology

Term	**Definition**
Adjudications	Disciplinary hearings within prisons
Assisted withdrawal	Previously known as detoxification. Main goal of treatment is to support the individual who is physically dependent on a substance(s) to come off it safely, with reduced adverse physical symptoms, using an alternative licensed drug within a planned regime; for example, a reducing dose of methadone may be used to assist someone to come off heroin. For most people, this can be done in the community but some people may need close monitoring and support, so will do this in a hospital setting
Benzodiazepines	A group of tranquilliser (see below) medications which have been used to treat: anxiety, agitation and restlessness; epileptic seizures/fits; mania; alcohol withdrawal; and sleeping problems. These include diazepam, chlordiazepoxide, clonazepam, lorazepam. Users may find that they are dependent on the drug and experience unpleasant withdrawal symptoms – nausea, tremors, panic attacks and depression
Black Mamba	A form of synthetic cannabis
Buprenorphine	Medication used to treat opioid dependence. Also known as Subutex and Suboxone in the UK. In lower doses, it is used for pain relief as Temgesic
Cannabis	Naturally occurring drug found in cannabis plants. Can make users feel happy and relaxed, and cause hallucinations, anxiety, paranoia, memory loss and loss of concentration
Class A, B and C	The classification of drugs based on their capacity for harm, as per the Misuse of Drugs Act 1971 (A = most harmful and carries the harshest punishments)
Cocaine	A strong, short-acting stimulant drug – comes in powder form
Codeine	An opiate drug used for pain relief
Crack cocaine ('crack')	An intense, short-acting stimulant drug produced from cocaine
Dependence	A cluster of physical, behavioural and psychological phenomena that may develop after repeated use of a substance. It typically includes a strong desire to take a particular substance, impaired control over its use, persistent use despite harmful consequences, a higher priority given to drug use than other activities and responsibilities, increased tolerance and a physical withdrawal reaction when the drug is discontinued. A diagnosis of dependence is made if three or more of six specified criteria have been experienced within a year. Dependence may relate to a single substance (e.g. tobacco, alcohol, heroin), a class of substances (e.g. opioids) or a wider range of different substances (e.g. alcohol, diazepam and heroin)
Depressants	Drugs causing a decreased awareness of surroundings, decreased alertness, a narcotic effect and blunted emotions (Fazel et al., 2006)
Dual diagnosis	The co-existence of mental health and substance misuse problems
Ecstasy	Also known by chemical name, 3,4-methylenedioxy-methamphetamine (MDMA). Makes the user energised, happy and awake for hours
Gabapentin	Prescription-only medication used to treat epilepsy and pain from damaged nerve tissue. It can enhance the euphoric effects of opiate drugs (with increased health risks)
Hallucinogenic [drugs]	Drugs that distort perceptions of reality, either found in plants and mushrooms (or their extracts) or man-made, such as lysergic acid diethylamide (LSD)
Heroin	An opiate drug (also called diamorphine)
HMI Prisons	Her Majesty's Inspectorate of Prisons

IDTS	Integrated drug treatment system – joint initiative by the Department of Health, Home Office, Ministry of Justice and National Offender Management Service to provide continuity of care for offenders between prison(s) and the community
Illicit/illegal [drugs]	'Illicit' means 'forbidden by law, rules or custom', whereas 'illegal' means 'forbidden by law (especially criminal law)' (www.Oxforddictionaries.com; last accessed 18 March 2014)
Illicit drug classification	Under the Misuse of Drugs Act 1971, illegal drugs are placed into one of three classes – A, B or C – broadly based on the harms they cause either to the user or to society when they are misused. Drugs controlled under the Misuse of Drugs Act are illegal to have, produce, give away or sell. Class A drugs are considered likely to cause the greatest harm, and attract the severest penalties related to offences involving these drugs. ***Class A drugs:*** Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth). **Penalty for possession:** Up to seven years in prison, an unlimited fine or both. **Penalty for supply and production:** Up to life in prison, an unlimited fine or both. ***Class B drugs:*** Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), specified synthetic cannabinoids, synthetic cathinones (e.g. mephedrone, methoxetamine). **Penalty for possession:** Up to five years in prison, an unlimited fine or both. **Penalty for supply and production:** Up to 14 years in prison, an unlimited fine or both. ***Class C drugs:*** Anabolic steroids, benzodiazepines (e.g. diazepam), gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat. **Penalty for possession:** Up to two years in prison, an unlimited fine or both (except anabolic steroids – it is not an offence to possess them for personal use). **Penalty for supply and production:** Up to 14 years in prison, an unlimited fine or both. ***Temporary class drugs*:** The government can ban new drugs for one year under a 'temporary banning order' while they decide how the drugs should be classified. Five compounds relating to methylphenidate, a Class B drug, were banned from 10 April 2015. **Penalty for possession:** None, but police can take away a suspected temporary class drug. **Penalty for supply and production:** Up to 14 years in prison, an unlimited fine or both
IP	'In-possession' – when a prisoner keeps their prescribed medication in their cell
Legal 'highs'	Substances that are not prescribed or illegal but which give users a 'high' similar to that induced by those types of substances. They are not controlled under the Misuse of Drugs Act, but it is considered illegal under current medicines legislation to sell, supply or advertise them for 'human consumption'. To get around this, sellers refer to them as 'research chemicals', 'plant food', 'bath crystals' or 'pond cleaner'. Generally, the term 'legal high' is now largely avoided as it can give a false impression of safety and the testing of so-called legal highs has shown that many contain illegal substances
Maintenance	Prescribing a stable dose of methadone or buprenorphine for an individual with a physical dependence on opiates over a sustained period, often while they address underlying social, physical or mental health issues and with psychosocial support
MDT	Mandatory drug testing – to identify and measure (and therefore tackle) illicit drug taking in prisons
Methadone	A synthetic opiate drug used to treat opioid dependence since the mid-1960s. It can be given orally once daily
Methcathinone	A stimulant drug

Mephedrone	Also known as 4-methylmethcathinone (4-MMC) or 4-methylephedrone, this is a synthetic stimulant drug of the amphetamine and cathinone classes. Slang names include drone, M-CAT, White Magic and meow meow. It is chemically similar to the cathinone compounds found in the khat plant of eastern Africa. It comes in the form of tablets or a powder, which users can swallow, snort or inject, producing similar effects to MDMA, amphetamines and cocaine. It was first synthesised in 1929 but was rediscovered in 2003; by 2006, it was reported to be available for sale on the internet and was very prevalent in the UK by 2010. Synthetic cathinones, including mephedrone, have been controlled as Class B substances since 2010. Mephedrone has been the most prevalent of the NPS reported but still represents a very small proportion of illicit drug use and appears to have reduced in popularity in many areas since its peak in 2010. The NPS Review Expert Panel September 2014 reported that it is likely that mephedrone use has fallen owing to a number of factors, such as control, a growing awareness of harms, and increased purity and availability of drugs such as ecstasy
Morphine	See 'Opiates'
Narcotics	Psychoactive compounds with sleep-inducing effects, but now commonly refers to opioids or, more generally, illegal substances
NDTMS	National Drug Treatment Monitoring System – collection, reporting and consolidation of drug treatment data to understand outcomes
NTA	National Treatment Agency for Substance Misuse. Now part of Public Health England
OASys	Offender assessment system – used by the Prison Service and Probation Service to measure the risks and needs of criminal offenders under their supervision
Opiates; opioids	Drugs with effects similar to opium. They stimulate opioid receptors in the brain and nervous system. They are used for pain relief and include codeine, morphine, buprenorphine and diamorphine (heroin) but can be used to 'get high' and can easily become addictive
OST	Opioid substitution therapy/treatment – the medical process of substituting an illegal opioid drug (e.g. heroin) with a less 'euphoric' opioid, under medical supervision
PPO	Prisons and Probation Ombudsman – investigates complaints from prisoners, people on probation and immigration removal centre detainees
Pregabalin	Prescription-only drug to treat epilepsy, pain from damage to nerve tissue, and anxiety
Psychoactive substance	A chemical substance that acts on the central nervous system to alter brain function – perception, mood, consciousness, cognition and behaviour
Psychosocial support	Refers to a wide range of support interventions that may be offered to an individual to address physical and psychological dependence in addition to any prescribing support. It may include support at different levels of intensity, reflecting the severity of the disorder or previous experience of treatment. It can be delivered by staff or peers as one-to-one or group sessions. It also often includes practical support and strategies to address social needs, increase confidence and build a positive social support network
PHE	Public Health England.
Security categorisation in England and Wales	Sentenced male adult prisoners aged 21 or over are given a security category. These categories are based on a combination of factors, including the type of crime, length of sentence, likelihood of escape and danger to the public if they should escape. The categorisation can go up

	or down during a sentence, based on assessed risk. There are four categories – A, B, C and D, with A being the highest category and D the lowest. The level of security in a prison is directly linked to the category of prisoner that the prison can hold, so category D (also known as 'open') prisons have little physical security such as perimeter walls and razor wire. Open prisons are an important part of reintegration into the community. Sentenced women are classified into three main categories: restricted status, which is similar to category A for men; closed, which is for women who do not require restricted status but for whom escape needs to be very difficult; and open, which is similar to category D for men. Additionally, women can be exceptionally categorised as category A. Sentenced young adult males (18–20) have the same categories as women
Sedatives	See 'Tranquillisers'
Sleepers	Tablets taken to induce sleep
Spice	A popular form of synthetic cannabis
Stabilisation	Initial phase of drug treatment, where the focus is on getting the client stable on a suitable dose of opiate substitution treatment (methadone or buprenorphine) that keeps them engaged in treatment without the need to supplement with other drugs. It includes psychosocial support
Stimulants	Include methylone, mephedrone and methcathinone
Strip-search	A search involving the removal of more than outer clothing
Suboxone	See 'Buprenorphine'
Subutex	See 'Buprenorphine'
Synthetic cannabis	Chemicals made to act like the active part of cannabis, a substance called tetrahydrocannabinol (THC), but are often much stronger. Their short- and long-term adverse effects are not fully known but experts predict that they have the potential to be more harmful than cannabis. Their effects are likely to be similar to those of cannabis – some users will feel happy and relaxed, and they may get giggly, feel hunger pangs and become talkative; others, however, may feel ill or paranoid. Synthetic cannabinoids are usually sold in herbal smoking mixtures but are available as a liquid. A large number of the compounds are now Class B controlled substances and it is impossible to tell what is in the mixture unless it is analysed
Tolerance	A decrease in the effect or response to a drug that occurs with continued use, so that increased doses are required to achieve the effect previously obtained with a lower use
Tramadol	Opiate-based painkiller
Tranquillisers	Sedatives. Drugs that induce periods of calmness, relaxation and sleep, and are therefore used to treat anxiety and insomnia. Available on prescription only

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Annex

Diverted medications

Synthetic cannabis

DIVERTED MEDICATION

What is diverted medication in a prison setting?

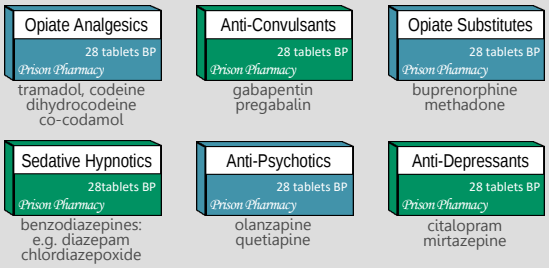
Medication is said to have been 'diverted' if it is in the possession of, or is taken by, someone other than the person for whom it was prescribed; or is in anyone's possession following supervised consumption or is outside the time-frame stipulated on the prescription

Medications (meds) that are commonly diverted (or traded) in prisons tend to be those that treat pain and/or have a mood altering effect

What are the effects of using diverted meds?

- Sedation
- Lack of coordination
- Depressed respiration
- Altered states of consciousness
- Gastrointestinal complaints
- Changes in blood pressure
- Changes in heart rate
- Interactions with other drugs and alcohol
- Potentiation of other drugs (increased effects)
- Tolerance and dependence
- Withdrawal e.g. anxiety, insomnia, seizures etc.
- Poly drug use - (taking 2 or more drugs together or sequentially) has been associated with deaths in custody

Which kinds of medication are most commonly diverted?



How is medication diverted?

Meds diverted in the community are **smuggled** in by arriving prisoners, visitors, prison staff, or thrown over prison walls

Meds are '**palmed**' - i.e. not swallowed during 'see-to-take' at meds hatches but are passed to another prisoner or taken away for later sale or use

Meds are swallowed by prisoners at the meds hatch and then later **regurgitated** & sold or given to others

Meds legitimately given to prisoners **in possession** may be sold or taken from them by theft or threats

Who diverts medication?

Some prisoners willingly sell their meds

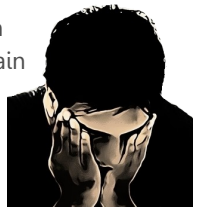
Bullies take meds from others by theft or threats

Some prisoners fake symptoms to get meds

Why take diverted medication?

Diverted meds are used to self-medicate:

physical pain
emotional pain
anxiety
stress
depression



sleeplessness
boredom
dependency
other health problems

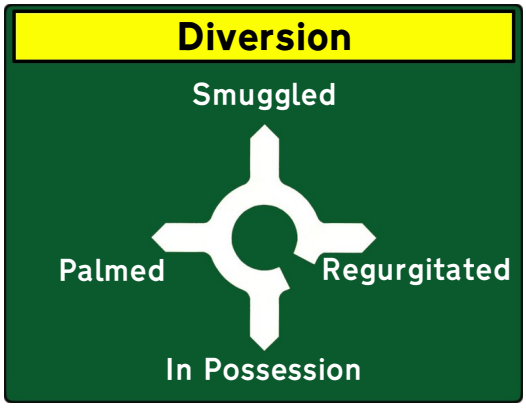
What are the effects a diverted meds problem on prison life?

Prescribers may be threatened to prescribe what prisoners want

Destabilisation of prison safety through debt, bullying, violence, self-harm or prisoners seeking segregation &/or transfer to avoid trouble

Some prescribers may overreact when prisoners fake symptoms by refusing to prescribe medications needed by other prisoners in genuine pain

When meds diversion is a problem, already limited officer resources have to be used to conduct searches & tests & supervise meds hatches



SYNTHETIC CANNABIS

What is synthetic cannabis?

Part of a broad group of drugs originally known as 'legal highs'; and now generally referred to as New (or Novel) Psychoactive Substances (NPS).

Synthetic cannabis (SC) is illicitly made to mimic the effects of the psychoactive ingredient of natural cannabis: Tetrahydrocannabinol (THC). SC is sprayed on to dried herbal matter or paper.

Two specific SC products have become popular: 'Spice' and 'Black Mamba'. These two names are now the most commonly used generic names for SC. The choice of which of the two names is used appears to be regional, but Spice is the most widely used name.

What are the effects of using Spice?

- Slurred speech
- Red eyes
- Sweating
- Vomiting
- Increased heart rate
- Loss of control & balance
- Psychotic episodes, paranoia
- Agitation, anxiety
- Panic attacks, amnesia
- Seizures, death

How does Spice get into prisons?

Spice can be **smuggled** into prisons by:

- newly arriving or transferred prisoners
- visitors
- corrupt staff

Spice also comes **over prison walls** by:

- associates of prisoners using catapults
- and even flying drones over walls to deliver Spice

How is Spice used?

Spice is normally smoked in a hand rolled cigarette

Because of widely varying strengths of Spice, the effects are very unpredictable. Some prisoners make others try a spice batch to determine the strength
This is called taking the 'Spice Challenge' or using a 'Guinea Pig'.
This practice is often used as a way to pay off debts



Who uses Spice?

Regular users of other drugs

Dependent Spice users

Experimental Spice users

Some have a good experience, but many do not

Some do not know they are smoking Spice until the side-effects start

Why is Spice used more than cannabis?

It is not detected by existing Mandatory Drug Tests (MDT)

Changing ingredients makes its legal status uncertain

It often smells like incense, which is permitted in prisons

It only takes a small amount to have a large effect

What are the effects of a Spice problem on prison life?

Healthcare staff are often called to medical emergencies when prisoners use Spice. This reduces healthcare capacity to provide care to other prisoners

Destabilisation of prison safety through debt, bullying, violence, self-harm or prisoners seeking segregation &/or transfer

When multiple prisoners have acute medical symptoms, local community emergency services can be put under huge strain, leaving the community with reduced ambulance cover

Whenever a prison has a drug problem, already limited officer resources have to be used to conduct searches & deal with violence and medical emergencies

How big is the Spice problem

According to the Prisons and Probation Ombudsman (PPO), the use of NPS including Spice, was a factor in at least 19 prisoner deaths between 2012 and 2014

The National Offender Management Service (NOMS) has said that addressing the *increasing use of synthetic drugs and the increase in violence and serious assaults linked to this* is a key target for the Prison Service in 2015-16