Submission to the Advisory Council on the Misuse of Drugs inquiry on Custody-Community Transitions

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the inquiry into custody-community transitions.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons and young offender institutions in England and Wales and immigration detention facilities across the UK. HMI Prisons also inspects police and court custody in England and Wales (jointly with HM Inspectorate of Constabulary and Fire & Rescue Services), and secure training centres in England (with Ofsted). At the invitation of Criminal Justice Inspection Northern Ireland (CJINI), HMI Prisons inspects prisons in Northern Ireland.

3. Since April 2015, HMI Prisons has worked in partnership with the Care Quality Commission (CQC) to jointly inspect healthcare provision in prison and immigration removal centres in England, producing a joint report on this aspect of inspections. CQC also joins HMI Prisons on inspections of health provision in police custody in England although a joint report is not produced in these settings as CQC does not regulate health provision in police custody (whereas it does regulate health provision in prisons and immigration removal centres). In prisons in Northern Ireland, the Regulation and Quality Improvement Authority joins inspections and in Wales, Healthcare Inspectorate Wales joins some inspections.

4. In the 2017/18 year (31 March 2017 to 30 April 2018), HMI Prisons published inspection reports following the inspection of 39 prisons holding adult men and two holding adult women in England and Wales, and CJINI published two reports in relation to prisons in Northern Ireland. We also published reports on inspections of police custody suites in eight force areas and two court custody areas.

5. Our response below is drawn from these inspection reports and aims to provide a summary of our findings in relation to outcomes for people who use drugs from our inspections of police custody, court custody and prisons. In addition, we annex the recommendations we made in December 2015 following our thematic inspection of changing patterns of substance misuse in adult prisons and service responses, and the response to those recommendations (in the form of an action plan). Our submission below evidences that many of the issues we identified in that 2015 thematic remain unresolved.

Police custody

6. When we inspect police custody, reports from custody and health staff indicate that a high proportion of detainees present with problematic drug and/or alcohol use. This includes people who are detained for offences directly related to their substance use such as driving

under the influence, violent acts whilst under the influence and acquisitive crime to fund their use, and also those who are in custody for offences unrelated to substance misuse but for whom a risk assessment has indicated problematic use.

7. The first transition challenge relates to maintaining the safety of detainees' who are under the influence of substances. Custody staff complete a risk assessment on all new arrivals to identify vulnerabilities and risks and this information should inform the person's care in custody and release planning. We find in most forces these are thorough, but we have raised concerns in a minority of forces relating to insufficient rigour. In many forces, insufficient privacy at the booking-in desk is an issue that may discourage disclosure.

8. Detainees who are intoxicated will require a rest period before they are fit to be interviewed. The College of Policing guidance[1] advises those who are drunk and incapable should be taken to hospital and those who are intoxicated should have rousing checks to ensure they are not lapsing into unconsciousness. Rousing checks are also required by the Police and Criminal Evidence Act (PACE) Code H.[2] Weaknesses in this process, such as not entering the cell or late checks, create a risk that deterioration in the person's condition including unconsciousness may be missed. The report by Dame Elish Angiolini in January 2017 highlighted weaknesses in the identification and management of intoxicated persons in police custody as contributory factors in a number of deaths in custody and made a number of recommendations to improve practice.[3] In our reports published between April 2017 and March 2018, we reported that staff knowledge of procedures to rouse intoxicated detainees safely was mostly but not always adequate.

9. Under PACE Code C, detainees should be referred by custody staff to be assessed by a health professional based on identified need and if the detainee requests it. This requires significant skill from the custody sergeant to identify need and should be underpinned by a robust service level agreement with a health provider. Each force commissions its own health provision. Some forces, but not all, use the NHS England service specification as a template and seek support from NHS England in this process. However, there are significant variations in the provision including agreed response times. For example, at the time of our inspection the Metropolitan Police had no agreed response times with its health provider which impacted negatively on outcomes. Many health providers struggle to see detainees promptly due to staffing shortages, high demand and large geographical areas. This means some detainees may experience excessive delays being assessed and receiving treatment for drug and alcohol withdrawals.

10. Symptomatic treatment for drug and alcohol withdrawals was available in all custody suites we inspected, based on clinical presentation and patient history. However, clinical drug testing is not completed in police custody. This creates problems if the person is administered benzodiazepines and/or opiates and then transfers to prison as there will be no baseline screen to support their longer-term care including the need for benzodiazepine detoxification.

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[1] College of Policing, *Authorised Professional Practice Alcohol and Drugs*, https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/alcohol-and-drugs/#under-the-influence-of-drugs-or-alcohol.
[2] PACE 1984 Code C paragraph 9.3 and Annex H requires "Those suspected of being under the influence of drink or drugs or both or of having swallowed drugs (…) or whose level of consciousness causes concern must, subject to any clinical directions given by the appropriate healthcare professional (…): be visited and roused at least every half hour; have their condition assessed as in Annex H; and clinical treatment arranged if appropriate."
[3] Rt. Hon. Dame Elish Angiolini DBE QC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody*, January 2017, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf.

11. A significant proportion of detainees go from police custody to court and then on to prison. During our police and court inspections we find that people are often transferred to court custody early in the morning and spend long periods there, even after their case has finished, prior to transferring to prison. The journey to prison can be further extended if nearby prisons will not accept detainees due to the late hour or lack of space and is often very long for women and children as there are fewer establishments. In most policy custody suites, withdrawal medication that may be due to be taken at court is not sent with the detainee. This is mainly due to health providers not being aware that medication can be administered by court staff providing it is labelled correctly and there are clear administration instructions. Health providers also cite concerns about what would happen to the dose if the person is released from court before the dose is due. This means detainees may experience significant withdrawals, which is particularly concerning for those withdrawing from alcohol due to the risk of seizures and other serious complications. Withdrawals will also impact on a detainee's mental state and their ability to engage effectively in court proceedings.

12. Some people entering police custody have been prescribed opiate substitution treatment (OST) in the community. OST, where clinically appropriate, should be consistently provided in police custody.[4] Continuity of treatment is important, particularly when someone may otherwise miss one or more doses due to being in custody. In some forces we inspect, continuity of treatment does not happen. This may be due to one or more of several reasons such as: the health provider will not continue OST; not all prescribers are happy to continue it; or its continuation is restricted to the highest risk groups such as pregnant women. Additionally, even where it is continued, the local rules in some forces require a doctor to administer it, which can lead to delays in doses as often there is only one doctor on call for the full force area. Tolerance to opiates drops quickly and health providers will often need to recommence OST at low doses if a person has missed two or more days of treatment. We regularly meet people in prison whose treatment was negatively impacted, sometimes significantly, by their OST not being continued in police custody.

13. Continuity of care and effective partnership working is compromised by the lack of a single electronic case system shared by health providers in police and prison custody. There are significant variations in custody based clinical recording systems between police forces and some still use paper records. This means that, even within a single force, continuity of care is often compromised by a lack of access to previous custody records. A few sites we inspected could access community records remotely which allowed health professionals to confirm GP prescribing promptly, but this is rare. In addition, police custody health assessments are not accessible to prison staff. This all results in duplication of effort and means key information is not shared. It also means that inconsistencies in a person's presentation or history between detention episodes and settings are not easily identified, resulting in sub-optimal care.

14. Some detainees are suspected of internally secreting or swallowing illicit drugs, which creates significant risks to the detainee, including overdose. Forces should have a clear multidisciplinary policy for this situation developed in partnership with health providers, ambulance trusts and local hospitals, but this is not always the case.

15. Section 136 of the Mental Health Act allows the police to remove an individual to a place of safety, which includes a police station (recent legislative changes mean that police custody is no longer a place of safety for those under 18). In the past, we found too many people detained in police custody as a place of safety under Section 136, rather than a health based

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[4] Drug misuse and dependence: UK guidelines on clinical management Section 5.3.1.2 Update 2017. Independent Expert Working Group (2017) Department of Health; and Access to supervised doses of opioid substitution for people in police custody (Public Health England 2015) https://psnc.org.uk/sheffield-lpc/wp-content/uploads/sites/79/2013/06/access-to-supervised-opioids-for-people-in-police-custody.pdf.

place of safety (HBPoS). Police custody is not a therapeutic environment and is not suitable for people experiencing a mental health crisis. Often intoxication was the reason used by a HBPoS to refuse to accept someone into care. The introduction of the Mental Health Crisis Concordat (an agreement between services and agencies involved in the care and support of people in crisis) in February 2014 and the recent legislative changes have resulted in far fewer people being held in police custody as a place of safety. However, it remains an issue in some forces often due to not enough suitable alternative places in the community.

16. There is a need for regular training updates for all staff who work in custody on substance misuse, local patterns of misuse, intoxication, rousing checks, withdrawals, management of overdose and recovery/ treatment options. There are opportunities for custody staff to provide brief evidence based interventions if trained to do so. However, we find that custody staff usually receive updated training on rousing checks but not always on the other aspects of training.

17. All police custody suites are smoke free environments. However, many do not provide any pharmacological support to those that smoke who are detained, which may increase their distress and discomfort.

18. A Person Escort Record (PER) is completed when a person is transferred between custodial settings and on escorted external appointments. This document should clearly detail all current risk information relating to the detainee prior to and during the escort procedure. We regularly find that these documents are not completed sufficiently well, which creates risks of poorer health outcomes. In police custody, a PER is generally completed by custody staff without direct input from health staff. Often custody staff print out health notes from the custody record and insert them as loose sheets into the PER. These sheets can be misplaced, which may breach medical confidentiality, and often do not clearly state the risk and potential actions required to address the identified risk. Unlike in police custody, in prisons, health staff complete the health sections with appropriate consideration of the need to share risk information, patient consent and confidentiality. Risk management would be improved if health staff inputted into these documents in police custody.

19. The government introduced the Drug Interventions Programme (DIP) in 2003 to provide consistent beginning to end care for drug users including arrest referral schemes, support within police and court custody and through-the-gate support from prison to the community. Ring-fenced funding for DIP ended several years ago, which has led to variations in provision. In some forces, local community drug and alcohol services attend regularly to proactively offer detainees support and the opportunity to engage in services, which improves take up of services. We are seeing fewer of these proactive services in custody suites we inspect, usually due to funding cuts. Custody and/or health staff may offer a referral to local services or information on services, but take up is often low.

20. People may be released from police custody at unsocial hours. We found that very few police forces offer clean injecting equipment on release even when there are drug workers on site, although clean injecting equipment was available in the suite at South Wales and Gwent.

21. Rates of drug related overdoses continue to increase in the community.[5] Overdose management training and Naloxone is an important harm reduction initiative. We rarely see

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[5] Office for National Statistics, *Statistical Bulletin Deaths related to drug poisoning in England and Wales: 2016 registrations*, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations.

this provided in police custody, but it was an excellent and developing initiative in the Gwent custody suites.

Prisons

22. The use of illicit drugs such as cannabis, synthetic cannabinoids and opiates and the misuse of medication continued to cause significant problems in most adult male prisons we inspected in 2017/18. In women's prisons we continued to find women misusing prescription medicines, with synthetic cannabis an occasional issue. This undermines the safety of prisons by contributing to high levels of debt, violence and self-harm. HMI Prisons conducts a survey of prisoners in each establishment we inspect. In our surveys published during 2017/18, significantly more women (42%) than men (28%) reported drug problems on arrival. A higher proportion of women (73%) than men (59%) said they had been helped with their drug problem in prison. Eighteen percent of men and 24% of women reported alcohol problems on arrival, with 58% and 55% of those respectively reporting they received help with that problem in prison.

23. Young adults tend to present with less dependency but will often report problematic use including binge patterns of misuse. Public Health England report that cannabis, alcohol, cocaine, nicotine and ecstasy are the top five drugs used.[6]

24. In general, problematic use of substances rarely exists as a problem in isolation and it is often linked with other problems including mental health issues, physical health problems, offending, social problems and other vulnerabilities. Recovery potential can therefore be increased by addressing these concurrent problems, including ensuring support is in place on release.

Clinical treatment

25. In most prisons we inspected in the past year the clinical management of substance misuse was satisfactory. We found that patients with clinical needs were identified promptly, including by utilising urine testing. We saw delays in first night prescribing in three prisons due to prescribers not being available and/or prisoners arriving very late from court.

26. In England, those dependent on illicit opiates receive first night prescribing of Opioid Substitution Treatment (OST) and other required medication for withdrawals if clinically indicated. This gives prisoners very rapid access to treatment compared to the community. The Integrated Drug Treatment System (IDTS) which introduced first night prescribing of OST in prisons in England was not implemented in Wales or Northern Ireland. In Wales and Northern Ireland, only people who arrive on a community prescription of OST can automatically continue it in prison. For those not on a community prescription of OST, only symptomatic prescribing is offered for illicit opiate use. This drives demand for illicit substances within prisons and increases the risk of overdose on release as prisoners have reduced tolerance. In prisons in Wales, it is possible for a prisoner to commence OST later in their sentence if this is recommended by community prescribers. However, we find that the timeliness and availability of OST in these circumstances is very variable. In Northern Ireland, there are no opportunities for those dependent on illicit opiates to start OST in prison due to prescriber staffing shortages, although it is hoped this will be introduced in the future. Long waiting lists for OST prescribing in community services in Northern Ireland

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[6] Public Health England and Department of Health and Social Care, *Secure setting statistics from the National Drug Treatment Monitoring System (NDTMS 1 April 2016 to 31 March 2017)*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/677500/OFFICIAL-SENSITIVE_secure_setting_annual_report_2016-17FINAL-v1.2.pdf.

further exacerbates delays. The result is that opportunities to stabilise people, engage them in treatment and reduce drug related harm are lost.

27. We expect newly arrived prisoners experiencing withdrawals in prison to receive additional monitoring (both during the day and overnight) in their early days in prison to identify worsening withdrawals and signs of over-sedation. Ideally their cells should have hatches that allow easy observation and the delivery of required medication overnight. In 2017/18, we reported that this monitoring did not take place in a small number of prisons.

28. Methadone and Buprenorphine are always administered under supervision in prison settings, primarily because these drugs are highly tradable and therefore their unsupervised administration may result in diversion and bullying. Buprenorphine takes significantly longer to administer than most drugs as it can take five to 10 minutes to dissolve. It is therefore normally crushed to granules for administration in prisons to reduce the potential for diversion. Buprenorphine is a very popular drug of misuse in prison as it provides euphoric effects when snorted. We have found some establishments that will either not prescribe Buprenorphine at all or have very restricted criteria for prescribing, including the prisoners having an arrival drug screen which is negative to all other substances and/or the prisoner being on a short sentence. We have seen some prisons change to prescribing Espranor in place of Buprenorphine to speed up administration and reduce diversion, although this is costly compared to generic Buprenorphine prescribing.

29. The 2007 Clinical Guidelines for Drug Misuse and Dependence stated that lower doses of Methadone were appropriate in prison due to limited drug availability. In addition, IDTS guidance identified sentence length as a key factor in prescribing decisions. We previously saw that the combination of these two sets of guidance led to some suboptimal prescribing, enforced reduction plans and poor outcomes for prisoners. However, the updated 2017 Clinical Guidelines for Drug Misuse and Dependence stress the importance of person-centred prescribing that considers the patient's preferences and considers factors such as recovery capital, which has helped to embed more recovery-focused prescribing. In 2017/18, we made recommendations about inflexible prescribing in around 15% of prisons.

30. It is important in prisons, as in any other setting, that psychosocial interventions and recovery are integrated with pharmacological approaches in order to support prisoners with substance use problems. Overall, we have found that joint working between clinical and psychosocial services has improved in recent years. A number of services we inspect employ joint prescribing reviews that include the prescriber, psychosocial worker and service user (which is a best practice approach as it supports continuity of care). However, many services we inspect struggle to achieve this due to resource issues. In addition, the high drug availability in a number of prisons means that a recovery focus is simply not possible.

31. Many prisoners present with chronic pain and the management of this can be challenging, particularly when prisoners arrive in prison on complex poly-pharmacy prescriptions which have not been prescribed in line with best practice and include known tradeable medications (such as pregabalin, gabapentin, benzodiazepines and other psychotropics). Attempts by prison prescribers to implement more evidence based prescribing may lead to self-harm and challenging behaviours including violence. Prison healthcare providers often need to undertake the necessary investigations and interventions to support prescribing (which should have been done in the community when the initial prescription was made). However, many prisoners are only in prison for short periods, which means the full process cannot be completed. There is therefore a need for more pain management services in prisons that link effectively with community services and we saw this taking place in the analgesia review clinic at HMP Coldingley. The NHS England pain formulary for prisons is also a very helpful resource, although the creation of a prison specific resource risks amplifying differences in prescribing between the community and prisons. The solution may be to ensure that best

practice in prescribing, which recognises the abuse potential of many medicines, is embedded across both community and prison treatment settings.

32. Prisoners will misuse varied substances depending on availability and will sometimes seek certain medicines to mitigate or enhance the effect of another. In Northern Ireland, misuse of prescription medicines is significantly more prevalent than use of heroin or other Category A substances. This poly drug use carries significant risks. Consequently, in all prisons it is very important that medication which is high risk for misuse is managed effectively. This includes effective observation of medication administration queues by officers to reduce the risk of diversion However, we often find that this is not a profiled activity in many establishments and can be inconsistent or inadequate.

33. Some people will develop drug problems or relapse in prison.[7] Most prisons we inspect will provide psychosocial support and/or clinical support as needed for those reporting illicit drug use in prison. However, very few establishments audit the numbers of prisoners presenting for secondary drug treatment, which means that data which could better inform service development is lost. We are advised and observe that rarely is there a sufficient supply of drugs in prisons for prisoners to develop physical dependence. However, illicit drug use in prison can nonetheless lead to very significant problems such as debt, violence and self-isolation. We have been told during some inspections that vulnerable prisoners are being used (or volunteering) to test new batches of Spice.

34. NHS England have generated a new service specification for substance misuse in prisons but it is too early to comment on the impact of this.

Psychosocial Support

35. In inspection reports published in 2017/18, many prison healthcare services had challenges recruiting and retaining health staff with appropriate skills. This is evident nationally throughout health and substance use treatment services but is often more acute in prisons due to staff needing to have additional skills and resilience to handle challenges associated with the prison environment. In addition, long delays in pre-employment security checks required to work in prisons lead to applicants dropping out of the process. In several prisons we inspected, the lack of healthcare staff impacted on service delivery such as waiting times for assessment and the range of provision.

36. We expect that the substance misuse team and/or prisoner recovery worker see all new arrivals in prison to advise them about the support services available and deliver prison specific harm reduction advice. Most services we reported on in 2017/18 were doing this, but a minority only saw those that were referred to the service. This meant the opportunity to reach those with problematic (but not dependent) use was missed.

37. In recent inspections we have found that psychosocial support for prisoners with substance misuse needs remained mostly good and timely, although we made recommendations at nine adult prisons about access and the range of provision not meeting the need. Although several prisons provided noteworthy support (the box below highlights good practice that we have seen in recent inspections), most services struggled to engage those who are misusing medicines and new psychoactive substances (NPS), a problem that also occurs in the community.

Good Practice

[7] HMI Prisons, *Changing patterns of substance misuse in adult prisons and service responses by HM Inspectorate of Prisons,* December 2015, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/12/Substance-misuse-web-2015.pdf. See recommendations and Action Plan.

"The provision of drug and alcohol harm reduction information to all new arrivals had raised prisoners' awareness of the dangers associated with substance misuse." HMP Sudbury

"The integrated substance misuse team (ISMT) included a fully qualified and accredited counsellor who provided sessions with prisoners to explore the issues underlying their substance use." HMP Dovegate

"Sleep hygiene groups helped prisoners to tackle sleeplessness without using illicit substances." HMP Dovegate

"Prisoners could contact the ISMT using their in-cell telephone, free of charge, if they needed support." HMP Dovegate

"The drama group exploring the effects of substance use on families gave prisoners valuable insights into their behaviour." HMP Huntercombe

"Prisoners with drug and alcohol problems had access to an impressive range of interventions that were enhanced by peer support and mutual aid. They also benefited from the structured and supportive environment of the stabilisation and substance recovery units." HMP Altcourse

"The CHASE programme helped prisoners tackle their own substance misuse problems and develop transferable employment skills that could be used in substance misuse services and the wider employment market on release." HMP Prescoed

38. Effective drug recovery wings can support prisoners in their recovery journey, particularly if the prison has high illicit drug availability (the box below highlights good practice in this area). However, we also find recovery wings that are ineffective as they do not have a recovery focus and are undermined by holding too many prisoners that are not in recovery.

Good Practice

"The substance misuse recovery unit (G wing) provided exemplary partnership working between the prison, clinical and psychosocial teams. It was an effective and supportive environment that encouraged prisoner recovery from addiction." HMP Preston

"The therapeutic community was a centre of excellence with a philosophy that encouraged personal responsibility. There was evidence of good outcomes for prisoners." HMP Holme House

"The drug-free unit provided a supportive environment that allowed prisoners to focus on their recovery." HMP Pentonville

39. We often see the level of provision of psychosocial services drop during periods of re-recruitment in the few months before a new provider begins and for the first few months of a new contract. This can lead to poorer outcomes for prisoners during that particular period.

40. We continue to see shortages of prison staff leading to restrictions in prisoners' ability to access psychosocial services in a few establishments. Shortages of prison staff mean that there may not be sufficient escorts to take prisoners to appointments or allow them to be unlocked to see services. However, overall, we found this had improved in 2017/18 compared to the previous two years.

41. Effective peer support is a significant factor in achieving positive outcomes for many prisoners across many areas, including health and substance misuse[8] where mutual aid such as Alcoholics Anonymous is important. In some prisons we have found that peer support

[8] HMI Prisons, *Life in prison: Peer support*, January 2016, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/01/Peer-support-findings-paper-final-draft-1.pdf.

generally runs very well, but in others we find that it is either not available or is only accessible for some prisoners. In relation to substance misuse, in some prisons we have seen competent, well-supported prisoner recovery champions working as an effective integrated part of treatment (recent good practice examples are in the box below). However, in others this support is still not fully developed due to issues such as turnover of prisoner mentors, insufficient community volunteers, delays in security clearances for volunteers or the scheme being de-prioritised when there are insufficient staff.

Good Practice

"The harm reduction initiatives developed by peer representatives ensured that prisoners played a prominent role in delivering health promotion messages." HMP Grendon

"Peer mentors were actively involved in service delivery, service development and officer training, and contributed to drug strategy meetings." HMP Northumberland

42. Families are key to many peoples' recovery. We have found some services which have embedded family support and engagement into their psychosocial support provision, but it was a significant gap in most prisons that we reported on in 2017/2018.

43. Recovery based drug testing is rarely funded anymore in prisons, although clinical testing for those prescribed OST normally occurs.

44. Historically in prisons, psychosocial case notes were paper-based whereas clinical notes were included in the computer based record (SystmOne). We were pleased to observe during 2017/18 inspections that some psychosocial support teams were beginning to use SystmOne to record case notes. This significantly improved the continuity of care.

Mental Health Support

45. There are strong links between mental ill-health and problematic substance misuse. Some prisoners use drugs to self-medicate for mental distress whereas for others drug use causes mental ill-health. Many prisoners therefore require support to address underlying mental health issues such as anxiety and trauma before they can progress effectively in their recovery.

46. The demand for mental health support is always high in prisons and this can increase further when there are additional environmental stressors such as high drug availability, a poor regime or a poor physical environment. In reports published between 19 January 2018 and 16 May 2018,[9] 45% of prisoners answering reported that they had mental health problems. Of those, 40% reported they had been helped with those problems while in prison. It is important that mental health provision in prisons is able to meet need as prison can present an opportunity to intervene to reduce reoffending and improve wider health outcomes. This is particularly the case for those with mild to moderate mental health problems and for those in crisis, including those at risk of self-harm and suicide. In addition, it is essential that mental health services in prison are able to be responsive as many people are held in prison on short sentences.

47. In reports published in 2017/18, we made recommendations to improve mental health provision in 21 prisons we inspected. In most cases, this related to gaps in the range of

[9]HMI Prisons introduced a new survey in adult establishments in September 2017 which introduced this question and the first figures were published from this survey in an inspection report published on 19 January 2018. The establishments included in the calculation of the figures referred to here are HMP: Liverpool, Leeds, Altcourse, Nottingham, Gartree, Lindholme, Usk, Rochester, Humber, Hindley, Prescoed, Spring Hill, Peterborough (women) and HMYOI Brinsford.

provision such as insufficient staff or a lack of specific interventions such as psychological services, counselling or support for those with learning disabilities. This often leads to an over-reliance on pharmacological solutions rather than supporting people to adequately address underlying issues. However, several prisons exhibited good practice (these are highlighted below). We also found that the identification of and support for those who have impairments due to acquired brain injuries and dementia is very inconsistent across the estate and insufficient in a number of establishments.

Good Practice

"Group work and a trauma service supported prisoners with sleep difficulties and distress from trauma." HMP Huntercombe

"The sharing of detailed supportive care plans with wing staff for prisoners with specific care and vulnerability needs supported their mental well-being and safety in prison." HMP Guys Marsh

"The prisoner health care representative encouraged women to access mental health services and provided them with useful peer-led information." HMP Downview

"There were care pathways for patients with neuro-developmental problems or speech and language needs, which facilitated the assessment and treatment of commonly unrecognised syndromes among prisoners." HMP Feltham B

"The weekly mood clinic run by the GP and an experienced mental health nurse was a good initiative that provided a joint care approach for patients with depression." HMP Thameside

"The Talking Therapies model provided patients with problems related to anxiety, depression and post-traumatic stress disorder with focused support to enable them to cope better and improve their mental health. "HMP Liverpool

48. Prison officers need regular mental health awareness training to be able to identify and support prisoners with mental health issues. However, this is not mandatory training and we often find that it is not available or poorly attended in prisons where it is available.

49. Generally, we are seeing more effective joint working between substance misuse services and mental health services, although pathways are sometimes underdeveloped. Some prisons now have integrated mental health and substance misuse services (such as at HMP Erlestoke, HMP Bristol and YOI Werrington) and this appears to have supported improved outcomes. There is benefit to both patients and providers if mental health and substance misuse providers work together to provide some interventions that would benefit clients from both groups and those with both issues. This might include group work around emotional regulation, anxiety management, mindfulness, coping strategies and relaxation.

Strategic Approach to Substance Misuse

50. Successful and effective integration of treatment and both demand and supply reduction are essential for optimum outcomes for prisoners around substance use. A whole prison approach to reducing substance use is required. However, we continue to find weaknesses in prisons' strategic approach. We made recommendations about these weaknesses in 17 prisons we reported on in 2017/18. The main weaknesses related to ineffective substance misuse strategy meetings, the strategy being out-of-date, strategies insufficiently addressing all required aspects, strategies not being informed by a current assessment of need, the absence of an action plan to support the implementation of the strategy or a combination of these factors.

51. In addition to weaknesses in strategic approach, demand reduction is often inadequately addressed and considered in prisons' approaches to substance use. An important aspect of demand reduction is ensuring prisoners are out of their cells and purposefully occupied. In

our reports published in 2017/18, we continued to find staffing shortages negatively impacting on the time prisoners spent out of their cells. In addition, prison regimes had often become less predictable, which was frustrating and unsettling for prisoners. In response to this, we found many prisons on temporarily restricted regimes in order to achieve predictability. However, this meant prisoners could be locked up at 6pm or earlier.

52. Mandatory drug testing (MDT) is a key part of many prisons' supply reduction strategy. Each prison completes a required amount of monthly random testing and can complete other tests based on suspicion or risk. The testing programme is intended to be a deterrent, as a positive result will result in punishment including loss of privileges. There has been some criticism that MDT drives patterns of use, including increased preference for Class A drugs that metabolise quickly over cannabis and increase use of drugs that will not be detected such as NPS and psychotropic medication. Testing for synthetic cannabis has been included in MDT for about 18 months, which means that test results now more accurately reflect use. However, there are still significant gaps in testing as few popular misused medicines are included and NPS drugs change regularly. In Northern Ireland, the MDT test does not include NPS but does include a wide range of psychotropic medicines, including tramadol, gabapentin and pregabalin, as those are the primary drugs of misuse. HMP Leeds is a fairly typical example of the rate of random positive results that we see across prisons in England and Wales. In the six months prior to our inspection, the random drug testing rate was 13.02%, rising to 29.9% when NPS were included. We have seen results of over 40% at some establishments. However, we do also find lower rates, for example, around 4.5% rising to about 10.5% when NPS were included at HMP Gartree. The number of medical emergencies relating to synthetic cannabis varied both between and within prisons (often coming in spikes). Although there were a significant number of emergencies in some prisons, overall it appears that medical emergencies relating to synthetic cannabinoids may be reducing. It is not clear if this is as a result of lower usage, prisoners learning to use in a safer way, prisoners more effectively hiding their usage or a combination of these factors.

53. Most prisons we inspected in 2017/18 were completing the required random drug tests, but many struggled to complete requested suspicion tests and/or suspicion searching. A number of prisons reported that the intended deterrent of MDT, resulting in loss of privileges for a positive result, is not resulting in changed behaviours. Some prisons are therefore trialling approaches which allow a prisoner testing positive to choose to engage with drug services as an alternative to punishment.

54. The implementation of smoke-free prisons has largely gone well but in some prisons, it was linked to problems such as abuse of nicotine replacement products and an increase in synthetic cannabinoid related medical emergencies (as these drugs are no longer being diluted by tobacco). Tobacco has now itself become a desirable substance.

55. Some prisons we inspected during the year reported staff being adversely affected by fumes from synthetic cannabis. Guidance from Her Majesty's Prison and Probation Service was welcomed by staff although some reported that it was too vague to be helpful. The Royal College of Nursing raised concerns that the guidance asks nurses to put their wellbeing at risk.[10]

Release Planning and Wider Resettlement Issues

[10] Royal College of Nursing, "The Spice drug epidemic in UK prisons is putting nurses and inmates at serious risk, the RCN has warned" 15 May 2018, https://www.rcn.org.uk/news-and-events/news/prison-spice-epidemic-putting-nursing-staff-at-risk.

56. We expect that, prior to release, prisoners will have an up-to-date plan for addressing their outstanding rehabilitation needs, which is managed in partnership with the community-based responsible officer. These plans should update those first completed when a prisoner arrives in prison and should include identifying risks of illicit drug use or misuse of medication. In inspections during 2017/18 we found that not all prisoners had a resettlement plan and the quality of plans that were in place was too variable. Plans failed to properly assess issues and often only signposted prisoners to community services without requiring concrete actions to be taken.

57. In relation to substance use, we found that release planning often includes referrals to community rehabilitation services. However, we find that prison substance misuse teams do not always share release planning information, including referrals to community rehabilitation services, with Community Rehabilitation Companies (CRCs) or the National Probation Service (NPS). This means that the opportunities for CRCs or the NPS to effectively support the prisoner on release, follow up referrals or make additional referrals are lost. In addition, the most recent Public Health England figures show a high non-engagement rate with community treatment. The proportion of people reported to engage in community treatment within 3 weeks of release is currently 30.3%, ranging from a low of 12.7% in Leicester to a high of 59.7% in Lincolnshire and Rutland.[11] While it is predictable that some people might choose to disengage on release, more work is required to understand and address such high non-engagement rates.

58. We found that psychosocial workers generally see all their clients in the days prior to release to discuss harm reduction. However, because workers focus on their clients, those that have exited treatment or did not engage in treatment do not get the benefit of this intervention. In a few prisons we found that psychosocial staff saw all people being released.

59. In a small number of establishments, we found community drug workers running regular clinics within the prison to support continuity of care. In addition, some services can access gate pick-ups for very vulnerable clients or those going to rehabilitation, but this is not widely available.

60. Sudden releases from prison used to lead to significant problems with continuity of prescribing but generally we find that this is now well managed. Many establishments have access to FP10 prescriptions to prevent any gaps in treatment.

61. Overdose management training and prescribing Naloxone are recognised as important harm reduction intervention exercises to prevent and treat overdose in the community on release. However, this is not yet available in all prisons, primarily due to commissioning issues. In our reports published in 2017/18, we made recommendations for this intervention to be implemented in seven establishments.

62. As highlighted above, substance misuse problems do not exist in isolation and often people have wider resettlement needs that must be addressed to support their recovery from substance misuse. This often includes assistance to find accommodation and work, make a benefits claim and with health needs. Our two thematic reviews of Through the Gate resettlement services undertaken jointly with Her Majesty's Inspectorate of Probation, highlighted prisoners' needs in this area and inadequate provision to respond to those

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[11] Public Health England, Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison 2016/17, https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/3/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/92544/age/168/sex/4.

needs.[12] Both reports indicated that CRCs were making little difference to prisoners' prospects on release. We found that CRCs focused on meeting their contractual targets to produce written resettlement plans rather than undertaking meaningful interventions (which we found were not specified or rewarded sufficiently in CRC contracts). In relation to substance misuse, we generally find that partnership working between substance misuse and health services within prisons and CRCs is very underdeveloped. In addition, CRCs in most prisons could only deliver very basic assistance to prisoners who were going to be released outside of the CRCs contracted area. We were particularly concerned in 2017/18 to find an increase in the proportion of people released from prison without suitable or sustainable accommodation. A new legislative requirement on local authorities in England to prevent those leaving custody from becoming homeless came in to force in April 2018[13] and a duty on governors and directors to refer individuals nearing release and at risk of homelessness to local authorities is due to come into force in October 2018.[14] It is not yet clear if these measures will reduce the number of people being released from prison without accommodation.

Conclusion

63. Transfer between the community to custody and from custody to the community offers opportunities for positive outcomes for people with substance misuse issues. However, too often these opportunities are missed for a range of reasons, including a lack of strategic management and planning, staff shortages (both in healthcare providers and prisons) or staff without sufficient expertise or training, inadequate provision to meet need and a failure to integrate difference services. Comprehensive and consistent pathways which bridge each transition are necessary to support people to maximise their recovery capital and achieve positive outcomes. These pathways need to consider supply reduction, demand reduction and treatment in an integrated way to ensure there is a whole system approach to reducing use, reducing reoffending and supporting recovery in the community and in custodial settings.

64. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me.

Peter Clarke CVO OBE QPM **June 2018**
HM Chief Inspector of Prisons

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[12] *An inspection of Through the Gate Resettlement Services for prisoners serving 12 months or more.* June 2017; *An inspection of Through the Gate Resettlement Services for Short-term Prisoners*, October 2016.
[13] http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted.
[14] http://www.legislation.gov.uk/uksi/2018/223/made.

Annex: Thematic report - Changing patterns of substance misuse in adult prisons and service responses

Changing patterns of substance misuse in adult prisons and service responses Action Plan https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/12/Substance-misuse-thematic-action-plan-updated-22-03-17-1.pdf			
1. **Rec.** **no**	**2** **Recommendation**	**3.** **Accepted/** **Rejected**	**4.** **Response** **Action Taken/Planned**
Recommendation **To Ministers**			
1.17	**The Prison Service should improve its response to current levels and types of drug misuse in prisons and ensure that its structures enable it to respond quickly and flexibly to the next trend. A national committee should be established, chaired by the Prisons Minister, with a membership of relevant operational experts from the public and private prison sectors, health services,** **law enforcement, substance misuse services and other relevant experts. The committee should be tasked to produce and publish an annual assessment of all aspects of drug use in prisons, based on all the available** **evidence and intelligence, and produce and keep under review a national prison drugs strategy.**	Partially Accepted	The Prison Safety and Reform white paper committed to a national drugs strategy for prisons, covering both the supply of and demand for drugs. However, within this national strategy it will be for individual prisons and governors to develop their own approach to substance misuse, based on the circumstances of their prison and its population. This reflects the current co-commissioning policy, in which substance misuse services will be commissioned by the NHS and prison governors based on a core specification which is then tailored locally based on a needs assessment to ensure gender and population specific services. We are taking urgent action to improve prison safety and security, alongside reforms to overhaul the system to focus on the rehabilitation of offenders, ensuring that appropriate treatment and interventions are in place to help prisoners with a history of drug addiction and use. We have already take steps to improve our response to substance misuse, in particular rolling out new tests for psychoactive substances across the estate – the first jurisdiction in the world to do so. Avoiding mandatory drug testing has previously been one of the biggest factors driving prisoners to choose psychoactive substances over traditional drugs.
Recommendations **To NOMS (now HMPPS)**			
1.18	**Individual prisons should have an up-to-date drug and alcohol strategy and action plan which includes supply reduction, demand reduction and treatment based on a comprehensive local**	Partially Accepted	As set out above, MoJ will develop a drugs strategy for prisons that will reassess our wider approach to tackling both the supply and demand for drugs in prisons. However, prison governors will need to develop an approach within that framework that addresses the

	assessment of need, overseen by a committee which includes consistent attendance from all departments and relevant community representation.		challenges of their prison. As part of co-commissioning and wider prison reform, we will look at the feasibility of drug and alcohol strategies for individual prisons being overseen by a committee. One component element of the Performance Agreements which are being negotiated with prisons is the prison's strategy. This would be the vehicle for the prison to set out its approach to addressing substance misuse. The prison Governor will be held to account for meeting this Performance Agreement, and the prison's performance will be assessed against a new performance framework, which includes a measure
1.19	**Work should be carried out to:** · **Provide education and information for families and visitors about synthetic cannabis and other forms of illicit drug use** · **Develop clear protocols for the involvement of families, where appropriate, in work with individual prisoners to reduce the harm caused by substance misuse** · **Provide and widely advertise a national, independent hotline that enables family members to report and seek assistance with threats related to the supply of illicit drugs and concerns about a prisoner's use.**	Accepted Accepted Rejected	Her Majesty's Prison and Probation Service (HMPPS) is working to ensure that all prisoners and visitors are aware of the very serious risks that substance misuse brings. Two Prison Radio Campaigns on the dangers of New Psychoactive Substances (NPS) have been undertaken. A third is planned for later in 2017. Posters and leaflets have also been produced along with a DVD for use on reception or induction or part of group work. Service users have been involved in the development. There have also been a number of local initiatives. Prisons will develop protocols as part of their local drug strategy (subject to answer to 1.18) Prisons currently have a variety of structures in place for families and friends to bring concerns to the attention of staff, and as such through their empowered approach, Governors should consider how to increase the awareness of these schemes and to make information about them more readily available to prisoners and their families and friends; this is likely to be the most effective way of ensuring that information finds its way to the staff who have the ability to act on it.
1.20	**It should be ensured that protocols with the police at national and local level establish effective actions to disrupt the supply of illicit substances by visitors, prisoners, staff and other sources.**	Accepted	The joint protocol on the Appropriate Handling of Crimes in Prisons was published in February 2015. The protocol, at the time agreed with ACPO, CPS and HMPPS, provides robust guidelines for joint working between prisons, police and CPS to ensure that wherever possible and appropriate, those who commit acts of violence or other

			serious crimes in prison are punished through the courts rather than by the internal disciplinary system. The protocol specifies that possession with intent to supply of any class of controlled drugs by prisoners visitors or staff and possession of controlled drugs by visitors or staff (any class of drug or any quantity) must be referred to the police. Other drug offences need only be referred to the police if there are other circumstances which merit referral (theses are described in the protocol at annex B) or by local agreement between the prison and police.
1.21	**Mandatory drug testing results should not be used as a measure of prison performance.**	Rejected	MoJ remains committed to seeing a reduction in drug dependence among prisoners. Drug use is a key indicator for a given offender's likelihood to reoffend and it is therefore in the public interest for prison performance to be measured, in part, by drug testing results.
1.22	**Prisoners should have a consistent range of purposeful activity throughout the week and at weekends.**	Accepted	The Government white paper announced that new dedicated officers, each responsible for supervising and supporting around six offenders, will make sure prisoners get the help they need, including by seeing prisoners spend more time on purposeful activity and less time in their cells. Under the empowered Governors policy, individual prisons will be able to use the Release on Temporary Licence (ROTL) tool to allow prisoners to engage in purposeful activity, such as work, as part of their sentence.
Recommendation To Ministers and NOMS (HMPPS)			
1.23	**Urgent action should be taken to reduce the harm caused by new psychoactive substances (NPS), particularly synthetic cannabis. This should include: a) Measures to reduce the attractiveness and profits of supply by:** · **Quickly introducing legislation that takes due account of the advice from the Advisory Council on the Misuse of Drugs, bans harmful psychoactive substances and so reduces the attractiveness of supply**	Accepted	In May 2016 the Psychoactive Substances Act was passed, making it a criminal offence to possess or supply psychoactive substances in a custodial institution. The maximum sentence is 7 years' imprisonment and an unlimited fine, with an aggravating factor for a supply offence to a prison. To further address the dangers posed by such substances, the Misuse of Drugs Act was amended in December 2016 to make all third generation synthetic cannabanoids (a group of psychoactive substances) a Class B drug. The Act is another powerful tool in charging those found in possession of psychoactive substances and carries a heftier sentence of 10 years' imprisonment. Most recently, in the Prisons & Courts Bill currently before

	Urgently developing and rolling out more effective testing methods	Accepted	Parliament, proposals have been brought forward to allow us to adopt the generic definition of a psychoactive substance contained in the Psychoactive Substances Act 2016 for the purposes of drug testing. This would mean that in future tests can be carried out for controlled drugs and for any psychoactive substances covered by the definition in the 2016 Act, without the need to add each newly identified psychoactive substance individually using secondary legislation. This change would enable us to more quickly respond to and test for any new drug or substance identified. We have rolled out new tests for psychoactive substances across the estate as part of mandatory drug testing – the first jurisdiction in the world to do so. Avoiding mandatory drug testing has previously been one of the biggest factors driving prisoners to choose psychoactive substances over traditional drugs. As noted above, we have also brought forward legislative proposals to ensure we are able to test for new compounds as they emerge, enabling us to more quickly respond to and test for any new drug or substance identified
	Regarding the persistent or large-scale supply of NPS as a security threat and recategorising the prisoners involved accordingly.	Accepted	Prisoners can be recategorised at any time whenever there is a significant change in the risks they present. Involvement in persistent and large-scale drug supply will normally trigger a review of security categorisation where the security conditions in which the prisoner is held are insufficient to manage the risks presented. Where the prisoner is already held in conditions of higher security, other alternatives to manage their behaviour may be appropriate. All instances of persistent or large scale supply of NPS should also be reported to the police who may decide to pursue a criminal investigation.
	b) The development by every prison of a peer-led programme of substance misuse education, with effective resources to educate prisoners, particularly new arrivals, about the dangers and	Rejected	It should not be mandated. It is for local commissioners to assess needs and commission services best placed to meet need. However, HMPPS encourages this approach where appropriate and many establishments do have schemes Prisoner peer support can be invaluable where there are suitable prisoners, support and resources available, including training but a local matter.

	other consequences of synthetic cannabis use. **c) The development and delivery of national resources to ensure that all staff in prisoner contact roles are trained to understand the symptoms and consequences of synthetic cannabis use and that they are aware of how to deal with it.**	Partially Accepted.	National resources have been developed and delivered to support staff to recognise, and manage NPS misuse. HMPPS have already put in place a staff awareness campaign and a new section in the Prisoner Officer Entry Level Training. In addition, a toolkit for both HMPPS staff and clinical staff has been developed by Public Health England alongside tools, resources and guidance on the staff intranet. There are also many locally developed initiatives aimed at helping staff to manage problems related to NPS. However, there is no 'national NPS course' that all officers are required to attend. This would have cost implications for HMPPS as well as curriculum development impacts and would need further consideration
Recommendation **To Welsh Assembly Ministers and NOMS (HMPPS)**			
1.24	**Prisoners in England and Wales should have consistent access to equivalent substance misuse treatment.**	Accepted.	HMPPS in Wales has responsibility for all the prisons in Wales, and retains responsibility for the provision of non-clinical substance misuse services in the south Wales public sector prisons, with NHS Wales responsible for the clinical interventions. In 2016 HMPPS in Wales and the South Wales PCC jointly commissioned the Offender Interventions 'Dyfodol' service to provide substance dependency support and treatment services to offenders in the community and also within the South Wales public sector prisons, where they work closely with the NHS clinicians and prison staff. The Dyfodol service includes a single case management system that supports the person's continuity of care from community to prison and on to their resettlement, which would help inform the treatment plan. Substance misuse services at HMP Berwyn are commissioned by the Local Health Board and delivered by NHS Wales. HMPPS and the Welsh Government work closely with Health Inspectorate Wales, Public Health Wales and key stakeholders in substance misuse services in Wales to review the effectiveness of the current drug detoxification treatment provided in prisons from reception to release. This will need to take into account any continuity of treatment prior to coming in to prison and provision on release for

			both the remand and sentenced population so that treatment within prison minimises any risk of harm and supports the best outcome for offender rehabilitation. The intention will be for the review to inform the update of the Welsh Government's Offender Treatment Framework, which is to be revised as part of the Welsh Government's Working Together to Reduce Harm (Substance Misuse) Delivery Plan 2016 – 2018 by March 2018.
Recommendation To NHS England			
1.25	**Commissioning arrangement should ensure that drug treatment and psychosocial services provide a comprehensive range of interventions that consistently meet current standards but encourage and develop innovative practice. Services should be individualised; well integrated with the prison, health services and community support; appropriate to the needs of the population; and include effective peer support, family support and services for NPS and illicit medication.**	Accepted	The Department of Health and the Welsh Government for prisons in Wales are responsible for determining the policy on substance misuse treatment and suitable approaches, including the balance between clinical treatment and psychosocial interventions. All health services in prison are commissioned on the basis of equivalence with services for the general public, and there is a focus on continuity of treatment between custody and community. Drug treatment in prisons is based on an assessment of need and designed to meet the needs of low, moderate and severe drug misusers within the prison population. Health Needs Assessments are undertaken in establishments with the input of Governors to inform the commissioning and delivery of services. Commissioners in conjunction with Governors have the discretion to commission services that accord with national clinical guidelines and that they judge are best oriented towards recovery (and consequential reductions in reoffending). An integrated service is bought which should be both clinical and psychosocial. This may include a range of accredited and non-accredited rehabilitative programmes, structured psychosocial interventions and other evidence based approaches in prisons that are designed to address prisoners' substance use, offending behaviour and contribute to their well-being.
Recommendation To NHS England and Public Health England			
1.26	**A cohesive national strategy to reduce the misuse of prescription and over-the-counter medication should be developed which includes:**		

	a) Monitoring of prescribing trends in the community and prisons, challenging prescribing that is outside normal ranges and the sharing of information on emerging trends locally and nationally. **b) Prompt access for prisoners to cohesive pain management services which include appropriate non-pharmacological and pharmacological options.** **c) Evidence-based clinical and psychosocial treatment for dependence on illicit medication.**	Accepted	The Government will look at options to address the misuse of prescribed medicines, especially when combined with illegal drugs, more effectively. The National Partnership Agreement between: HMPPS NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016 contained the following commitments: 2.36 We will build on our work to date to review the management of prescription medicines working together with professional bodies to tackle abuse of medications and extend this to look at wider issues about medicine management in prisons as well as look at responding to the reported risk in harms from New Psychoactive Substances (NPS) in prisons. · 2.37 Continue to work together with professional bodies to promote changes in prescribing practice and tackle abuse of medications including publication of recommended national prison formularies and implementation tools for specific therapeutic areas including pain relief. **New Psychoactive Substances** - The Alcohol, Drug and Tobacco (ADT) division within Public Health England's Health and Wellbeing Directorate have worked with HMPPS and NHS England partners to develop an NPS toolkit aimed at supporting both healthcare and custody staff in prisons. It does this by providing key information and practical advice to inform and improve practice in dealing with the increasing challenges for staff presented by NPS. The toolkit is due to be published by PHE shortly and a programme of training for prison staff based on this resource, has already commenced in prisons that were part of the "through the gate" initiative in the North West. The ADT division will be rolling out this training nationally across the prison estate between January and March 2016.

			Pain management – in July 2013, in conjunction with the Faculty of pain Medicine, Royal College of General Practitioners and the British Pain Society, PHE published "Managing persistent pain in secure settings" (http://www.nta.nhs.uk/uploads/persistentpain.pdf). This is guidance targeted at prison based clinicians that sets out best practice diagnosing and managing the symptoms of persistent pain. The guidance was supported by a national training programme. In 2015, the Prison Healthcare Board (England) approved a programme of work to deliver a recommended national pain management formulary for use in HM Prisons. The aim of this work is to support and empower prison based clinicians to implement more consistent prescribing practice and tackle abuse of medications and reduce the diversion of prescribed medicines. The formulary was published on 11th December 2015 (https://www.england.nhs.uk/commissioning/health-just/pain-formulary/) The formulary implementation guide explains how medicines need to fit into the pain care pathway. Evidence from prisons that have implemented specific pain management clinics has shown success in the quality of prescribing and outcomes. The next phase of the pain formulary work (Jan-March 2016) is to collate examples of pain management/care models being provided and share these on the web-site. The PHE training for prison teams on wider Addiction to Medicines and imminent publication of the Opioids Aware resource have all been part of the strategy to improve care for pain and minimise harm from misused or diverted pain medicines. **Monitoring prescribing trends and challenging prescribing that is outside normal ranges** - The next clinical IT system for Places of Detention (PoDs) will include the capability for commissioners to extract anonymised prescribing data on a national, regional and provider/site basis. This will give commissioners and providers the mechanism to look at prescribing data in a similar way that we can for new Electronic Prescribing Analysis and Costing (ePACT) service in the community. There may also be scope for adding additional fields to look at clinical outcomes alongside the prescribing data.