Coming Clean

Combating drug misuse in prisons

Max Chambers

Coming Clean

Combating Drug Misuse in Prisons

Max Chambers

Policy Exchange

About the Author

Max Chambers joined Policy Exchange in February 2009 and is a Research Fellow in the Crime and Justice Unit. Before joining Policy Exchange, Max worked as a researcher for the Shadow Justice and Home Affairs teams in the House of Commons and was involved with a number of the Conservative Party's crime and justice policy reviews. He graduated in 2007 with an LLB (Hons) from the University of Nottingham and is currently studying for an MA in Public Policy at Kings College London. This is the fifth report he has authored for Policy Exchange.

Published by
Policy Exchange, Clutha House, 10 Storey's Gate, London SW1P 3AY
www.policyexchange.org.uk

ISBN: 978-1-906097-77-6

Printed by Heron, Dawson and Sawyer
Designed by SoapBox, www.soapboxcommunications.co.uk

Contents

Acknowledgements

Policy Exchange thanks Serco for its generous support for this project.

We would also like to thank all those prison governors, prison officers, healthcare staff, civil servants and the hundreds of prisoners who took the time to speak to us for this report.

Executive Summary

It is an open secret that our prisons, traditionally thought of as secure institutions, are awash with drugs. The easy availability of drugs in prisons undermines treatment programmes, allows prisoners to maintain anti-social habits during their sentence, and leaves them unprepared for release and primed to reoffend.

What is less widely known is how drugs worth an estimated £100 million really get in to prisons, and what really goes on inside prisons in an effort to get inmates off drugs and prepared for release.

There is no doubt that significant additional funding was provided during recent years by the previous Government, attempting to both reduce the supply of drugs and to reduce demand for them through engaging prisoners in treatment programmes.

However, this report contends that there are a series of fundamental problems with the way these issues are approached – and that despite repeated warning signs, the Prison Service appears destined to continue down the same failed path.

Following extensive consultation with senior figures involved in tackling the problem of drug misuse in prisons, this report outlines a series of recommendations which would make a real difference in helping prisoners to get off – and stay off – illegal drugs.

Problems with efforts to reduce the supply of drugs

- The Prison Service has a huge problem with corrupt staff. But their role in smuggling drugs and mobile phones is significantly misunderstood and inadequately analysed. This report contends that the majority of drug-dealing within prison is highly-organised and involves the collusion of around 1,000 corrupt members of staff – around seven prison officers per prison. They are able to smuggle drugs due to lax security arrangements and, given the inflated value of drugs in prison, are able to make substantial profits without fear of detection. A prison officer bringing a gram of heroin into prison every week (about the size of two paracetamol tablets) could expect to more than double his basic salary.
- Although the Serious Organised Crime Agency (SOCA) appears to understand the scale of the threat from corrupt staff, the Prison Service and the National Offender Management Service (NOMS) appear completely unwilling to get a grip. Accusations of corruption are not routinely investigated and information on the number of officers accused, charged, prosecuted or convicted of smuggling drugs or other contraband is apparently not collected at all by central government. The previous Government stated that to find out would incur disproportionate cost. It is difficult to imagine how finding out how many members of staff are involved in illegal corruption, putting the safety of colleagues and the public at risk, could possibly involve disproportionate cost.

- The Blakey Review, commissioned by the Justice Secretary in 2007 to make recommendations on restricting supply, represented an enormous missed opportunity to make any real progress on this issue. It contained assumptions that social visits, mail and prisoners returning from court are the main smuggling routes for drugs. But there is no evidence to suggest that these are the predominant routes. In fact, smuggling attempts along these routes tend to be small-scale and ham-fisted. Less than one in a thousand visits take place in closed conditions, and despite all the investment in technological solutions such as CCTV, body orifice scanning equipment and sniffer dogs, the number of drug seizures along these routes is still extremely low.
- The best way to measure the prevalence and effectiveness of the various smuggling routes would be for the Prison Service to analyse the type of drugs entering through the various routes and the *quantity* of drugs which are brought in along those routes. But incredibly, no such analysis takes place.
- One of the key policies for reducing the number of prisoners on drugs – Mandatory Drug Testing (MDT) – is badly flawed. The fact that prisons are required to meet a certain target for the number of positive tests – and the fact that the overall performance of the prison is partly judged according to how low this figure is - disincentivises staff from building up a true picture of the scale of drug misuse. Prisoners and the public need fair, accurate and workable testing regimes.
- The number of prisoners using drugs is hugely underestimated. MDT figures indicate that just 7.7% of prisoners are using drugs, but a survey of prisoners conducted for this report puts the figure at 35%, with 16% using drugs at least once a week – equivalent to around 14,000 prisoners.
- The problem of smuggled mobile phones will only intensify as technology improves and handsets become smaller. In 2008, 8,847 mobile phones and SIM cards were seized (one for every ten prisoners) and the Prison Service admits that this is an understatement of the actual number of finds because of poor reporting practices. The Prison Service should recognise however, that these phones serve a predominantly social function – due to the fact that access to phones on prison wings is so restricted. Until the problem of wing phones is addressed, it will be difficult to get a grip on the issue of mobile phone smuggling.

Recommendations to reduce the supply of drugs

Increase the budget of the Corruption Prevention Unit by £5 million: Currently able to be little more than a policy and research directorate, the extra resources will enable the unit to run targeted tactical operations and investigations in conjunction with the police. There is plenty of intelligence as to the identities and whereabouts of corrupt staff and organised prison drug-dealers, but little resources to take it forward. Corrupt officers need to be rooted out, prosecuted and convicted. This enhanced body will be able to make much more significant in-roads into tackling the estimated 1,000 corrupt prison staff.

Scrap Mandatory Drug Testing and replace it with a system of 'Prevalence Testing': This would involve quarterly testing of at least 50% of the entire population of

each prison (which could easily be achieved with existing resources). These anonymised results will establish a new baseline against which future progress can be judged in the future. Much higher levels of illicit drug-taking will be revealed, giving a true picture of the scale of the problem in each prison

Compel the Prison Service to properly analyse how drugs really get into prisons: The Prison Service should collect information from every prison on the quantity, weight and types of drugs seized in every prison; the location of the seizure, which will, by implication, give an indication of the smuggling route; and the method by which the seizure was made, giving an indication of the effectiveness of the Government's investment in various security measures. Where possible, the Prison Service should also obtain intelligence and data to analyse the size and type of prison drug markets. Such information would include the price and purity of seized drugs, including prison-to-prison and regional variations.

A two-pronged strategy to curb the use of mobile phones: Mobile phones are not, in the main, used for nefarious purposes. The Ministry of Justice should encourage much more use of in-cell telephones for prisoners (and should include the technology in future building and operating contracts). Based on the existing PIN-phone system (whereby prisoners are only allowed to call a limited number of vetted contacts) in-cell phones would be much easier to police than trying to intercept mobile communications. The key benefit is that the prison would now have complete control over outgoing communications. This should go hand-in-hand with a comprehensive strategy to crack down on, and eliminate, mobile phone use through the use of mobile phone signal blocking technology. In prisons with in-cell phones, there would be no need whatsoever for prisoners to use smuggled mobile phones, except for criminal purposes.

Problems with efforts to improve drug treatment

- Drug treatment policies aimed at getting prisoners off drugs have been too readily influenced by the threat of litigation. This has led to a dramatic increase in the use of opiate substitutes such as methadone.
- Methadone, along with similar drugs, are also being prescribed too easily by prison healthcare. This is due to a combination of risk-averse clinical guidelines (in part due to fear of litigation) and inexperienced prescribers. Perversely, the massive increase in opiate substitute medication has also created a new kind of trade for drugs in prisons, as methadone and buprenorphine are readily traded amongst inmates.
- The line between prisoners who are 'detoxified' and those who are 'maintained' on methadone (and similar drugs) has become blurred. In fact, as a letter from the Department of Health to Policy Exchange has confirmed, the vast majority of the 45,000 prisoners who are undergoing detoxification programmes are in fact undergoing 'gradual reduction' prescriptions which routinely last for 12 weeks, and often longer. Only a tiny fraction of prisoners undergo a detoxification programme lasting just a few weeks. This is not 'detoxification'; in reality, this serves as another form of maintenance because prisoners are not getting drug-free during their sentence.

- Clinical guidelines for the treatment of prisoners do not take account of the appropriate relationship between the type of treatment given and the length of sentence a prisoner is serving. Maintenance treatment should only be given to prisoners serving 13 weeks or less (i.e. a 26 week sentence or less – as prisoners are let out at the half-way point). However, this has not been happening, and it has become normal for prisoners who have been receiving methadone in the community to simply be maintained on arrival to prison, regardless of sentence length. This is wrong – the guidelines should properly reflect the fact that a prison sentence is an opportunity to get drug-free. Recent 'clarifications' to the guidance by the Department of Health will not change this situation.
- As a result of these problems, we conservatively estimate that one in six prisoners at any one time is receiving daily doses of methadone (or buprenoprhine). This is equivalent to 14,000 prisoners – and the true figure is likely to be even higher, since our Freedom of Information requests made to individual prisons have suggested figures as high as 20-25%. By 2011, when the Integrated Drug Treatment System is fully rolled out to all prisons in England and Wales, an additional 8,788 prisoners a year will be receiving methadone maintenance treatment, rather than being weaned off their habit.
- Psychosocial treatment and case management teams are characterised by bureaucracy, box-ticking and poor targeting of addicts. The distribution of programmes is illogical and too much money is spent on low-threshold, low-intensity programmes which are unlikely to make any real difference to severely dependent addicts with ingrained lifestyles. There is also a lack of end-to-end management of treatment, with poor transitional provision for prisoners who are released to Criminal Justice Intervention Teams (CJITs).

Recommendations to improve drug treatment

A proper balance between the use of opiate substitute drugs and the need to get prisoners drug-free: The guidance on detoxification and maintenance must be strengthened in favour of a more abstinence-based approach. The current guidance says that longer-term prisoners "*can be encouraged to use their time in prison to achieve abstinence*" and that "*this option should be discussed*". Instead of merely being encouraged, this should be mandated. Prisoners should not be in a position to dictate their own drug treatment; longer-sentenced prisoners should be expected to work towards being drug-free and this should be a condition of their parole.

As the use of prescriptions falls due to the new guidance, the future budget of the Integrated Drug Treatment System should be cut by £10 million, as the system is rolled out across the rest of the prison estate. The savings should be allocated towards abstinence-based treatment programmes and increasing the budget of the Corruption Prevention Unit.

More money for psychosocial programmes: The Government should redirect approximately £25 million of the £34.2 million currently spent on case management through CARAT (Counselling, Assessment, Referral, Advice and Throughcare service) teams into a new model of end-to-end offender management. The new model

would see CJITs and CARATS form one integrated drug treatment team based on an in-reach model, ensuring better throughcare. The £10 million saved should be spent on psychosocial programmes.

More sensible distribution of psychosocial programmes: With the expanded budget for psychosocial programmes of £45 million, the distribution of psychosocial programmes should be organized so that each local prison has a short duration motivational enhancement programme that is focused on motivating and initiating recovery, and moving participants on to second stage treatment. In addition, each training, female or high security prison should have an intensive programme, with a mixed market of therapeutic community, or 12-step models.

1
The Scale of Drug Misuse in Prison

In August 2007, it was reported that a recovering heroin addict absconded from an open prison to escape the drug-taking culture among inmates. Shaun Melfah, who had managed to become drug-free while serving his sentence, was so concerned that he might succumb to the temptation of freely-available drugs that he risked the near-certainty of another prison sentence for absconding, simply to ensure that he remained drug-free.[1]

Keeping drugs out of prisons, while simultaneously reducing demand for them, is a difficult task. A successful strategy for reducing drug misuse and the reoffending rates of addicted offenders requires intelligent targeting of those who are smuggling drugs into prisons and a sensible drug treatment strategy which gives addicts the best possible chance of getting drug-free. This report will set out a series of steps which need to be taken if these goals are to be met.

Official Government statistics

Building up an accurate picture of the scale of drug misuse in the prison system is a fundamental prerequisite for addressing it. But there are wildly conflicting figures about the extent of the problem. The preferred measurement of the previous Government was through figures produced by random Mandatory Drug Testing (MDT), whereby a small proportion of a prison is tested at random each month. According to the Prison Service, "*this provides the most accurate indication of the level of drug-misuse in prisons.*"[2] MDT would indicate that just 7.7% of prisoners take illicit drugs while in prison. This represents a decline of 68 per cent since 1996/97, when 24.4% of random tests were positive.[3] This decline, according to the previous Government, demonstrated the Prison Service's "*considerable success in reducing the level of drug misuse*".[4]

However, other government studies have indicated much higher levels of drug misuse:

- A 2006 report found that 40% of all prisoners used CARATs (Counselling, Assessment, Referral, Advice and Throughcare service), a drug treatment service available across the entire prison estate.[5] According to a commentary, this figure "*illustrates just how widespread drug problems are amongst the prison population in England and Wales.*"[6]
- A Home Office survey of six prisons undertaken in 2005 estimated that 60% of inmates had used heroin at one local prison, with cannabis use as high as 70% in another prison.[7]

1 *Former addict fled open jail to escape the drugs*, Daily Mail, 16th August 2007

2 Prison Service Order 7100, Key Performance Indicators, Key Performance Targets and additional measures: Sources and Calculations Guidance Notes 2006 – 2007, 18th October 2006

3 National Offender Management Service, Annual Report 2008/09

4 WPQ, Commons Hansard, Column 503W, 23 Feb 2010

5 Chris May (2005), *The CARAT Drug Service in Prisons: Findings from the Research Database*, Findings 262. London: Home Office, Research, Development and Statistics Directorate

6 A profile of those that use the CARAT drug service in prisons, Probation Journal 2006; 53; 176

7 Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05

- Other government reports have estimated that up to 55% of new receptions to prison are problematic drug users (PDUs), the majority of whom will be short-sentenced prisoners (i.e. sentenced to less than twelve months).[8]

As long as there is no robust measure of the scale of drug misuse within the prison system, there is little hope for either tackling the problem effectively, or assessing the success (or otherwise) of the previous Government's policies.

Policy Exchange Survey

To provide a new assessment of the scale of drug misuse, Policy Exchange has conducted one of the largest independent surveys of prisoners ever undertaken in England and Wales.

While it is inherently difficult to make a written survey representative of the prison population (not least because, according to official figures, 48% of prisoners have reading and writing skills at or below Level 1),[9] the results strongly indicate that drug misuse is much higher than figures produced by MDT would suggest:

- 35% of prisoners – or around 30,000 prisoners - have used drugs in prison.
- More than a fifth of prisoners have used heroin in prison
- Around 14,000 prisoners use drugs at least once a week

If you have been tempted, did you end up using illegal drugs (while in prison)? (%)	
Yes	35%
No	24.7%
Never tempted	41%
What drugs did you use? (%)	
Cannabis	30%
Heroin	21.5%
Ecstasy	0.5%
Amphetamine	0.3%
Cocaine	10%
How often do you use illegal drugs? (*% of drug users*)	
More than twice a week	30%
About once a week	16%
About once a fortnight	5%
About once a month	6%
Less than once a month	43%

8 First Report of Session 2004-05, Rehabilitation of Prisoners: The Government's response, March 2005

9 Social Exclusion Unit Report 'Reducing re-offending by ex-prisoners', July 2002

2
Tackling the Supply of Drugs

The evidence and research in this report demonstrates that the Prison Service's strategy for tackling the supply of drugs into prisons is failing for four important reasons:

- The number of prisoners taking drugs is hugely underestimated;
- There are many assumptions but a shocking lack of real information about how drugs enter prisons;
- It is likely that the issue of staff corruption is significantly underestimated; and
- The recommendations of the previous Government's major study on the issue will make little difference.

The availability of drugs in prison

A wide variety of official sources all confirm the easy availability of drugs in prison. A 2009 report by Her Majesty's Chief Inspector of Prisons reported that "*in local and high security prisons, inspection surveys showed that over a third of prisoners reported that it was easy to access drugs in prison – and in some it was nearer a half.*"[10] The Blakey Review also stated that "*certainly substantial amounts of all types of drugs do get into prisons*".[11]

The survey conducted for this report concurs with these findings: 85% of prisoners reported that they could get hold of drugs should they want to, with almost half reporting that they were easily available.

Thinking about your prison, how easily available would you say that illegal drugs are? (%)	
If I wanted to get hold of drugs, I could do so easily	44.2%
If I wanted to get hold of drugs, I could probably do so	28%
If I wanted to get hold of drugs, I could do so but with some difficulty	12.5%
It would be very difficult for me to get hold of drugs	15.2%

Source: Policy Exchange survey, conducted December 2009 – January 2010

A former National Offender Management Service (NOMS) Drug Strategy Coordinator has estimated that the value of prison drug markets may be as high as £100 million per year. How does such a vast quantity of drugs get into prisons?

10 HM Chief Inspector of Prisons for England and Wales, Annual Report, London: HM Inspectorate of Prisons, January 2009

11 Disrupting the supply of illicit drugs into prisons: A report for the Director General of National Offender Management Service by David Blakey CBE QPM DL, July 2008

Smuggling routes

There are a number of commonly-cited ways in which drugs get into prisons:

- drugs coming over the wall and being "fished up" by prisoners;
- drugs coming in through visits (both personal and official);
- drugs coming in through the post (including official letters or those masquerading as official);
- drugs coming in through those returning to prison from the courts or on reception to prison;
- drugs coming in through corrupt staff.[12]

However, there is very little comparative evidence about how much the various routes are used and how effective they are for smuggling. Just one government study has ever undertaken any analysis of the prevalence of different trafficking routes for illegal drugs. This took the form of a 2005 Home Office qualitative study, *Tackling Prison Drug Markets*, in which 158 prisoners, ex-prisoners and staff were asked to identify the main smuggling routes.

Route of supply	Prisoners/ex-prisoners identifying route	Prison staff identifying route	Total identifying route
Social visits	97.5%	92%	95.5%
Mail	72.7%	59%	70%
New receptions	60%	62%	60%
Prison staff	46%	54%	48%
Over perimeter wall/fence	30.5%	73%	40.5%
Reception after court visits	17.3%	16%	17%
Total no. of interviewees	121	37	158

This would indicate that social visits, mail and new receptions are the three main ways that drugs get into prisons. The survey conducted for this report also suggests that visits and new receptions after court visits predominate.

Our survey did not include an option for prisoners to name prison officers or staff as the main way that drugs get into prisons. But, without even specifying this as an option, 23% of prisoners wrote that prison officers or other staff were the main supply route for illegal drugs. This suggests that if we had been in a position to specify this as an option, far more would have identified this as a route.

What do you think is the main way that drugs get into prisons? (%)	
Visitors	52.6%
Prisoners arriving in prison for the first time	35%
Over the wall	23.4%
Prisoners returning from court	11.7%
Post and parcels	9%
Other, please specify	31.6%

12 Djemil, H, *Inside Out: How to get drugs out of prisons*, Centre for Policy Studies, June 2008

The current strategy

The Prison Service has a number of measures to reduce the supply of drugs in prison, including:

- passive and active search dogs (around 440 in total); with passive dogs available to all prisons for use during visits. Active dogs are used to search all prison areas including cells, vehicles and goods;
- CCTV surveillance of all social visits' areas and low-level fixed furniture in Category C prisons and above;
- comprehensive measures to tackle visitors who smuggle or attempt to smuggle drugs – closed visits, visit bans and police arrest;
- Mandatory Drug Testing – each year around 60,000 random and 40,000 targeted tests are undertaken;
- intelligence systems – including monitoring of telephone traffic through the PIN-phone system;
- working with police – targeting serious criminals outside who are increasingly involved in supply – each prison has access to a Police Liaison Officer;
- deployment of mobile phone detectors, trials of mobile phone signal blockers and analysis of recovered phones;
- use by all prisons of the Supply Reduction Good Practice Guide, enabling effective measures to be replicated nationwide;
- clearly-defined searching policies in accordance with National Searching Strategies.[13]

The Blakey Review

David Blakey was commissioned to conduct a review by the Director General of the National Offender Management Service (NOMS) as part of a drive against drugs announced in a prison policy update by the previous Government in January 2008.

The purpose of the review was to make recommendations on how to improve the effectiveness of the Prison Service's measures for disrupting the supply of illegal drugs into prisons and whether any additional measures might be possible. The review consisted of visits to various establishments, contact with interest groups, meetings with internal stakeholders and a review of the relevant literature.

The review was completed in 40 days by Blakey; there was no research team, no research commissioned and not a single prisoner was spoken to as part of the review.

The report's recommendations were undoubtedly germane to the issues, but none got to the heart of the problem. Discussions with various officials involved with the Prison Service have underlined a number of problems with the report, including a lack of real analysis, a series of undemanding recommendations and the fact that they are extremely unlikely to make any perceptible difference.

Blakey recommended the following:

- A nominated senior governor should lead the Drug Strategy for each prison
- An update to a 2003 document outlining good practice for reducing drug supply
- The monitoring of new legislation and a commitment to working with others

13 Prison Policy update briefing paper, Ministry of Justice, January 2008

- The establishment of an R&D department within the Prison Service to enhance the use of technology;
- The fostering of intelligence and a review of the rules relating to legally privileged documents;
- An internal review of prison dogs policy; and
- The installation of Body Orifice Security Scanner (BOSS) chairs across the prison estate and further work on mobile phone signal blocking

Government progress in implementing Blakey's recommendations

Despite the relatively undemanding nature of the recommendations, the previous Government appears to have made little progress in implementing those measures which did not relate to work which was already ongoing.

Eighteen months on, the Ministry of Justice has yet to implement a review of prison dog policy,[14] is yet to publish revised guidance on intelligence gathering and sharing,[15] and has reviewed the operation of legally privileged documents but decided to make it *more* difficult for staff to intercept correspondence.[16] The previous Government had not updated the Supply Reduction: Good Practice Guide document either. In fact, Ministers refused to publish the guide, arguing that it would provide significant intelligence to those who would wish to smuggle drugs into prisons.[17] This, of course, ignores the fact that prison staff – themselves responsible for supplying contraband into prisons – have access to the document.

14 Commons Hansard, 10 February 2010, column 1080W

15 Commons Hansard, 26 February 2010, column 796W

16 Commons Hansard, 10 February 2010, column 1078W

17 Commons Hansard, 10 February 2010, c1081W

3
Problems with the Prison Service's Approach

There are a number of problems with the Prison Service's strategy. Some of these were identified by Blakey but no solutions were proposed. Others have been identified for this report through consultation with senior officials involved in the sector, visits to various secure establishments and following a thorough literature review.

Mandatory Drug Testing (MDT)

The first problem, as discussed above, is the issue of accurately measuring the scale of drug misuse within prison. Mandatory Drug Testing not only forms a central plank of NOMS' strategy to reduce the numbers of prisoners misusing drugs, but is also supposedly the most accurate way of measuring drug misuse.

A programme of MDT based on urine analysis was implemented in all prisons in England and Wales in March 1996. It involves testing:

- of a random proportion of prisoners in each prison each month;
- where there is suspicion of possession or use;
- as part of a frequent testing programme of prisoners already known to have a history of drug use;
- as part of normal risk assessment, for example in considering temporary release; and
- on reception to some prisons.

The stated aims of MDT are to:

- increase significantly the detection of those misusing drugs and to send a clear message to all prisoners that if they misuse drugs they have a greater risk of being caught and punished;
- help prisoners resist the peer pressure often placed on them to become involved in drug taking, due to the increased possibility of detection;
- help to identify prisoners who may need assistance to combat their drug problems with assistance offered to those who want it;
- provide, by means of the random testing programme, more accurate and objective information on the scale, trends and patterns of drug misuse, allowing prisons to manage and target more effectively their resources for tackling drug problems; and

- enable the proportion of prisoners testing positive for different drug types on the random testing programme to be used as one performance indicator of drug misuse.[18]

However, not only is MDT unreliable for a number of reasons, but more than this, it is now also unhelpful – actively hindering any strategy to restrict supply or help prisoners to recover from their addictions.

MDT rates are targets – not reliable indicators

The fact that prisons are required to meet a certain target for the number of positive tests – and the overall performance of the prison is partly judged according to how low this figure is – disincentivises staff from building up a true picture of the scale of drug misuse. The Key Performance Target (KPT) also discourages staff from addressing the various other problems associated with MDT (below).

MDT is open to abuse

The prison service is the only criminal justice or health system in the UK that still relies on urine testing (rather than mouth swabs). This causes problems because legal advice taken by the Prison Service has indicated that it would amount to inhuman or degrading treatment under the terms of the Human Rights Act for prison staff of the same sex to directly view the urine sample being given.[19] This allows the switching of samples to take place.

Her Majesty's Chief Inspector of Prisons has also implied that prison staff are abusing the MDT system, saying last year that "*some prisons were found to manipulate these (MDT) figures by excluding those prisoners who were subject to suspicion or frequent tests because they were considered most likely to use drugs. Other prisons did not disaggregate test results, disguising heavy usage in some areas.*"[20] This is clearly a direct consequence of the fact that MDT is treated as an artificial target instead of an accurate measure.

The Blakey Review conceded that "*there are sceptics both in and out of the Prison Service who will point out how this Key Performance Indicator (KPI) can be manipulated, and if a KPI can be manipulated in any organisation then it will be by someone, somewhere. Also those being tested have been known to attempt and sometimes succeed in beating the process by substituting their urine for a 'clean' sample.*"[21]

MDT is not truly 'random'

MDT is constrained by resources. Lower proportions of tests are performed at the weekend (just 14% of testing is mandated to take place at weekends)[22] and prisoners perceive they can minimise the risk of testing positive for opiate use by timing their use accordingly.[23] Once the system of testing becomes predictable, prisoners are able to get around it – particularly as opiates only remain traceable in urine for between 24 and 36 hours after use. The need to meet the KPT disincentivises staff from ensuring that testing is truly random.

18 Prison Service Order 3601, Mandatory Drug Testing, 6th March 2007 www.pso.hmprisonservice.gov.uk/PSO_3601_mandatory_drugs_testing.doc

19 Ibid.

20 HM Chief Inspector of Prisons for England and Wales, Annual Report, London: HM Inspectorate of Prisons, January 2009

21 Disrupting the supply of illicit drugs into prisons: A report for the Director General of National Offender Management Service by David Blakey CBE QPM DL, July 2008

22 HM Chief Inspector of Prisons for England and Wales, Annual Report, London: HM Inspectorate of Prisons, January 2009

23 Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05

MDT encourages the use of Class A drugs

MDT rates and punishments for a positive test make no distinction whatsoever between hard drugs and 'softer' drugs such as cannabis. This incentivizes the use of harder drugs which are more difficult to test for as they remain traceable for much shorter periods, especially compared with cannabis which can remain in one's system for up to a month.

> "MDT rates and punishments for a positive test make no distinction whatsoever between hard drugs and 'softer' drugs such as cannabis"

This was emphasised by a number of prisoners in response to this report's survey. In response to the question: "If there was one thing you would change about your prison to make drug rehabilitation better and to reduce the availability of drugs, what would it be?", one prisoner from HMP Maidstone replied "*mandatory drug testing has made heroin the number one problem – hard (Class A) drug is out of system in 3 days, cannabis takes up to 4 weeks to leave system! Which one do you take?*"

There is no distinction between hard and soft drugs

Over a decade ago, the Home Affairs Select Committee recommended the KPT used for addressing drug abuse be "*recast in such a way as to give greater emphasis to the fight against harder drugs; this could be done either by setting a target for harder drugs alone, or by setting a separate sub-target for harder drugs within the overall target.*"[24] One prisoner responding to the survey for this report argued that rehabilitation would be improved if the Prison Service were to "*discourage Class A drugs and soften the approach to cannabis.*"

However, the previous Government merely noted the Committee's view and the Prison Service apparently considered the creation of a more sophisticated target. Ten years on, no separate measure or target for opiate-positive rates of MDT has been adopted.

The use of opiate substitutes covers up illicit drug use

Drugs prescribed by prison healthcare, for the purposes of detoxification or maintenance, often take the form of opiate substitute medications such as methadone (this issue will be discussed more fully below). This is a huge problem for the reliability of MDT because it means that any positive tests for illicit opiate use invariably result in medical mitigations for positive tests. This allows prisoners to use illicit drugs 'on top' of their prescribed medication with no chance of being caught or punished. As this report calculates later, it is conservatively estimated that one in six prisoners are receiving opiate substitutes at any one time, meaning that for around 14,000 prisoners, MDT tests are almost completely useless.

High standard of proof required

An MDT test must contain more than a trace of drugs for a positive indication to be beyond reasonable doubt. This helps exclude contaminated samples and accidental positives, especially for longer-lasting drugs which may have been taken prior to imprisonment (such as cannabis and benzodiazepines). However, this standard of proof may result in under-reporting since some 'false' positives may in fact reflect custodial use.

24 Fifth Report of the Home Affairs Select Committee, Session 1998-99, Drugs and Prisons

The punishment for a positive test is no deterrent

A government review found that the overwhelming majority of prisoners and ex-prisoners who had ever used drugs in prison stated that the threat of punishment from a positive MDT did not deter them from using drugs.[25]

There was a general consensus that the deterrent effect of MDT had been reduced for two main reasons. First, a European Court of Human Rights ruling in 2002 led to the transfer of power to impose additional days, added to the end of a prison sentence, as a punishment from prison governors to independent adjudicators. This has meant a reduction in the use of additional days as a punishment. Second, prisoners have learnt a number of procedural and legal ways in which a positive test can be avoided or challenged, including refusing to do the test (which attracts a lesser punishment), or, as above, ensuring they are being prescribed opiate-based medication through healthcare (to cover illicit opiate use). Prisoners may also be released before the appeal process has been exhausted and a punishment can be imposed.

The survey conducted for this report reinforced the view that MDT does very little to discourage drug misuse, with most prisoners reporting a very minimal deterrent effect, and a significant majority stating that MDT did nothing to help people stay off drugs.

Do you think mandatory drug testing (MDT) helps prisoners stay off drugs? (%)

Yes	25%
No	64%
Don't know	11%

Policy Exchange survey, conducted December '09 – January '10

Is the punishment for a positive mandatory drug test a sufficient deterrent? (%)

Yes	17.6%
No	58%
Don't know	24%

Policy Exchange survey, conducted December '09 – January '10

If there was one thing you would change about your prison to make drug rehabilitation better and to reduce the availability of drugs, what would it be?

Male prisoner, 30s, HMP Gartree: "*stop drug testing people who do not take drugs and test the people who do. Forget about how many negative tests you need so the prison looks good and deal with the problem full on – short term it will look bad but in the long run the prison will come out on top.*"

Male prisoner, 40s, HMP Risley: "*the damage has been done by MDTs.*"

Male prisoner, 30s, HMP Albany: "*test inmates more regularly – not the non-users who don't take drugs in order to get better results!*"

25 Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05

A number of prisoners were openly critical of MDT in their responses to the survey. A common theme was that prisons were seen to be testing those inmates who did not take drugs in order to keep their MDT figures low.

A thorough review of the literature, coupled with extensive consultation with prisoners and prison staff, indicates that the system of MDT – a central plank of the fight against drug misuse – is failing. There is very little value in retaining the existing system and no value at all in retaining MDT rates as a Key Performance Target.

Recommendations:

The Government should abolish the mandatory drug testing regime. It should be replaced by a system of 'prevalence testing'. Prevalence testing should include the following elements:

- Quarterly, randomised testing of at least 50% of the entire population of each prison. The prisoners should be selected under a system designed to eliminate any possibility of the prison gaming the selection process. These anonymised results will establish a new baseline against which future progress can be judged;
- Compulsory testing on reception to prison for both sentenced and unsentenced prisoners (this is relatively common but is by no means mandatory);
- Compulsory testing every time an inmate leaves prison for transfer or on release; and
- The retention of testing 'on suspicion' (allowing prisons to retain the ability to punish prisoners who are openly misusing drugs) and the retention of voluntary testing.

Prevalence testing of more than half of an establishment's population will establish a new baseline against which progress can be measured in the future. Much higher levels of illicit drug-taking will be revealed, giving a true picture of the scale of the problem in each prison. This will also inform a local needs assessment, indicating how resources for treatment programmes and healthcare should be allocated across the prison estate.

Compulsory testing on reception and on release will allow for a more sophisticated measure of 'distance travelled' towards getting people off drugs and into recovery.

4
How do Drugs Get into Prisons?

The second major problem with the Prison Service's strategy is the astonishing lack of knowledge about how drugs get into prisons, compounded by a seeming indifference towards taking any steps to rectify this issue. Apart from a 2005 qualitative study involving just 158 prisoners and staff, there has been no other attempt to examine the different smuggling routes.

The Blakey Review highlighted good practice for disrupting supply for each of the known smuggling routes, but made no attempt to analyse the effectiveness or prevalence of the routes themselves. There was an assumption that social visits and legal mail dominate (as indicated by the Home Office survey), but, as this report will go on to contend, there is very little evidence to support this; in fact, the majority of drug-dealing in prisons is highly-organised and involves the collusion of corrupt staff who are incentivised to smuggle due to the potential for huge financial rewards and the negligible chance of being caught or punished.

> "The majority of drug-dealing in prisons is highly-organised and involves the collusion of corrupt staff who are incentivised to smuggle due to the potential for huge financial rewards"

Visitors

A typical prison visit will be arranged in advance and in the reception area are posters reminding visitors the penalties for drug smuggling. The visitors are 'airport' style searched and sniffed by a drug dog. They then go into a Visiting Hall where they will sit at a table with the prisoner they have come to see.

There are 3 or 4 Prison Officers in the room either at raised desks or walking around the Visits Hall. In addition, in a room next door is another Officer watching the tables on CCTV. When the visit is over the prisoners are searched before they go back to their cells.

A commonly-known method is for visitors to secrete a wrap of drugs in a body orifice (called 'plugging' or 'crutching') and, having been to the toilet to extract the wrap, pass it to the prisoner inside a plastic cup or crisp packet.

The Blakey Review stated that "*it might be thought that getting drugs into a prison through the visiting process must be a rare event. It is not. I have seen videos of visits showing sleight of hand worthy of a stage magician and I have no doubt that a significant amount of drugs get into prison with the help of visitors.*"[26]

26 Disrupting the supply of illicit drugs into prisons: A report for the Director General of National Offender Management Service by David Blakey CBE QPM DL, July 2008

Post and Parcel

The Blakey Review, like the 2005 Home Office study, also implied that the other route which predominates is that of legal mail. The Review stated that there is a particular issue with prisoners receiving confidential letters, and often bundles of documents, from their legal representatives. Under prison rule 39, it used to be the case that prison staff were not permitted to open this correspondence, unless the Governor of a prison had reason to believe that the package contained illicit material. Blakey noted that "*there is a strong feeling particularly amongst junior staff that the process is being abused*", because prisoners would receive the packages unopened, so long as there the envelope had 'RULE 39' written on it. Blakey warned that "legal staff or legal impostors could be smuggling drugs this way."

In its response to the Review, the previous Government committed to pursue a review of Rule 39 post and parcel, to maintain this privilege whilst preventing misuse. The Serious Organised Crime Agency (SOCA) has pledged that "*working with partners, including the Law Society, we will tighten procedures to identify and tackle abuse, whether by organised criminals, their associates, or bogus solicitors.*"[27] However, since this assurance was given, the previous Government in fact made it more difficult for prison staff to open correspondence which they suspect to contain illicit materials. Now, approval for interceptions must be given by the Chief Operating Officer of NOMS, rather than a Prison Governor.[28]

Are social visits and legal mail really the most prevalent smuggling routes?

Despite social visits and mail being identified by almost all respondents as the two major smuggling routes in the Home Office survey, the same study revealed that the principal way drug-using prisoners actually *obtained* drugs was to purchase them on their wing, or to be given them by a friend or cellmate (i.e. they did not receive them directly from visitors or through mail). This indicates that although prisoners are able to suggest potential routes when asked in surveys, they actually get their drugs from prison drug dealers.[29] Two-thirds of prisoners obtained their drugs through prison drug dealers, clearly implying that a small number of individuals within prisons have access to large amounts of drugs – smuggled in for them to sell to inmates.

Method of obtaining drugs	First drugs used (n=93)	Subsequent drugs used (n=87)
Purchased on wing	40	45
'Given' drugs by friends/cellmate	26	21
Imported drugs through reception	22	1
Received drugs through social visits	5	17
Mail	-	3

Source: Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05

The best way to measure the prevalence and effectiveness of the various smuggling routes would be for the Prison Service to analyse the type of drugs entering through the various routes and the *quantity* of drugs which are brought in along those routes. This is surely the key question: one route might be very good for

27 *Extending our reach: A Comprehensive Approach to Tackling Serious Organised Crime*, Serious Organised Crime Agency, July 2009

28 Commons Hansard, Column 1079W, 10th February 2010

29 How prisoners/ex-prisoners obtained their first and subsequent supply of drugs in prison (n=93), Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05

smuggling very small amounts through unnoticed, whereas others may allow for smuggling on a much larger scale.

One key way of measuring this would be to simply record the location of drug seizures, which would give a very strong indication of the smuggling route. But, incredibly, the Prison Service does not collect this information. As Blakey pointed out, "*one measure of drug availability in prisons might be the amount of drugs seized*", but that "*it is not possible to gauge this for the Service as the amounts seized are not collated nationally. Some are given to the Police for disposal, some are sent for analysis and some are destroyed. This is a pity as much intelligence and management information is potentially being lost.*"

The only information available is the number of seizures made of the different types of substances.[30]

Drug	Number of seizures (2008-09)
Heroin	776
Cocaine	262
LSD	3
Amphetamines	94
Barbiturates	11
Cannabis	1,731
Tranquilisers	32
Other	2,160
Total	5,069

Source: Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05)

Not only is the location of seizures (and, by implication, the smuggling route) not recorded, but the weight and quantity of seizures is not recorded. The previous Government revealed in a recent answer to a Parliamentary Question that "*there are no plans to record it*".[31] There is absolutely no good reason why this information should not be collected.

Information about how drug seizures are made is not collected either – for instance, whether seizures are attributable to drug dogs, searches of visitors or prisoners, CCTV, searches of cells or police intelligence.[32] All of this seems extremely odd; shouldn't the Prison Service and NOMS want to know how much contraband is being seized, where it is being seized, and by what methods? How else can a strategy for tackling the problem be devised, let alone progress be judged?

Apart from all the things NOMS and the Prison Services do not know, what conclusions can be made or implied from the available data?

The assumption that 'a significant amount' of the estimated £100 million worth of drugs is smuggled into prison through social visits appears to be based on little other than conjecture and guesswork.

The two principal methods for tackling visitor smuggling are the use of closed visits (where there is a glass partition between prisoner and visitor) when it is suspected that a prisoner or visitor is attempting to smuggle, and the prosecution of those visitors attempting to do so.

Several million social visits take place in prisons every year.[33] Yet in 2008/09, closed visiting conditions were imposed on just 1,817 occasions – less than one in every thousand visit.[34] This is an incredibly low number given the assumption

30 Commons Hansard, 23 March 2010, column 185W

31 Ibid.

32 Commons Hansard, 25 February 2010, column 664W

33 Tackling prison drug markets: an exploratory qualitative study, Home Office Online Report 39/05

34 Commons Hansard, 22 March 2010, column 21W

made by Blakey that a significant amount of the drugs trade within prisons is trafficked using this route.

The number of visitors arrested for attempting to smuggle is also amazingly low, especially as it is national policy to report all incidents where drugs are found in the possession of visitors to the police. Despite all the investment in numerous measures to catch visitors, including sniffer dogs, airport-style security and BOSS chairs, and in addition to the various campaigns to deter would-be visitor-smugglers, less than 500 visitors a year are arrested – the majority of whom will be under suspicion for drug-related offences.[35] This again implies the problem of social visits is hugely overestimated.

Year	Number of visitors arrested
2004-05	439
2005-06	429
2006-07	374
2007-08	424
2008-09	460

Commons Hansard, 28 January 2010, column 1030W

While nobody should be in any doubt that social visits are one way of smuggling drugs, conversations with those involved in drug supply reduction at a central level in government have confirmed that, given the way in which visitors have to smuggle to avoid detection, the amount of drugs that visitors are able to bring in to a prison is very small – attempts are usually small-scale and ham-fisted. A number of people in the Prison Service have suggested that the reason visitor prosecutions are low is simply because they smuggle relatively infrequently.

In the same vein, no-one should doubt the possibility for drugs to get into prisons via legal mail. In this instance however, the evidence for the prevalence or effectiveness of the route is practically non-existent (because nobody knows know many packages are intercepted). In any case, two simple steps could mitigate the risk of prisoners receiving illicit materials or substances this way. First, the decision of the Ministry of Justice to raise the level of authorisation for the interception of such communications should be reversed; decisions on whether to intercept communications should be taken locally and should not require approval by a senior civil servant in Whitehall.

Secondly, the Prison Service could adopt a policy of automatically intercepting communications purporting to be legally privileged, where the communication was not sent through Document Exchange (DX). DX is a mail service which is widely used by the courts, Crown Prosecution Service, Driver and Vehicle Licensing Agency, HM Revenue and Customs and over 12,000 members of the legal community.

Recommendations:

Despite his revelation that the Prison Service does not record the quantity or location of drugs that are found,[36] Blakey did not even recommend that this information should be collected.

35 Commons Hansard, 28 January 2010, column 1030W

36 Disrupting the supply of illicit drugs into prisons: A report for the Director General of National Offender Management Service by David Blakey CBE QPM DL, July 2008

It is absolutely vital that the Service collects and collates the quantities and types of drugs that are seized, and crucially, where they were seized – in order to give a better indication of the most prevalent and effective routes.

The Prison Service should collect information from every prison on:

- The quantity, weight and types of drugs seized in every prison;
- The location of the seizure, which will, by implication, give an indication of the smuggling route; and
- The method by which the seizure was made, giving an indication of the effectiveness of the Government's investment in various security measures.

Where possible, the Prison Service should also obtain intelligence and data to analyse the size and type of prison drug markets. Such information would include the price and purity of seized drugs, including prison-to-prison and regional variations. As the former Drug Strategy Coordinator for NOMS has argued, if routine data about levels of drug use in prison were collected and analysed, along with data on the cost of drugs and purity levels in prisons, then some trend data and market characteristics could be compiled. This would allow "guesses" to be replaced by "facts".[37]

37 Djemil, H, *Inside Out: How to get drugs out of prisons*, Centre for Policy Studies, June 2008

5
Staff Corruption and Organised Dealing

The evidence strongly indicates that the majority of drug-dealing that takes place in the prisons system is highly-organised. Often dealers in the community, these prisoners have the contacts and resources to ensure a continuous supply of larger quantities of drugs into the establishment. This level of dealing often involves the use of mobile telephones smuggled into prison.

This conclusion is substantiated by a 2009 report by the Serious Organised Crime Agency (SOCA) which declared that organized criminals are becoming increasingly sophisticated in their methods and seek to exploit every opportunity to continue their operations from within prison.[38] The report highlighted the pressing need to implement a major anti-corruption programme to "*reduce the risk of serious criminals conditioning vulnerable members of prison staff.*"[39]

> "This report's discussions with prisoners and prison staff indicates that drugs in prison are typically at least 1000% the street price of drugs"

While the SOCA report indicates that there are echelons of the Government where the threat of staff corruption and organised criminality is more appropriately understood, this report's examination of the available evidence, together with discussions with senior officials, points towards a more widespread misunderstanding, and a huge underestimation, of the role of corrupt staff in smuggling contraband into prisons.

So far it has been established that:

- the prison drug supply trade may be worth as much as £100 million a year (or almost £1 million per prison);
- prisoners primarily obtain their drugs through prison drug dealers – and do not have their own personal supply; and
- the assumptions about the most prevalent and effective smuggling routes are not supported by any of the available evidence.

In 2006, leaked details of a year-long investigation by the Metropolitan Police estimated that there were around 1,000 prison staff involved in corruption. This amounts to an average of seven corrupt prison officers per prison.

One of the most damaging claims contained in the report was that when intelligence is received about corrupt officers, often no action was taken to tackle it. For example, one Prison Service area manager was quoted in the report as saying

38 *Extending our reach: A Comprehensive Approach to Tackling Serious Organised Crime*, Serious Organised Crime Agency, July 2009

39 Ibid.

that 70 Security Intelligence Reports filed by officers identifying colleagues as corrupt had never been referred to headquarters and no action was taken against them as a result.

If the former NOMS Drugs Strategy Coordinator is correct in estimating a £100 million trade in drugs in prison, and if the Metropolitan Police are correct in estimating that there are an average of seven corrupt officers per prison, this would mean that each corrupt member of staff could be individually responsible for an average of £100,000 of the drugs trade each year.

The potential proceeds for staff are huge when the inflated price of drugs is taken into account. Though prices will vary from prison to prison, this report's discussions with prisoners and prison staff indicates that drugs in prison are typically at least 1000% the street price of drugs. Given that the starting salary for Prison Officers is £17,187, it is easy to see why the temptations are so high. An officer bringing a gram of heroin into prison every week (about the size of a couple of paracetamol tablets), with a street value of around £40,[40] could be more than doubling his gross salary every month – with a negligible chance of being searched or detected.

The response of the Ministry of Justice to the Met's report was to set up a new Corruption Prevention Unit in May 2008 (which would work with the police to identify corrupt staff) and to commission the Blakey Review.

The Blakey Review did touch on the issue of staff corruption but, astonishingly - given David Blakey's professional experience (as a former Chief Constable) – the issue of corrupt staff and links with serious organised crime were given a somewhat cursory glance – and there was not a single recommendation which dealt with the issue.

Blakey praised the hard-headed approach he encountered within the Prison Service, stating that, "*no one I have spoken to in the course of this Review doubts that staff corruption is a live issue for the Service or that it constitutes a way of getting drugs into prisons. I was particularly impressed by the frank and realistic manner in which Governors spoke to me about this matter. There is a proper debate about the actual level of corruption but I did not encounter the 'head in the sand' response that might have been the case in many organisations both now and in the past.*"

This is certainly not a debate that has been conducted in public, and there appears to be a huge degree of either indifference or complacency towards the issue within the Prison Service and the Ministry of Justice.

This is illustrated first by the revealing fact that it was felt necessary recently for a new Memorandum of Understanding between the Association of Chief Police Officers (ACPO) and the Prison Service to be signed. It makes clear that corruption is a crime and that the Prison Service has a duty to report it, and that the police have a duty to investigate it.

Secondly, there is no formal requirement to notify NOMS headquarters when a member of staff is accused of misconduct. Instead, the matter is merely reported at a local level. For this reason, according to the previous Government, details of the number of prison officers accused of bringing drugs into a prison in the last three years could be obtained only by consulting all prisons across England and Wales, which would incur disproportionate cost.[41]

The same is apparently also true for the numbers of staff who have been charged under internal disciplinary proceedings – this is not held centrally, and again could be provided only at disproportionate cost. Information about staff who have been charged by the police with smuggling drugs is likewise unavail-

40 Commons Hansard 13th January 2009, column 705W

41 Commons Hansard, 30 November 2009, column 444W

able. It is difficult to imagine how contacting every prison in England and Wales to find out how many members of staff have been accused of involvement in corruption could possibly involve disproportionate cost.

Similarly, there are no figures for the number of prison officers who have been prosecuted or convicted for bringing drugs into prisons. This is because until the Offender Management Act 2007, there were no specific criminal offences covering prison officers bringing drugs into prisons. Offences by this group of people would have been prosecuted under the Misuse of Drugs Act 1971 and the Ministry of Justice does not hold information which would identify the circumstances in which offences relating to prison-smuggling were prosecuted. Figures for prosecutions and convictions under the Offender Management Act 2007 will not be available until July 2010.

According to centrally held records within NOMS, just three prison officers have been dismissed under the internal disciplinary procedures specifically for bringing drugs into a prison since January 2007 (two during 2007 and one during 2008). Of course, as outlined above, it is impossible to know whether they were reported to the police.

The Prison Service is taking a 5 step approach to tackling staff corruption. These steps are:

- Identify the extent of the threat
- Improve intelligence
- Implement common standards
- Establish a culture where corruption is not tolerated
- Work closely with other agencies, especially the police.

The Corruption Prevention Unit is leading this work. But it is primarily a policy and research directorate, with a small budget and almost no capacity to run investigations or targeted operations against staff suspected of corruption or prisons deemed to have particularly endemic corruption problems.

When the problem is as big as this report (and others) contends, when the Prison Service has been accused of being institutionally corrupt and when just three prison officers have been dismissed for smuggling drugs in the last two years, this is simply an inadequate response.

Recommendation:

NOMS has a good degree of intelligence about which prisons suffer from serious staff corruption issues and who the members of staff are. The problem is that there are next to no resources to take the intelligence forward. These corrupt prison officers need to be rooted out, dismissed and where possible, taken to court. A policy and research directorate setting commons standards and coordinating intelligence will not do that; only a dedicated team of investigation units able to run operations inside prisons will make a real impact.

For this reason, the annual budget of the Corruption Prevention Unit should be increased by approximately £5 million. This will enable the Unit to establish dedicated investigation teams and run joint tactical units together with the police across the country – not just in London. This is the most effective way to address the issue of staff corruption and the corresponding supply of illegal drugs.

Mobile phones

As stated above, serious organised criminals often use mobile phones to coordinate the supply of drugs into prisons. Of course, mobile phones have also been used to organise murders and other criminal activities from behind prison walls. These developments are particularly worrying given that mobile phone use in prisons is significantly underreported and rising quickly.

The number of mobile phones seized has risen by almost 60% since 2006 alone: in 2008, a total of 8,487 mobile phones and SIM cards (or one for every ten prisoners) were seized and sent to a central unit for analysis.[42] The Government admits that this is likely to be an underestimate and an understatement of the actual number of finds, because their figures do not include items retained by the police for evidential purposes and because there has historically been some underreporting.[43] In addition, there are phones sent to the central unit which are not analysed, and these are not included in these figures.

In any case, this represents a huge number of mobile phones, and the increasing numbers should again be seen in the context of all the increased expenditure on seemingly ineffective security measures. Again, there is very little hard evidence about how phones get into prison. Policy Exchange has been advised that the role of staff corruption is also significantly misunderstood or poorly analysed in this respect.

The temptations for staff are just as high in relation to phones as for drugs. A handset which would cost just around £25 outside can typically sell for between £250 and £300 in prison. On a conservative estimate then, the size of the mobile phone market in prisons is likely to exceed £1 million.[44] The problem of mobile phones will likely only get worse as technology improves and handsets become smaller.

Given this, it is vital that the same examination of supply routes for drugs (as recommended above) should be undertaken by the Service for mobile phones: the Prison Service needs to know exactly where mobiles are found (and by implication, the smuggling route) and how they are found (to give an indication of the effectiveness of the efforts to restrict supply).

The Prison Service is currently trialling the use of mobile phone blocking technologies at a number of establishments. The previous Government claimed not to be able to estimate the likely costs of rolling out this kind of technology across the prison estate due to commercial sensitivity.[45] In addition, there are difficult technical issues that need to be worked through – the blocking technology can potentially disrupt the signal coverage in the area surrounding a prison, which is a particular concern in built-up, urban areas.

Even if this technology is proven to work in the medium term, in the short term difficulties with mobile phones will only become more acute so long as the issue of access to wing phones remains unaddressed. There is no suggestion that all of these mobile phones are being used for nefarious purposes. Many – and in all probability, the majority – will be used for social purposes. Access to wing phones for prisoners is very restricted, particularly at the times of day when prisoners want to speak to their family and friends (often last thing at night or to coincide with a child's bedtime) and is often prohibitively expensive. Indeed, restrictions to wing phones are such that they are often a primary cause of stress and even violence. For this reason there is some degree of tolerance of mobile

42 Lords Hansard, 14 December 2009, column 186W

43 Ibid.

44 Calculation based on over 4,000 phones being seized in 2008.

45 Commons Hansard, 8 February 2010, c787W

phone use amongst some prison staff. These problems will only be exacerbated if real-term cuts to the NOMS budget result in even less time-out-of-cell for prisoners than they are afforded at present.

However, the issue of wing phones should not just be addressed because of the threat from mobile phones – in fact, the benefits of increasing prisoners' access to families and friends are enormous. Research consistently shows that the existence and maintenance of good family relationships helps to reduce re-offending, and the support of families and friends on release can help offenders successfully settle back into the community.[46] 55 per cent of male prisoners describe themselves as living with a partner before imprisonment and 35 per cent of women prisoners describe themselves as living with a husband or partner before prison, yet almost half of prisoners report losing contact with their families following imprisonment.[47]

In-cell telephones

The problem of mobile phones (and with it, the coordination of the highly-organised arm of the drugs trade) can be diminished in tandem with a strategy for improving family contact and reducing reoffending.

First, the option of providing a form of in-cell telephony should be explored by the Ministry of Justice. Policy Exchange has been advised that in-cell telephony, based on the existing PIN-phone system (whereby prisoners are only allowed to call a limited number of vetted contacts) would be much easier to police than trying to intercept mobile communications. The key benefit is that the prison would now have complete control over outgoing communications. Indeed, in-cell phones would also provide another lever by which prisons can moderate and encourage good behaviour.

There are other benefits too: where in-cell telephony has been trialled (for instance at HMP Lowdham, a privately-run prison in Nottinghamshire), there is strong evidence that prisoners speak more freely and openly than on wing phones, meaning that where in-cell phones are used for nefarious purposes, significant intelligence can be garnered.

In-cell phones would immediately cancel out any perceived 'need' for mobile phone use amongst prisoners, except for criminal and nefarious purposes. This would also militate against any degree of tolerance amongst staff of the use of mobile phones by prisoners.

This should go hand-in-hand with a comprehensive strategy to crack down on, and eliminate, mobile phone use. In prisons with in-cell phones, there would be no need whatsoever for prisoners to use smuggled mobile phones, except for criminal purposes.

Recommendations:

As a first step, all newly-commissioned prisons could be tendered with a requirement for the installation of in-cell telephony and/or internet access. They should all provide in-cell telephony and its use should be closely evaluated. Installing internet access would also 'future-proof' the new prisons, and ensure that when the Ministry of Justice decides to initiate a bolder, consistent and far more ambitious approach to using technology in prisons, the technology will be already available.

46 K Haines, *After-care services for released prisoners: a review of the literature,* Home Office, 1990; J Ditchfield, Family ties and recidivism, Home Office Research Bulletin 36, 1994.

47 Reducing reoffending by ex-prisoners: report by the Social Exclusion Unit, 2002

This should not cost any significant extra money – it can simply be mandated as a specification for new building and operating contracts.

These newly-built prisons should simultaneously be installed with the most cost-effective mobile-phone blocking technology available (as a consequence of the trials being run by NOMS). In the longer-term, NOMS should explore the costs and benefits of rolling-out in-cell telephony in existing prisons, together with the new signal-blocking technology, as resources allow.

6
Reducing Demand for Drugs

Reducing the supply of drugs is, of course, just one part of the picture. A successful strategy for preventing drug abuse in prison must go hand in hand with a comprehensive drug treatment strategy which gives offenders the best possible chance of getting into recovery and rebuilding their lives.

Increasing resources

The past decade has seen a significant increase in funding for drug treatments in prison: spending has increased ten-fold since 1997. This year (2010-11) a total of £109.1 million will be spent on a mixture of treatment programmes.[48]

Case management and a range of psychosocial programmes have been introduced in prisons to treat addiction, where previously there was little such provision. Responsibility for prisoner healthcare, including the clinical aspects of drug treatment, was transferred from the Prison Service to the Department of Health in 2003. This led to a split between the commissioning and funding of interventions for drug treatment: NOMS now commissions case management and psychosocial programmes and Primary Care Trusts now deal with clinical interventions (i.e. pharmacological interventions).

This section will deal with clinical and psychosocial interventions in turn and will then turn to the commissioning and performance management arrangements for both.

Clinical interventions

Background

A series of clinical negligence claims by prisoners and ex-prisoners have been advanced in the last five years, which many argue has directly led to this increase in expenditure. In April 2008, it was reported that almost 200 prisoners had received a £750,000 payout from the Ministry of Justice, having claimed that their human rights had been breached due to the drug treatment provision available in some prisons. The previous Government had settled out of court shortly before November 2006, when the hearing was about to begin.

The solicitor representing the 'Opiate Dependent Prisoners Litigation Scheme' (a group of around 1,000 prisoners who have claimed or are claiming clinical negligence in this respect) argued that "*many of the prisoners were receiving methadone treatment before they entered prison and were upset at the short period of treatment using opiates they encountered in jail. Imposing the short, sharp detoxification is the issue.*"[49]

48 Commons Hansard, 23 Feb 2010 : Column 507W

49 Inmates win 'cold turkey' payout, The Times, 18th April 2008

In conducting research for this report, Policy Exchange has become aware of at least one more such case which is currently underway in the Royal Courts of Justice.[50]

Integrated Drug Treatment System (IDTS)

In part as a result of this litigation, efforts were made to expand the quantity and quality of drug treatment within the prisons system. The Integrated Drug Treatment System (IDTS) went live in October 2007. The objectives of IDTS were to:

- Increase the range of treatment options available to those in prison, notably substitute prescribing;
- Integrate clinical and psychological treatment in prison into one system; and
- Integrate prison and community treatment to prevent interruptions either on reception into custody or on release back home.

The roll-out of IDTS across the prison estate has had the (intended) effect of increasing the numbers of prisoners receiving forms of opiate substitute medication (most commonly methadone or buprenorphine). Most notably, the numbers of prisoners receiving an opioid 'maintenance' prescription (i.e. a dose of methadone or buprenorphine which is constant and for the long-term) has ballooned. There are now almost 20,000 prisoners receiving maintenance treatment in prisons every year, a rise of 57% on the previous year.

Year	Prisoners maintained
2007/08	12,518
2008/09	19,632

Source: Commons Hansard, 11th Nov 2009, Column 487W

Historically, UK prisons have not consistently offered opioid maintenance. Even where it has been offered, the means by which it is delivered has been inconsistent between prisons and prisoners.[51]

The stated rationale for increasing the numbers of prisoners who are maintained on opiate substitutes is:

- to provide a gateway to community substitute treatment for those who request this as a treatment option, assuming that this can be continued upon release back into the community;
- to continue community methadone or buprenorphine prescribing programmes that will, in turn, be re-established following release ('clinical throughcare');
- to increase tolerance to opioids, which reduces – but by no means eliminates– the risk of fatal drug overdose upon release from prison; and
- to reduce self-harming and suicidal behaviour among prisoners with a chronic drug dependence.[52]

There have been three major problems with the way IDTS has been rolled-out which have not yet been publicly debated or adequately addressed. The first problem is that opiate substitutes, whether for the purposes of detoxification or maintenance, have

50 Goodale & Ors v The Ministry of Justice & Ors [2009]

51 Report to the Department of Health and Ministry of Justice: Review of Prison-Based Drug Treatment Funding, Pricewaterhouse Coopers, March 2008

52 Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health, November 2006

been prescribed too readily. The second problem relates to the definitions of 'detoxification' and 'maintenance'. The third issue is the relationship between the length of sentence a prisoner is serving and whether he/she is detoxified or maintained. These problems, it will be contended, have meant that the roll-out of IDTS has been mismanaged, leading to a huge waste of scarce resources and in the process, thousands of prisoners have become trapped on opiate substitutes when they could be getting drug-free and successfully into recovery.

Opiate substitutes are too easily prescribed

The first issue is that opiate substitutes, of whatever ilk, are being doled out too freely. This has directly contributed to the spiralling costs of IDTS and it has also created a new market in the trade for drugs within prisons: opiate substitutes are now traded just as illegal drugs are inside prisons.

The first reason that opiate substitutes are being prescribed too easily is the fear of litigation. Since responsibility for drug treatment was handed over to the NHS, there has been a much more risk-averse attitude towards the treatment of prisoners, in order to pre-empt more litigation and ward off further accusations of clinical negligence. This has been reflected in the way clinical guidance has been constructed (as will be detailed below) and it has had such an impact that senior officials now admit that giving out methadone and other substitutes has become 'the easy option'.

Opiate substitutes have also been prescribed too easily because of the particular setting in which prison healthcare teams have to operate. Many healthcare staff are very inexperienced – a problem compounded by the intimidation and threats some of them inevitably endure, and the fact that many prescribers give out medication without a prison officer present.

In massively increasing the volume of drugs given out by prison healthcare, the policy has inadvertently exacerbated the problem of a new kind of drugs trade. Visits to prisons conducted for this report confirm the findings of a Home Office study which described the various ways in which opiate substitutes can be sold on to other prisoners. Interviews with prisoners and ex-prisoners indicate that drugs prescribed in liquid form (i.e. methadone) could be kept in the mouth and spat back into a container when not being observed. Drugs prescribed in tablet form and required to be taken under supervision can be stuck under the tongue, by the gum or on the roof of the mouth, to be scraped off later in the cell, or spat down prisoners' jumpers or tracksuit bottoms for later retrieval. The length of the medication queue means that it is often easy to avoid being caught.

Prescription drugs dispensed for self-administration (referred to as 'in-possession medication') were considered by many to be far too easy to obtain and trade, and are often traded for goods from the canteen such as tobacco or other commodities. Almost every prison has a problem with the trade in legal medicine. The most commonly traded drugs in prisons include benzodiazepines, antidepressants (particularly amitriptyline) and those prescribed for heroin detoxification (methadone, dihydrocodeine and buprenorphine).

'Detoxification': maintenance by another name?

Historically, detoxification programmes (where they were available) were short periods of time (generally 14-28 days) during which drugs such as benzodiazepines

were used to 'assist withdrawal' from heroin. It is these sorts of shorter treatments which the prisoners who took legal action against the Ministry of Justice claimed breached their human rights.

However, since the roll-out of IDTS, the methods used to detoxify prisoners have changed. Now, methadone or buprenorphine are used routinely instead, following a 5 day stabilisation process (in which these drugs are also used). This has far-reaching consequences that have not been publicly debated to date. It means that prisoners who are 'detoxified' are a) prescribed drugs (which are extremely addictive in themselves) when they may not want this or when it may not be necessary; and b) they are often left to languish on 'detoxification' regimes for months at a time.

> "Detoxification treatment programmes regularly exceed three months in length. This is not detoxification; it is simply maintenance by another name"

In 2008/09, 45,135 prisoners entered a detoxification treatment programme – the vast majority of which will now have involved methadone or burprenorphine prescribing. The clinical guidance governing the detoxification of prisoners states that "*following a minimal five-day stabilisation on either of the above two agonists (i.e. methadone or buprenorphine), detoxification should routinely be for a minimum of 14 days.*"[53] There is a very specific instruction in relation to prisoners who are withdrawing from methadone misuse – that "*detoxification will often need to be for 21 days or more if methadone has been used regularly prior to arrest.*"[54] The implication of this guidance appears to be that detoxification remains a relatively quick process – typically 14 days detox plus 5 days stabalisation. However, this is extremely misleading.

It has been confirmed to Policy Exchange in a letter from the Department of Health that "*the reality is that only a very small number of prisoners undertake the 19 day regime.*" In fact, the Department "*encourage(s) "extended/individualised" withdrawal regimes, which now commonly comply with the "out-patient's model", but taking into account the particular stresses of prison, can be extended further as required.*"[55]

The out-patient's model is for a gradual reduction in methadone/buprenorphine doses over *12 weeks* – not 14 days – and, as the letter states, prisoners can often 'detox' for longer than this.

In fact, new guidance issued by the Department of Health suggests that 'gradual reduction regimes' (or what the previous Government called detoxification) within prisons should be reviewed only every three months. This clearly implies that detoxification treatment programmes regularly exceed three months in length. This is not detoxification; it is simply maintenance by another name.

The relationship between sentence length and the decision to maintain

There is little doubt that for some short-sentenced prisoners who are already receiving methadone treatment in the community, maintaining their prescription for the short time they are in prison is sensible. Such prescribing reduces the risk of overdose on release (by maintaining opoid tolerance) and guarantees a degree of continuity or 'clinical throughcare'.

The guidelines reflect this reality for both short-sentenced prisoners and prisoners who are being held on remand, stating that "*all individuals with a history of dependent opiate use who are received into custody on a short sentence (ie up to approximately 26 weeks*

53 Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health, November 2006

54 Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health, November 2006

55 Reply to Policy Exchange request, letter dated 19th April 2010

– of which prisoners will typically only serve 13 weeks or less) should be given the option of continued maintenance following stabilisation. A community prescriber should be located to ensure that treatment continues upon release…A chronic opiate user who is received into custody on remand should also be offered a maintenance methadone prescription."[56]

It is beyond the scope of this report to assess the effectiveness, quality or morality of the drug treatment provision available in the community (where substantial amounts of public money have also been pumped into opiate substitute treatment).

However, it is clear that there is no good reason for inmates sentenced to more than 6 months imprisonment (of which they will serve 13 weeks or less) to be maintained on methadone as they would be in the community – it must only take place in the most exceptional of circumstances. The guidance should take into account the fact that prison and the community are different places – a prison sentence should be an opportunity for a prisoner to get clean, in a controlled environment. But this is not what the guidance allows for. It states that, "*community maintenance programmes should be continued in prison following stabilisation, unless the patient or the existing community prescriber indicate otherwise.*"[57] This does not recognise any link whatsoever between the decision to prescribe maintenance and the length of sentence handed down, and it places too much power in the hands of the offender in directing their own drug treatment. It also takes no account of the fact that the methadone regime *has already failed*: the person being treated has committed more offences (probably acquisitive criminal offences because of their use of drugs 'on-top' of their prescription) and has been sent to prison.

Neither the Ministry of Justice nor the Department of Health currently holds any data which would allow for an analysis of the relationship between those prisoners who are being maintained and the length of their sentence, so we do not know, for instance, how many of the 20,000 prisoners who were maintained in 2008/09 were serving sentences of more than 6 months. FOI requests indicate that a joint Home Office, NOMS, National Treatment Agency (NTA) and Department of Health project has redesigned the Drug Information Record (DIR) and Prison Activity Form and mechanisms are now in place for prisons to collect this information, but it will not be available until 2011-12.

However, is very likely that the poor drafting of the guidance has resulted in thousands of longer-sentenced prisoners being maintained on methadone inappropriately.

In April 2010, this was tacitly admitted by the Department of Health in new guidance which was sent to all prison healthcare teams. The guidance was reported in the press as representing a new 'curb' on methadone handouts.[58] However, whether it will truly alter the status quo is questionable.

The guidance states that there is "*concern that maintenance prescribing is being initiated without systematic review arrangements in place…and therefore the continuation of some prescriptions may be clinically inappropriate.*" *The guidance stresses the need to "ensure that prisoners do not remain on open-ended maintenance regimes when detoxification or a gradual reduction tailored to the individual's need would be the more appropriate option."*[59]

It restated the original guidance in a different way, directing that maintenance should be considered for prisoners on remand, for those sentenced to less than 26 weeks and "*where on the basis of a full clinical assessment, it is considered necessary to protect the prisoner on release from the risks of opiate overdose.*"[60]

56 Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health, November 2006

57 Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health, November 2006

58 Inmates face curb on methadone handouts, The Times, 14th April 2010

59 http://www.nta.nhs.uk/docs/updated_guidance_for_prisons_march10.pdf

60 http://www.nta.nhs.uk/docs/updated_guidance_for_prisons_march10.pdf

However, the guidance left the door open for longer-sentenced prisoners to continue to receive methadone maintenance treatment, on occasions involving:

- A history of injecting drug use in prison;
- A history of any serious mental health problem; or
- Impending significant events, including release, uptake of antiretroviral therapy, early period of sentence or continuing remand, transfer to another prison

Needless to say, as these instances include almost every single prisoner who has had a drug problem, the new guidance is unlikely to make any difference to the already spiralling numbers of prisoners who are receiving methadone.

'Retoxification'

In April 2010, it was reported that a number of prisoners (406 over five years) who had successfully undergone detoxification and had become drug-free were put back on methadone (or similar) prior to release, to protect against fatal overdose. The information was obtained through a series of Freedom of Information Requests (submitted by *The Sun* newspaper) to every Primary Care Trust in England and Wales.

As the new clinical guidance states, "*where a prisoner has been detoxified and remained drug free there may be circumstances where it would be appropriate for them to be re-inducted into opiate substitute treatment prior to release.*"[61]

While the 2007 guidance makes it clear that this should only happen in exceptional circumstances (i.e. where there is a history of non-fatal overdose, polydrug dependence and severe opoid dependence), the occasions on which retoxification occurs, and the prisons in which the treatment is available, should be brought to light and the information publicly available.

How many prisoners are receiving methadone today?

Although we know the annual figures for those receiving methadone or buprenorphine for detoxification or maintenance purposes, we do not know what proportion of the prison population at any one time this represents.

Using the Department of Health's admission that detoxification 'commonly' takes place for 13 weeks (including stabilisation) and often longer, an estimated 11,283 prisoners will be receiving methadone on a gradual reduction basis at any one time[62]. This represents an estimated 13.5% of the prison population. In addition, there are almost 20,000 prisoners being maintained on methadone. Even if it is assumed that all of these are short-sentenced or remand prisoners, this means that on average, there are an additional 3,012 short-sentenced and remand prisoners being maintained at any one time.[63] In total, on a very conservative estimate, there are approximately 14,295 prisoners receiving opiate substitutes on any given day. This equates to 16.5% of the prison population - or one in six prisoners. Given that a sizeable portion of the 20,000 maintenance prescriptions are likely being given to longer-sentenced prisoners, the true number is likely to be even higher. Freedom of Information requests submitted by Policy Exchange to individual prisons have indicated that, in some prisons, the proportion of prisoners receiving opiate substitutes is as high as 25%.

61 http://www.nta.nhs.uk/docs/updated_guidance_for_prisons_march10.pdf

62 Given that there were 45,135 prisoners detoxified in 2008/09 and assuming an equal distribution of prisoners across a calendar year.

63 Calculated according to the average sentence served by short-sentenced and remand prisoners.

All of this should be seen in the context of the phased roll-out of IDTS. The latest figures only relate to the financial year 2008/09, when just 76 of England and Wales' 139 prisons had implemented IDTS. By the time IDTS is fully rolled-out across the prison estate by 2011, and using the figures for the phased roll-out of IDTS so far, it is estimated that there will be 8,788 more prisoners being maintained on methadone in a year's time.[64]

Recommendations:

The Government should immediately address the spiralling numbers of prisoners receiving opiate substitute prescriptions and the associated costs that go with this. The best way to do this is to slow the increase in spending on IDTS as it is rolled out across the entire prison estate, whilst at the same time, changing the framework under which IDTS operates (as described below) so that only those prisoners who genuinely need to receive methadone or buprenorphine receive it - and only for the shortest period necessary. It is recommended that the 2011 budget for IDTS be cut by £10 million. As will be outlined below, half of this should be reallocated towards evidence-based abstinence programmes and the other half should go towards meeting the costs of improving corruption prevention.

- The guidance on detoxification and maintenance must be strengthened in favour of a more abstinence-based approach. The current guidance says that longer-term prisoners "can be encouraged to use their time in prison to achieve abstinence" and that "this option should be discussed". Instead of merely being encouraged, this should be mandated. Longer-sentenced prisoners should be expected to work towards being drug-free and this should be a condition of their parole.
- The routine maintenance of prisoners (sentenced to more than 6 months) who had been receiving maintenance in the community must end. This should only happen in the most exceptional cases.
- The Ministry of Justice and Department of Health should more accurately categorise the treatment that is being given to prisoners. A clear distinction between detoxification lasting 19 days and detoxification lasting much longer (so-called 'gradual reduction') should be made and this should be reflected in the way both departments talk about drug treatment and in much more transparent guidance. At present, Government figures and Government guidance is misleading and gives the impression that only a very small amount of prisoners at any one time are being given opiate substitutes, when in fact the opposite is the case. It is recommended that a new categorisation of treatment be introduced, with detoxification, gradual reduction and maintenance as three distinct classes of treatment. Information on the length of time a prisoner's dosage is reduced for should also be routinely kept.
- The Ministry of Justice and the Department of Health must ensure that the Drug Information Record (DIR) accurately records the length of sentence for those receiving maintenance treatment. By 2011, the DIR will be able to produce figures indicating the numbers receiving maintenance where they are sentenced to less than 1 year.[65] But this will not address the issues described above – it is vital that both Government departments are confident that prisoners are not being maintained when their sentence is longer than 6 months. Therefore it is

64 Based on a calculation of the increase in numbers on maintenance between the second wave of IDTS and the third wave. As IDTS was rolled out to 51 more prisons between 2007/08 and 2008/09, an extra 7114 prisoners received this treatment. Once IDTS is rolled out to all 139 prisons, it is projected that 8788 new maintenance prescriptions will be made.

65 Answer to a Policy Exchange FOI request

recommended that the DIR be amended to provide further breakdowns. PCTs and central government should also be aware of the individual clinicians who are prescribing maintenance prescriptions to longer-serving prisoners so that action can be taken against those who are routinely making clinically inappropriate prescribing decisions. The DIR should also collect figures for the numbers of prisoners who are 'retoxified', having become drug-free.

Psychosocial interventions and case management

In addition to the £40 million spent on clinical interventions by Primary Care Trusts, a further £69.6 million is spent through NOMS on psychosocial programmes and case management. Despite increased spending, the experience has been broadly one of misdirected investment, with bureaucracy and lower threshold services prioritised over the more intensive services that are proven to promote and achieve the goal of abstinence.

Case management: CARATS teams

For prisoners with sufficient time in custody, CARATS teams (Counselling, Assessment, Referral, Advice and Throughcare service) construct a care plan following a substance misuse assessment, which plans future interventions including structured one to one work, group work, and referral to short and longer-term programmes. CARATS received £34.2 million worth of funding in 2009/10.

However, since the rationale for having a case management function as part of drug treatment is strong and given that drug addiction is a chronic relapsing condition with complex interventions required, it is difficult to know how services could be delivered without case management and associated assessment. It is important, therefore, that case managers have the skills to support prisoners with a wide range of complex needs, and have a range of services available when constructing care plans.

There is a significant amount of bureaucracy and waste (mainly through duplication) involved with the delivery of CARATS. As Patel's own review pointed out, "*little research has been commissioned to examine the efficacy of CARATS teams that provide case management assessment, care planning, review, transition and release planning and handover). Since performance data focuses on quantity of activity rather than quality and outcome, it is difficult to prove its effectiveness.*"[66] What this means in practice is that CARATS focus their energies on meeting targets for the number of assessments made instead of delivering programmes to the right people or worrying about whether they are successful in reducing reoffending. For instance, some staff select programme users based on their availability to complete the programme rather than on the severity of prisoners' dependence or the timeliness of the intervention for the individual.[67] These Key Performance Targets need to be recast to place more emphasis on outcomes rather than simply the number of assessments made or interventions begun (rather than completed). Policy Exchange is advised that significant savings would be made by recasting the KPTs to reward success in reducing reoffending rather than pure activity.

There is also significant duplication. Interviews conducted for this report have highlighted the fact when offenders go into custody, agreed care plans should already be in place with the CJITs (Criminal Justice Intervention Teams) in the

66 Report to the Department of Health and Ministry of Justice: Review of Prison-Based Drug Treatment Funding Final Report, December 2007

67 Report to the Department of Health and Ministry of Justice: Review of Prison-Based Drug Treatment Funding Final Report, December 2007

community. However, this is rarely the case, so the CARAT worker starts the entire assessment process again. Likewise, a handover with an agreed care plan is supposed to take place between the CARAT worker and the CJIT on release but again, this rarely happens. CJITs and CARATS teams report a lack of capacity to conduct effective transitional handovers.[68] The two teams use different assessment forms, and the Drug Intervention Record designed to enable information to be passed from one to the other is paper-based and may get lost. These problems could be overcome by the creation of joint CJIT/CARATS teams, or teams that also include clinical staff. As the external review of prison drug treatment estimated, based on experience in other sectors, "*a productivity gain of 10% minimum could be expected*",[69] for example through eliminating duplication of effort. It would also potentially make it easier to keep track of remand prisoners with unplanned releases.

Current delivery

In addition to the £34.2 million spent on CARATS, a further £22.4 million is spent on the delivery of psychosocial treatment programmes. As can be seen from the table, the number of psychosocial programmes pales in significance compared to the number of clinical interventions delivered. In addition, the programmes which are more widely used (such as the Short Duration Programme and Cognitive Behavioural Therapy) are short, of low intensity and are very unlikely to make any impact on the ingrained lifestyles of severely dependent offenders. They will invariably involve simply two or three meetings with a CARAT worker and a four week group course based on educational theory. There is more research evidence for the efficacy of the longer-term programmes such as 12 Steps and Therapeutic Communities.[70]

Intervention type	2007/08	2008/09
Detoxification/maintenance	58,810	64,770
12-Step	870	850
Cognitive Behaviour Therapy	4,070	4,100
Short Duration Programme	6,030	5,550
Therapeutic Communities	280	260

Source: Commons Hansard, 9 September 2009, column 2036W

Recommendations:

The Government should redirect approximately £25 million of the £34.2 million currently spent on case management through CARAT teams into a new model of end-to-end offender management, whereby CJITs and CARATS form one integrated drug treatment team based on an in-reach model, ensuring better throughcare. The £10 million saved should be spent on psychosocial programmes, while Key Performance Indicators should be changed to focus on long-term reoffending rates rather than input measures, ensuring that practitioners are focused on delivering quality programmes to the right people rather than making assessments or ensuring that prisoners complete programmes that they do not need, simply to meet targets.

68 Ibid.

69 Ibid

70 Ibid

As stated above, £5 million of the 2011 IDTS budget should be moved into psychosocial programmes, and another £5 million should be allocated to an enhanced Corruption Prevention Unit, to allow the rooting out of the estimated 1,000 corrupt prison staff.

With the expanded budget for psychosocial programmes of £45 million, the distribution of psychosocial programmes should be organized so that:

- Each local prison has a short duration motivational enhancement programme, that is focused on motivating and initiating recovery, and moving participants on to second stage treatment.
- Each training, female or high security prison has an intensive programme, with a mixed market of therapeutic community, or 12-step models.

Conclusion

By accident or design, the drug misuse that fuels so much of the crime in our communities is being allowed to continue inside prison walls. The true scale of drug misuse is not being properly measured, the ways in which drugs get into prisons are being ignored and drug treatment programmes are failing to get prisoners drug-free, because maintenance programmes and opiate substitutes have become the easy option.

The Prison Service needs to be up-front about the issue of staff corruption and a long-term, well-resourced plan for dealing with it needs to be put in place quickly. Proper analysis and recording of how drugs are smuggled will allow guesses to be replaced by facts and will compel the Prison Service to analyse which routes are the most prevalent and effective. In addition, Mandatory Drug Testing needs to be replaced so that the Government has a much better idea of how individual prisons are performing, and of the national picture. Mobile phone use is a growing problem and official figures seriously underestimate the extent to which phones are being smuggled. But tackling this will require a recognition that mobile phones are also used for social purposes: problem mobile phone use can only be dealt with if steps (such as in-cell telephony) are taken to improve prisoners' contact with their families.

Curbing the supply of drugs and mobile phones will only deal with part of the problem; getting addicts clean and prepared for release is just as crucial to reducing reoffending. To achieve this, drug treatment programmes need to be refocused so that methadone is no longer the first port of call, but instead, acts as more of a last resort where there is a real risk of a short-sentenced prisoner overdosing and dying on release. Clinical guidance should properly reflect the fact that a prison sentence is a chance to get drug-free, not an opportunity to be wasted simply because continuing maintaining a prisoner's addiction is easier than tackling the underlying causes of offending.

These changes could make a real difference, but they will require a degree of honesty about what has gone wrong and some courage in taking the necessary steps to put things right. If the Prison Service comes clean, prisoners could start to get clean, ending the invidious cycle of addiction and acquisitive crime – and making Britain a safer place.

An estimated £100 million worth of drugs are smuggled into prisons every year. But there is a worrying lack of knowledge about how they get there. A review commissioned by the previous government contained assumptions that smuggling routes such as social visits and legal mail predominate, but there is very little evidence to support this. In fact, the evidence points to the fact that the bulk of drug-dealing within prisons is highly-organised and involves the collusion of around 1,000 corrupt members of prison staff – an average of seven for every prison. This report recommends that the Prison Service comes clean about the level of corruption and outlines proposals to root out and prosecute corrupt staff. We argue that these steps, together with compelling the Prison Service to properly analyse which smuggling routes are the most prevalent and effective, will make a big impact on curbing the supply of drugs.

Coming clean also means we need a new measure of the scale of drug misuse. Mandatory Drug Testing significantly underestimates the number of prisoners who use drugs, and the fact that prisons have to meet targets for reductions in the number of positive tests discourages any accurate assessment of the true scale of the problem.

Coming clean also requires a recognition that in too many prisons, maintaining prisoners' addictions has become the easy option. A prison sentence should be a chance to get drug-free, not an opportunity to be wasted simply because continuing maintaining a prisoner's addiction is easier than tackling the underlying causes of offending.

Psychosocial treatment has so far been characterised by bureaucracy, box-ticking and poor targeting of addicts. The distribution of programmes is illogical and too much money is spent on low-threshold, low-intensity programmes which are unlikely to make any real difference to severely dependent addicts with ingrained lifestyles. We recommend a reorganization of the distribution of programmes, so that that each local prison has a short duration motivational enhancement programme that is focused on motivating and initiating recovery, and moving participants on to second stage treatment.

£10.00
ISBN: 978-1-906097-77-6

Policy Exchange
Clutha House
10 Storey's Gate
London SW1P 3AY

www.policyexchange.org.uk