Huseyin Djemil continues his monthly column on the addiction-recovery world.

NHS vs prison health

ADDICTED, TREATED + LIVING RECOVERY

In 2008, I wrote a pamphlet entitled *Inside Out: how to get drugs out of prisons* which was intended as a wake-up call for prisons and policy-makers. Ten years on, the state of affairs has gone from bad to worse. In fact, prisons minister Rory Stewart, announcing a £10million crackdown on violence, drugs and phones in the 10 worst prisons, promised to resign in 12 months if assaults do not fall as a result. Resigning is exactly what Mr Stewart will be doing unless he breaks free from the failed solutions of the past and casts his advice-net more widely. That would be embarrassing for him but far worse for the prisons and their ever more demoralised staff.

He needs to understand that the presence of drugs in prisons, licit as well as illicit, undermines any attempt to clean up prisoners from pre-existing addictions; that drugs prevalence increases the chances of recidivism and staff corruption; and – most importantly from a drug user's perspective – that the 'dealer' can be an illicit trader or the State, in the form of the NHS prescriber. The former says 'Commit crime to get money to buy drugs'; the latter says 'Stop committing crime and we will give you free drugs'. Both want control. Neither offers freedom. Both harness the power of the drug to influence behaviour – and neither for the good.

Successive governments have had a failed policy of prescribing substitute drugs such as methadone to prisoners rather than stopping their addiction. This is defeatism and a lack of ambition. It is 14 years since the NHS took over responsibility for health care in prisons from the prison service. Since then prison drug treatment has come to mirror the methadone treatment the NHS offers in the wider community.

What could be described as 'situationally sensitive' help for people entering the prison system with a pre-existing drug problem has all but been abandoned, as has post-prison residential support and rehab for any who achieved abstinence in prison. Nor is there much sympathy in the community for those who picked up their drug problem 'inside'.

Once, prison was seen as a chance to make a break from 'the life' (addiction to or problematic use of drugs) even if this was in too many cases low-level symptomatic relief of withdrawal from drugs or in extreme cases 'cold turkey'. It was a chance to go to the gym and get fit, to eat properly and gain weight, visit the dentist, and sort out neglected health issues. But the NHS's prison methadone and other opiate substitutes 'prescribing pathway' put an end to all that. It's the worst of all worlds, incurring high costs against little benefit.

It was not meant to be like this. Shortly after I took over responsibility as the area drug strategy coordinator for the seven London prisons (2003-07) there was a death in custody. I was tasked to support the prison's drug strategy team and help to improve the detox function. We began with replacing the prison's 11-bed 'detox' area (which was more like an old-style Eastern Bloc sanatorium than a clinical detox facility) with a 54-bed detox unit, light and airy with sofas and a fish tank, staffed by volunteer officers

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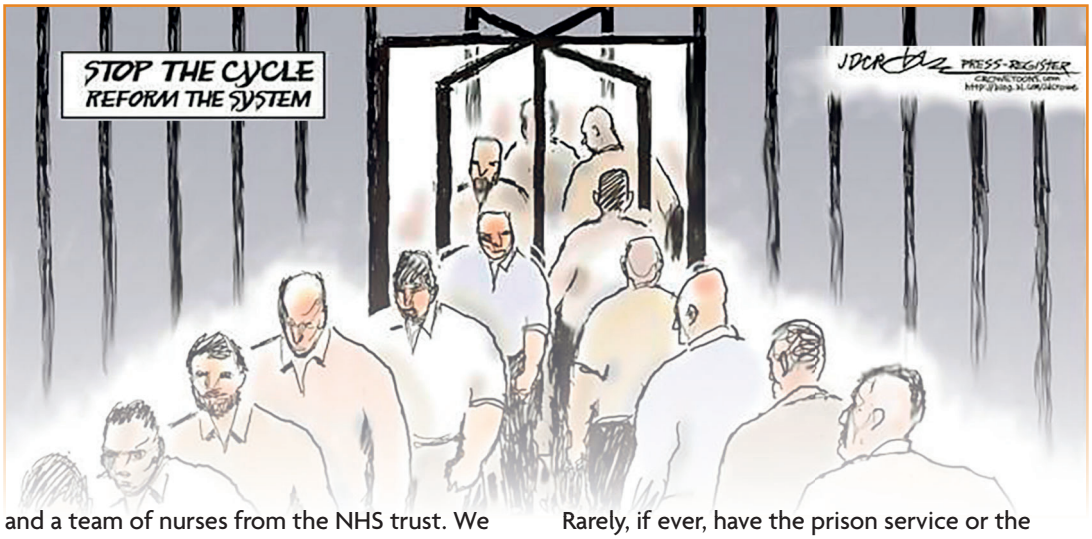

and a team of nurses from the NHS trust. We abandoned the standard urine testing on the unit and introduced mouth-swab saliva testing. Prison staff helped the 'detoxing' prisoners to exercise and stabilised their sleep patterns with 'night packs' which didn't contain caffeine, and gave extra food as their appetite returned.

The aim was to get them better and it worked.

This good practice could have become everyday routine for the rest of the prison service. Instead we got an 'Integrated Drug Treatment System' which became a huge prison-based methadone maintenance prescribing programme rolled out over three years across the whole estate, with methadone hatches in cell doors and iris-recognition dispensing machines. In the name of saving lives, offenders became trapped on medication in their revolving door prison trips.

Of those who come in without an addiction, about 6% pick one up in prison. Prisons are awash not only with traditional illicit drugs (heroin, cannabis etc.) but increasingly with the prescribed drugs buprenorphine, pregabalin and gabapentin, as well as methadone, via the prison's NHS treatment supply or other routes. All become currency in the prison's internal drug trade, alongside new psychoactive substances.

The government's supply disruption policy is equally inept. It has been characterised by a 'follow-the-drug' mentality, focusing exclusively on finding and following the drug, at point of entry, in the post, over the wall, through visits, and staff searches. It has been a total failure.

Rarely, if ever, have the prison service or the Ministry of Justice widened their perspective to look at the whole market for drugs in a given prison area, at clusters of prisons, at the prison estate nationally or between prisons and the community. Such an approach was first mooted in the sensible Justice Inspectorates Thematic report: Changing patterns of substance misuse in adult prisons and service responses, whose recommendations successive governments have ignored. Another of their key recommendations was to end the use of mandatory drug testing results as a measure of prison 'performance' or success in how well they were controlling drugs in prisons. Typically, however, in practice there are issues with selection of prisoners, testing integrity (for example prisoners and/or guards swapping samples), and the validity of test results where illicit drug use may be masked by prescribed drug use, particularly when the prisoner is on an opiate substitute. It is a poor measure of drugs control. Despite this, the government remains wedded to the policy:

The problem as I outlined it 10 years ago has not changed. Recent proposed measures are similar to those outlined in the 2005 strategy. Understanding and dealing with the drug markets in prisons, restricting and reducing drug supply needs to become a cross-government priority and must include the National Crime Agency and the Home Office. This, with the reintroduction of proper detox and treatment programmes which include education and purposeful activity, is the key to safer prisons, to reducing the reoffending rates of those leaving prison and to a safer society for us all.

About the author:

"I entered treatment for addiction to heroin and freebase cocaine in 1986. I was 23 years old and had been using daily for 7 years. I spent 2 years in rehab, then re-started my life without drugs. Today, I describe myself as being in long-term recovery from addiction. I have worked in the substance misuse treatment, criminal justice, and social care sector since 1993, have been a freelance consultant since 2007 – and have lived through radical policy change."