
New psychoactive substances: a case for integration between health and criminal justice services

Roundtable seminar with Nigel Newcomen CBE, Prisons and Probation Ombudsman and Kate Davies OBE, Head of Health and Justice, Armed Forces and Public Health, NHS England

Reform, 45 Great Peter Street, London, SW1P 3LT
Monday, 9 May 2016

Reform is an independent, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity. Our aim is to produce research of outstanding quality on the core issues of the economy, health, education, welfare, and criminal justice, and on the right balance between government and the individual. We are determinedly independent and strictly non-party in our approach.

Reform is a registered charity, the Reform Research Trust, charity no.1103739. This publication is the property of the Reform Research Trust.

REFORM

Reform
45 Great Peter Street
London
SW1P 3LT

T 020 7799 6699
info@reform.uk
www.reform.uk
[@reformthinktank](https://twitter.com/reformthinktank)

Reform comment



Andrew Haldenby,
Director, *Reform*

In December last year Nick Hardwick, the Chief Inspector of Prisons, declared that new psychoactive substances (NPS), also known as legal highs, were the greatest threat to safety in UK prisons. Not only their effects on prisoners' health conditions, but also the behavioural threats they create, and the consequences of large debts built up by some prisoners, have consolidated NPS as one of the biggest challenges facing the prison estate.

Users of synthetic cannabinoids are 30 times more likely to have been admitted to a hospital emergency room because of their drug use compared to users of actual cannabis, the charity RAPt reported last year. The debt incurred by prisoners who buy the drugs are creating dangers both to them and their families, and NOMS has furthermore noted the existence of a link between use of NPS and violent behaviour in its latest annual report.

The dramatic increase in seizures of NPS over the past few years have made the Ministry of Justice alert to the problem's severity. In January last year, then Secretary of Justice, Rt Hon Chris Grayling, introduced new powers to punish prisoners found using or dealing NPS. He also announced new measures to enhance the ability of prisons to discover NPS, as the current mandatory drug testing and specialist dog teams are not able to detect most legal highs.

Further efforts have been made this year, with an NPS toolkit published for prison staff and a Psychoactive Substances Act that came into force on 26 May. The Act makes it an offence to produce and supply all forms of substances intended to produce a psychoactive effect, something which could reduce the supply of NPS to prisons.

In May 2016 *Reform* partnered with G4S to host a policy roundtable on the rise of NPS and how health and criminal justice services can cooperate to tackle it. The discussion was led by Nigel

Newcomen, CBE, Prisons and Probation Ombudsman, and Kate Davies OBE, Head of Health and Justice, Armed Forces and Public Health, at NHS England.

Several key themes emerged from the debate. Firstly, it became clear that there is already comprehensive communication and cooperation between the criminal justice system and health services when it comes to handling NPS use in prisons. This is important in order to deal with the different sides of NPS use, one relating to the regulation of prisoner behaviour, and another relating to prisoners' health.

Secondly, the discussion revealed that prisoners themselves have a major role to play in limiting the spread of NPS. Some of the best and most effective interventions have been from prisoners who have been using NPS and are able to convey its damaging consequences to other offenders.

Thirdly, prevention is considered key. Not only will this spare many prisoners, their families and prison staff of extremely unpleasant and dangerous experiences, prevention is much more cost-effective than treatment.

Fourthly, the use of NPS in prisons may turn out to be a repository of knowledge about effective reduction of NPS consumption in the wider population.

Finally, there was a general sense that more autonomy for individual prisons would better enable governors to create effective prison-specific strategies. Further devolution of powers to prisons is a part of the Government's current criminal justice policy. There was however also a call for a unified strategy across the country, allowing for widespread sharing of best practice.

NPS pose a serious and distinct challenge to the prison estate, and the exchange of knowledge and ideas will be absolutely crucial to the creation of an effective response to this challenge.



**Peter Small,
Director of HMP Birmingham**

New psychoactive substances (NPS), or what previously had been referred to as 'legal highs', have now been the subject of long-awaited legislation in order to make possession of these deadly substances illegal. Inside prisons, they can have a devastating effect on prisoners, their families and the overall stability of the regime. They have different characteristics which not only vary from drug to drug but between batches as dealers change the chemical composition. Until recently, that made them incredibly difficult to test for and therefore to prove cases against prisoners in order to impose appropriate sanctions as we would for other drugs. Worse still, it is almost impossible to predict how users will react and what dangers they may then pose to themselves and others around them.

I can recall instances where several members of staff have been required to restrain prisoners in order to prevent them inflicting considerable injuries on themselves after a bad reaction to NPS. In one case, several members of staff had to prevent a prisoner biting through their own thumb after a bad reaction to one of these new substances called 'Spice'. Staff put themselves at considerable risk to prevent the man causing a serious, permanent damage to himself.

Understandably, the public expect us to prevent all contraband from entering prison but every prison officer in the country will tell you that it is a constant battle to stay ahead of criminal gangs inside and outside of prison. From crudely trying to throw packages over prison walls to sending associates inside with contraband secreted inside body cavities and use of drones to try and deliver packages to cell windows, criminal networks are attracted by financial returns which are significantly higher than they can make on the outside.

At HMP Birmingham, we have developed a strong partnership with West Midlands Police so that we can act against prisoners, visitors, criminal associates on the outside and sadly in a few cases, corrupt staff, to tackle this pernicious problem. Every year about 10,000 prisoners will come in and out of the prison and a significant number will come inside with banned substances or contraband secreted on their person. Our methods to detect drugs on prisoners and around the site are constantly improving through the use of technology and specially trained drugs dogs who can stay alert to the changing chemical composition of NPS.

But the way to meet this challenge is not simply to remove supply. We must also reduce demand. This requires us to harness the talents of all the experts, including healthcare professionals who work in prisons, to understand the drugs' toxicology and improve our diversion and treatment services. Within G4S, our approach has been to develop a taskforce so that every part of our business that works in prisons – both as operators and healthcare professionals – can contribute to our understanding of the problem and develop techniques to both reduce demand and tackle supply. There is still some way to go but new legislation and testing regimes together with the relentless work of dedicated prison officers and partners in the police, is having an impact.

This paper is an important step towards a more joined-up response between healthcare and prison professionals and we are committed to sharing the learning and insight that we develop with any other organisations working in the custodial estate in order to improve safety in prisons across the UK, focus more on rehabilitating prisoners and ultimately cut the number of future victims of crime.

Attendees



Dr Kostas Agath
Medical Director,
Addaction



Mark Darby
Senior Policy Officer,
Association of Police and
Crime Commissioners



Kate Davies OBE
Head of Health and
Justice, Armed Forces
and Public Health, NHS
England



Ken Everett
Acting Head of Security
Group, National Offender
Management Service



Blair Gibbs
Policy Adviser to the
Secretary of State,
Ministry of Justice



Andrew Haldenby
Director, *Reform*



Dr Linda Harris
Chief Executive, Spectrum
Community Health CIC



Gail Jones
Deputy Chief Executive,
Rehabilitation for Addicted
Prisoners Trust



Jan King
Chief Executive, The
Angelus Foundation



Kate Laycock
Researcher, *Reform*



Dr Angela Lennox CBE
Head of Clinical
Governance, G4S



Oliver Lodge
Director, Ministry of
Justice Value for Money,
National Audit Office



Martin Lomas
Deputy Chief Inspector
of Prisons, Her Majesty's
Inspectorate of Prisons



John McCracken
Drugs Programme
Manager, Department of
Health



Nigel Newcomen CBE
Prisons and Probation
Ombudsman



Ann Norman
Professional Lead,
Learning Disabilities and
Criminal Justice Nursing,
Royal College of Nursing



Éamonn O'Moore
Director, Health and
Justice Team, Public
Health England



Dr Jo Peden
Consultant, Health and
Justice Team, Public
Health England



Victoria Prentis MP
Member, Justice Select
Committee



William Rial
Controlled Drugs
Accountable Officer, NHS
England



Ben Ryan
Business Development
Director, G4S



George Ryan
Senior Clinical Adviser,
Public Health England



John Shaw
Managing Director, Public
Services, G4S



Peter Small
Director, HMP Birmingham



Martin Stephens
Senior Manager
Health, Wellbeing and
Substance Misuse Co-
Commissioning, National
Offender Management
Service



Paul Tarbuck
Deputy Head of Healthcare
Inspection, Her Majesty's
Inspectorate of Prisons

Edited transcript

Andrew Haldenby: Good afternoon, everybody. A very warm welcome indeed to this *Reform* / G4S policy roundtable, “New psychoactive substances: a case for integration between health and criminal justice services”.

I’m going to invite four people to speak at the beginning giving very short introductions, please. As you can see, we’ve tried to have both the criminal justice and health voices here, and because of that I’m absolutely thrilled that our first speaker will be Nigel Newcomen, the Prisons and Probation Ombudsman. Nigel, welcome.

Nigel will be followed by Kate Davies, the Head of Health and Justice, Armed Forces and Public Health at NHS England. Kate has been in that role since 2012 and before that held very senior positions in the health service commissioning and regional side.

And then our final speakers will be John Shaw, the Managing Director of Public Services for G4S, and Peter Small, the Director of HMP Birmingham, which is run by G4S.

Nigel Newcomen: For those unfamiliar with what I do, the Prisons and Probation Ombudsman has two functions. The first is to act as an independent complaints adjudicator for prisons, immigration, detention and the probation services. But secondly, and perhaps more pertinent for today’s discussions, I investigate all deaths in custody, including prisons, immigration detention and approved premises.

The purpose of these fatal incident investigations is to establish the facts, help bereaved families to understand what happened, support the inquest system, and identify learning for the organisations I investigate. And since I was appointed nearly five years ago I’ve also put a great deal of store by trying to join up the dots by producing learning lessons publications. And one of these learning lessons publications came out in July 2015. It was on the emerging threat to safety in custody from new psychoactive substances (NPS). I’ll lean on this bulletin in my very short talk.

However, from the outset I must say I’m no expert on NPS, nor is the

expertise easy to find. NPS are a wide array of relatively new and regularly changing substances for which testing is in its infancy. And of course many NPS are readily available in the community, and most are cheap. These features compound the difficulty of reducing supply and demand for NPS in prisons. They also make it difficult to draw firm conclusions about health impact and links to fatalities, which is why I commissioned a learning lessons bulletin to look at the issue, of which the data has been updated for this presentation, as you’ll note.

The bulletin focused on synthetic cannabinoids, often known as Spice or Black Mamba. It was very cautious about drawing conclusions, but adds to the increasing evidence that NPS pose dangers both to physical and mental health, including links to suicide and self-harm. Staff and other prisoners may be at risk from users reacting violently to the effects of NPS. There are even cases of prisoners being given spiked cigarettes by others who wanted to test new batches of NPS as a way of gauging the effect before taking it themselves. In other more unpleasant cases, prisoners have been used as unwitting NPS guinea pigs just for the amusement of others.

We have now identified 39 deaths in prison between June 2013 and June 2015 where the prisoner was known or strongly suspected to have been using NPS before their deaths. The link to the deaths is not necessarily causal, but nor can it be discounted. Of these deaths, two have no known cause of death. Two were the result of drug toxicity, and the drugs included NPS. Six were the result of natural causes in which NPS may have played a part. In one case, for example, the prisoner died of a heart attack after taking NPS, and our clinical reviewer considered NPS may have been the trigger for the attack. One death was a homicide of a prisoner involved with NPS by another prisoner suspected of smoking NPS. And the remaining 28 deaths were self-inflicted. Some involved psychotic episodes, potentially resulting from NPS. For others NPS appeared to exacerbate vulnerability.

“

Most prisoners haven’t got a clue what they’re taking when they’re taking it.

”

Overall our findings from the fatal incident investigations suggest three types of risks from NPS. First, a risk to physical health, for example through drug toxicity, seizures or heart failure. Second, a risk to mental health with extreme and unpredictable behaviour and psychotic episodes sometimes linked to suicide and self-harm. And third, the risk of associated problems with debt and bullying.

While NPS are relatively cheap in the community, their illicit and restricted supply in prison attaches a premium. Combined with the limited resources of many prisoners, use of NPS often results in prisoners getting into debt with prison drug dealers. This in turn creates the potential for self-harm or suicide amongst the vulnerable as well as adding to security and control problems.

The bulletin I’ve mentioned has a number of case studies. I have time for just one, if you’ll allow me, just to give you a flavour of the sorts of cases that Peter and other directors and governors around the system are living with. Miss B had served 19 months. She had several long-term medical conditions and had frequent contact with prison healthcare and hospital consultants. She had no history of self-harm and had not shown any sign that she might hurt herself.

Those who saw her on the day of her death said she seemed normal and had been seen joking with other prisoners. Early in the afternoon officers said they heard singing coming from her cell, but this changed to a loud and aggressive noise. The officers went to investigate, and at first they thought she was having a bad dream, but instead Miss B had made a very deep cut in her arm, severed an artery and lost a lot of blood. Despite a swift emergency response, Miss B died in hospital later that day.

After her death, some prisoners said that Miss B had been using NPS and cocaine. Our clinical review considered the drugs might have triggered a rapid onset psychotic episode which led Miss B to harm herself. Otherwise her actions were entirely out of character. Now that's just one story out of many, and there are various other stories out of the bulletin. There are certainly too many stories that I could go on and describe later on.

So what is to be done? Our work on NPS has added to the increased concern that these substances pose serious risks in prison, and I've highlighted five areas of learning. First, supply needs to be reduced. Trafficking in NPS needs to be tackled by effective local drug supply and violence reduction strategies. Second, staff awareness

needs to be increased. Prison staff need better information about NPS and how to spot that a prisoner is taking them. Third, governors need to address the bullying and debt associated with NPS. Fourth, drug treatment services need to address NPS use and offer appropriate monitoring and treatment. Fifth and finally, demand for NPS among prisoners needs to be reduced, with prisons and healthcare providers ensuring there are engaging education programmes for prisoners that outline the risks of using NPS.

Commendably, the prison and healthcare service has begun to act on this learning. Efforts to reduce supply are beginning. For example, testing regimes are being redirected towards NPS. Adjudication awards are being revised, and prison security paraphernalia is being

“
Without a doubt NPS is our biggest single issue right now.
”

refocused. This includes targeted intelligence, revised search routines, newly trained dogs, and even efforts to intercept drones. I think a drone was shot down at Pentonville Prison over the weekend.

However, staying one step ahead of the chemists and the traffickers is a huge challenge. Importantly, educational efforts to reduce demand are also gearing up with posters, leaflets and DVDs about the dangers of NPS, and these are now widely available. I myself have written articles for prison newspapers and spoken on prison radio,



Ken Everett, Oliver Lodge, Martin Lomas, Mark Darby, Kate Davies OBE and Nigel Newcomen CBE

but some of the best materials have been written by prisoners themselves with first-hand experience of the risks. We must hope that these efforts have some effect, but there is a long, long way to go. Finally, as one prisoner put it to me: “Spice is a bird killer, but we need to tell people it is also a prisoner killer.”

Kate Davies: First of all, thank you very much for inviting me to come and speak on what I think is probably one of the biggest challenges we have as part the integration between prisons, prison reform, and healthcare in the future. What I want to do in a very short period of time is just to put into context how integration within the criminal justice system and healthcare works, how we want to particularly put a lens on what that means for NPS and what that means for the future.

I’m very pleased to say, as the Director for NHS England leading on health and justice commissioning, that over the last three and a half years we’ve really, under the Health and Social Care Act, focused on what good healthcare looks like for patients within secure and detained settings.

Éamonn and I have actually just been at the MoJ [Ministry of Justice] this morning, in the partnership board for prisons, and discussed how we work to ensure that the partnership agreement we have with the MoJ and NOMS [National Offender Management Service] is executed, but also reviewed and updated as part of the challenges that we face now.

It is also important to say that we have a wide range and field of providers in health and justice, both from the NHS sector, the independent sector and the third sector. And that collaborative approach is absolutely crucial to achieve the outcomes around the changing field of substance misuse and NPS.

But most importantly, the lived experience element has really driven us very clearly to write formally on a number of occasions to the MoJ and NOMS and the YJB [Youth Justice Board] to say we are extremely concerned, as commissioners commissioning and

providing healthcare services within the detained and secure estate, that the job is increasingly becoming a challenge for our healthcare providers because of a number of contributing factors.

So I can say to you very clearly and very formally as part of this short presentation that NHS England will be doing a formal service review and deep dive of substance misuse services commissioned across the detained and secure estate within 2016-2017.

As part of that deep dive and review of substance abuse issues, we do expect that there will be quite a significant change in the way that we commission and use current allocations and resources to support the growing issue of NPS. We have commissioned a fairly extensive piece of work that has been led by user voices, for service users across 10 prisons to actually say from their perspective what the situation is, what it feels like with regards to NPS within the estate and also within the community. And let’s not forget what that correlation means.

I think it’s important to say that one of the key findings – and this is yet to be published, so I’m giving some early updates here – but many of the service users within the prison estate do say that there is actually a very different culture when you look at NPS sitting inside HMP so-and-so compared to when you’re in the community. One is about availability and also about the culture that is materialising more and more within every prison estate and prison environment.

There is an estimation from the service user input that in up to 60 per cent of any one prison there is a prevalence and use of NPS at the moment. Most people who are using Spice, as the most well-known name and headline for NPS and designer drugs, going into prison don’t even know what Spice is. They don’t even know what’s in Spice, and they haven’t got a clue what they’re taking when they’re taking it. There is certainly an overriding issue, supported by the work that Nigel has been doing around deaths in custody, about how NPS has been used within the

prison population as part of testing it out with different cohorts of people.

What is really important as part of our review from NHS England is that we will very formally follow, as part of the *Five Year Forward View*, the gaps around health and wellbeing and the radical upgrades, and what that means for prevention for this area of work. Secondly, the care and quality gap and what that means for new models of good care or existing good practice, of which there is many, and improving that. And thirdly, what that means around the funding gap and where we need to look at efficiencies in investments, but also allocations of existing funds.

What I don’t want to do as part of a very short presentation is be incredibly negative, though this does warrant a massive amount of seriousness. I am very proud of leading and supporting with commissioners, providers and service users, and my partners within the criminal justice system, a real scrutiny over the last two or three years on what healthcare should look like within the detained and secure estate.

“
We know that prisoners are prepared to risk their lives by taking NPS.
”

There have been many challenges. NPS is undoubtedly the headline at the moment. And we will give full support to that collaboration, particularly with the new mental health taskforce but also what that means for early interventions and reduction of deaths in custody.

Lastly, we’ve done a bit of work as far as a call to action on areas of substance misuse good practice around the recovery models within the prison estate. And I think we are particularly keen to emphasise that we do have from our providers a recovery-orientated input. We have an increase – and I think we need to consider it even more – as far as a peer mentoring and support

“

We need to see them as victims in this and come up with some solutions that can help them.

”

element. This seems to be key for NPS. It seems to be part of the model that is emerging from the NPS findings of wellbeing focus, because it's the broader health needs and broader issues of social care and isolation that is part of an NPS body of information.

We need to make this very much a client-focused piece of work, not a substance misuse-focused piece of work. We need to ensure service users and their families and carers are part of the engagement. We actually find with all substance misuse that families and carers and that support structure is crucial to recovery but also identification. And lastly, we should assure that the excellent public partnership work that we have already focuses on how we deal with what a good model of practice looks like, and early intervention as part of liaison and diversion rollout across the country in police custody courts and crisis care.

So I leave it there. NPS doesn't have any one cohort. It's men, it's women, it's about adults, it's about children and young people, it's all ethnicities and all genders, and it's really important that as we look at this review in 2016 we work together, not apart. Thank you very much.

Andrew Haldenby: Thank you very much indeed.

John Shaw: I look after public services which encompasses both the police and secure settings for healthcare. And at the moment I think I've got about 19 prisons that we provide healthcare in. About 13,000 patients in our care – currently 11,500 in police custody – that we see. And without a doubt NPS is our biggest single issue right now. We provide that medical service across police forces – about one third of forces across the



Dr Linda Harris, Dr Angela Lennox CBE, William Rial, Peter Small, Andrew Haldenby, John Shaw and Éamonn O'Moore

UK. So I have really good visibility across the country of what is happening. There is no set pattern across location, geography, as you say – demographic. It's everybody.

So it's a real big problem that we're struggling to come to terms with. And to give you a sense of the scale of that across the estate, in December in one prison we had 22 NPS-related incidents in one weekend. Two juveniles who were medevacked up to hospital as a result of that, which had a massive implication for the establishment. I'll talk about establishments and the implications, but healthcare and our provision of healthcare to the rest of the community was clearly affected quite significantly in that weekend.

The other big problem for us is the secondary effects. We had in one case four healthcare staff professionals working on a person who had ingested NPS who were themselves secondary ingesters of NPS, who were then hospitalised as a result. So that took four healthcare workers out of a secure establishment, which again puts more pressure on the system. So it really isn't just about the service users. It's actually

also about the staff, the health sector risks, and everything that goes around that. And although the legislation that is coming into effect on May 26 is very welcome, I don't think it's going to make a lot of difference to us for the foreseeable future. I think downstream it might make a difference, but what we're seeing across police custody and in secure healthcare is that actually this is a pervasive problem, probably on a scale that I haven't seen before.

What we've been trying to do about it locally is we've got working groups together. We're looking at each site, each region, and we've got our own staff coming together to give us their view of what best practice looks like so far. We're trying to bring others in, and we've had a conference recently where we've brought in lots of speakers externally to talk about how we might manage this, but the picture is very fragmented. And I think this event is very welcome, because it's an opportunity to start to create a national narrative around NPS. Some of that goes across private and public and across all providers in fact into the estates.

One of the things that has become evident about NPS, I think, from the work that colleagues have done, is the need and want to change has to be much further upstream for people. So we've got to do much more work earlier in the cycle than we would naturally see currently. That is a challenge for us because by the time a lot of the people are coming to us, it's too late. So there is a lot of work that has to happen with partners that we would like to be involved in, and we absolutely stand ready to play our full part in that. But in order to be able to do that, we've got to have some sort of systemic approach to this that allows us to interface with it. And again, just some scary facts, as a cannabinoid it's up to 100 times more potent than cannabis. Which, if you think about the known effects of cannabis on populations, when you extrapolate that down, we don't yet know because we don't have any data or evidence to support this, but we've got to assume that the impact longer term on people is going to be more serious and therefore that's going to have a wider implication both on repeat offenders but also on the wider health system. So again very welcome that we are discussing this really important topic today.

Andrew Haldenby: And our final presentation from Peter Small, please.

Peter Small: Thank you. In the face of a huge increase over the last three to four years in the use of NPS in prisons and the community, G4S colleagues met to discuss the issue and look at some practical solutions to it. Colleagues from our healthcare, police and prisoner escort and prison business spent a day discussing the effects of these drugs. We know that prisoners are prepared to risk their lives by taking NPS, and we've just heard that cannabis, the synthetic version, is 100 times stronger than the traditional cannabis that we've seen. But that still doesn't seem to stop people.

The composition of these substances is continually being altered, which makes testing all the more problematic. The only thing that we can

be certain of is that any such substance is untested and extremely unsafe. The risks are immense in prisons, not only to those in our care. My colleagues deal with people under the influence of these substances which make them unaware of their actions and sometimes give them superhuman strength. NPS have a profound impact upon regimes within prisons and risk serious injury to colleagues both in prisons and in the NHS.

It's important that we educate prisoners and the wider community about the devastating impacts to health that NPS pose. We provide information to prisoners upon induction which is important. But it doesn't seem to carry the same impact as one of their own peer group warning through personal experience of the dangers of NPS. We recently had a prisoner request to speak to a group of violence reduction representatives about his use of NPS. He described the fact that he was now routinely wearing nappies as a result of the damage these substances had done to him. The effect was clear to see, and the message he gave carried around the prison.

The challenge is how to repeat that in a local setting with a high turnover of prisoners. At HMP Birmingham, as with other prisons, we face a constant battle to reduce the inflow of contraband. That's a difficult task, and made more so by the fact that we're a large inner city prison. We mitigate that with netting and other changes to the site, but the rise in the use of technology such as drones complicates those efforts significantly.

The key issue that I believe we need to concentrate upon, including raising awareness of the dangers of long-term health implications as a result of the use of NPS, also includes testing for the presence of these substances and the pending legislation, which I'm pleased to say we've been notified comes into effect on 26 May. Work is already underway with West Midlands Police in preparation for this date with a clearly stated intention to prosecute those who bring these substances into our prisons and use them.

Testing and legislation I believe will see an impact on prisoners' behaviour

“

Five years ago I think it would have been unthinkable to have had a prison council in Birmingham. We've had one which does very well, produces good, well thought out proposals.

”

and has already started to do so, as evidenced by our mandatory drug test rates from the last quarter where cannabis use has risen, having been dormant for a number of months. I hope that as part of our *Reform* discussion today we can hear the insights of other experts around the table and continue to look at further solutions to this issue. Thank you.

Victoria Prentis: John, you said about the four members of staff that had to have medical treatment. Can you explain that a bit more? Because I'm afraid I left prison service work two years ago now, and I have some idea of the effects on behaviour of psychoactive substances, but I'd like to really understand what it does to staff.

John Shaw: Well, I think there is some concern amongst staff, first and foremost because it's an unknown, whereas other drugs are understood and we've lived with them for a long time. Therefore they might have very harmful effects, but we kind of know what they are. NPS by its very nature is just a completely constantly changing picture. And the staff members in this particular point were working in a confined space with somebody who had ingested NPS and were overcome by fumes.

Victoria Prentis: So he had been smoking in the normal way, but the fumes were coming from where?



Nigel Newcomen CBE and Ann Norman

Angela Lennox: I think it's been the fumes from the smoking that has done it. And we've also got to remember these guys may have been on their fifth Code Blue call that day, not knowing whether it's cardiac arrest, not knowing what they're going to find. They then come into a smoke-filled room, and already their adrenaline is high. It's not easy for all of us clinicians who deal with Code Blues. It's an adrenalin-making event. And they felt very unwell after being in a cell.

Kate Davies: Just to help answer the question as well, because one of the things that I didn't mention as part of my own review, is that this is a real opportunity around the smoke-free estate. So one of the things that they're doing in conjunction with Public Health England and our colleagues in the MoJ, is looking at the rollout of the smoke-free estate across England and a review of that with the Secretary of State thereafter.

The absolute key issue is how that can really work to support some of the challenges that are going to come as part of NPS use, and the increase in the use of bongs etc., but also how the lessons

learnt, particularly from working with the Prison Officers Association and other staff around the smoke-free estate, will absolutely duplicate work to do with NPS because it's a similar issue around passive association with your work environment.

“
Perversely, because the staff are so good at responding to these events, prisoners carry on using because they know that the staff will rescue them and it's their job.
 ”

Victoria Prentis: That's obviously also for other inmates and staff. How is the smoke-free estate going in Wales? This is clearly a solution, isn't it?

Éamonn O'moore: The south-west region have also been rolling out smoke-free prisons, so we have what is called the Exeter cluster which have now been introducing smoke-free prisons as well as Wales. So we're learning in England as well. Initial reports are generally positive. We've had some anticipated issues. They were understood beforehand, and they have been managed very well by colleagues in the prison estate. But I think the point Kate is making about how one aspect of public health programmes or practice can impact in a positive way, but also can raise other issues that perhaps we need to consider, which we are as part of the whole programme of rolling out smoke-free, including use of e-cigarettes and so on.

Victoria Prentis: Is somebody doing some research on these substances in particular and the effect in smoke-free prisons?

Éamonn O'moore: There is an evaluation that is being conducted by the National Institute of Health Research looking at the impact of smoke-free prisons. We're doing it with academic partners, so it will capture all aspects of the implementation. Plus we're also working very closely with NHS England colleagues, with NOMS colleagues and with Ministry of Justice on our own operational impact assessment.

Nigel Newcomen: Could I just add a little rider to that? I'm investigating the first case where it is alleged in a south Wales prison that the lack of available tobacco was the cause, the trigger for the suicide that I'm investigating. I offer no evidence for that whatsoever, but I just give it as a little salutary warning of the sorts of issues that we have to grapple with. But, as you say, maybe smoke-free environments do have a lot of health benefits, including affecting NPS.

Kate Davies: That's why they're early adopters because the whole point of having the Wales cluster and the south-west cluster is to make quite sure that we don't do anything that is done too quickly without lessons learned and particularly

for the impact of all substance misuse actually, not just NPS. And I think to put this in context, is that there are a few of us around this room that have been in this field for a very long time, and I'm one of those. And we had exactly the same challenges around heroin and crack cocaine around 20 years ago.

It is absolutely crucial that this is about how our communities, our service users, and our families change their substance misuse. They adapt. They look at what is more available, what is less detectable, what is more usable, what is cheaper. That's where we are with NPS. That's where we are with other substances as well. And tobacco is another one because a large number of people in prisons and out of prisons want to change their tobacco using behaviour. But NPS is very much cited as being part of the strategic review and evaluation.

Andrew Haldenby: Thank you. We've started with the smoke-free estate. That's an important idea. Peter, how do you take that?

Peter Small: I come at this as a non-smoker, so I've got to be in favour of not smoking. That said, having worked in prisons for a long time, I also understand that the removal of something that a lot of people use to cope brings with it its own challenges and its own vulnerabilities. And I also have experience of somebody who wanted to not go into a healthcare department because they couldn't smoke in there, and subsequently it ended tragically. I just think it is a mistake to think that the removal of smoke in prisons will cure NPS.

Paul Tarbuck: This is entirely speaking from a number of inspections that we undertake, particularly to the south of England and central England, and that is the inability of some prisons to recruit both prison officers and also the health providers to recruit permanent staff, both of which are quite major factors in controlling patient behaviours, some of which relate to NPS and also tradable drugs. And it's particularly a big issue at the moment in Kent and Sussex where



Dr Angela Lennox CBE, William Rial, Peter Small, Andrew Haldenby and John Shaw

“
The prisons are a repository of expertise and everybody can and should be learning from them.
”

we've seen a couple of examples where the prison has been actually unable to supply officers to cover healthcare, resulting in some very serious situations in the health department. And I think that's got to be factored into any kind of range of solutions. Where do you actually get the staff to make these things happen? You can put netting in and all sorts, but in the end a lot of this boils down to good ongoing relationships between staff and prisoners.

Ann Norman: I absolutely agree. I'd just like to add to that, we've got a really finite resource of staff. We've got some fabulous quality staff, but we need to retain them. We can't afford for some of those great

staff to move on. So therefore we've got to absolutely invest in making sure that they understand how to deal with emergencies, how to deal with the day-to-day management. And I know the public health guidance and toolkit around NPS has been really beneficial, but I think we need to take that out there to every establishment to make sure everybody understands their responsibilities and their duties.

I'm particularly concerned about the people that don't want to engage in NPS. Those people might feel vulnerable. Somebody in prison that thinks, "I don't want to get involved in that", but actually they might be exploited. There is a safeguarding issue here. I've heard first hand when I've visited a prison in the south of England, somebody saying, "I'm going to punch somebody so I can get into the segregation unit because it's scary out here."

Jan King: Great to hear what's going on, because coming at it as an outsider to the prison system, we've recognised and seen that there has been quite a few things going on around the place, but actually it hasn't been as coherent or joined up as it needs to be. And we've always approached this

issue as actually a lot of people being duped into taking these things for whatever reason. There might be some complicity in it of course, but actually they are being duped into taking stuff. And we need to see them as victims in this and come up with some solutions that can help them.

And my concern is with the change in the law. Eminently we're just going to go down the route of punishing people that are quite vulnerable, and I'm not sure that is going to help too much. And this sort of effort, something that is joined up, needs to be the way forward because otherwise the problem isn't going to go away. It's just going to get worse and more. So I think if we look back we could have been a lot more proactive. We now need to be proactive.

“
From the limited experience I have of seeing prisons, what struck me about the best prisons is the way that you've got the potential for an in-built community of individuals who are mutually supportive in tackling their substance misuse.
”

Andrew Haldenby: Do you have bits of good practice in your own experience which you look to?

Jan King: A lot of work – some of the things have been mentioned already. A lot of stuff around peer review. Good training for staff. Support for staff who are often quite frightened and panicked by this. So those things. Good materials that work, that are accessible, and are created by some of the inmates in this case.

Mark Darby: I don't think the two are exclusive. I think we need to do both because the holistic approach you're describing is absolutely right, but the economic drivers on this stuff are huge at the moment because it's cheap, can be delivered easily, and the mark-up is immense. So when you're up against that sort of driver, we describe it as a tsunami of substances going into these institutions, I think criminalisation and enforcement is pretty critical.

Jan King: I quite agree. I think my concern is a tendency to go down heavy on one route and less on the other. And that is my concern.

Peter Small: Just to say a little bit about the education process about NPS amongst the prison population. In my experience, there is a real misconception that you can't get off it. What they're saying is with heroin, for instance, you can get methadone. And there is almost this view that you need a drug to get off a drug, whereas actually when you talk to the DART [Drug and Alcohol Recovery] teams, they'll say no, hang on. If you get stomach cramps, we'll give you some symptomatic relief. If you get headaches, we'll give you something for that – and sweats and so on. But actually that needs to be coupled with the determination to desist, the same as with any other substance. And I think there is a job for us to do to put that message round amongst prisoners: that you're not helpless, you can get off it. You just need the willpower as well as the assistance to do it.

George Ryan: To give some feedback between the 25 training developments we've done: these tend to be about staff morale, discipline, categories of prison, immigration and removal centres, and secure mental-health hospitals. So a very diverse audience totalling about 600 people since last November. The idea was to launch the toolkit, but we segued it into getting the feedback from the staff attending these events as well. And I could go on all day with the findings. We'll get the tip of the tip of the tip of a very big iceberg. We will prepare a

thematic analysis getting the main points which came out.

A few headline things then. I think it is clear from the training we've done, especially over the six months that it's been running, that all staff are dealing with the adverse health and other consequences of NPS use with increasing confidence and competence. I think that's come across loud and clear. A lot of points have been brought up about extreme self-harm, risk to vulnerable people, so I won't labour those. But when we do the thematic analysis we will look at the issues for prison staff, examples of good practice, but also wish lists. We ask people if we could wave a magic wand, what would make a big difference?

We've also identified a number of issues which are significant for service providers and commissioners which will come out in the report when it is done. I think two points which are worth reiterating are the importance of having prisoners as peer mentors and support, and providing a whole range of materials – the horror stories etc. And people have touched on the issue of secondary exposure. I think one thing that needs to be acknowledged, and you alluded to it, Peter, is the effect on staff of repeatedly dealing with an unknown extreme event day in and day out. Perversely, because the staff are so good at responding to these events, prisoners carry on using because they know that the staff will rescue them and it's their job. And that is an issue.

So in spite of the continuing media reports – we've had some in today's *Independent* and *Guardian* and so on – there is a sense that staff in all domains are just rolling up their sleeves and getting on with this in a very effective and pragmatic way. And there is a lot of willingness to go the extra mile and a lot of unsung heroes. The one wish which comes up time and time again is more staff, especially to interrupt the supply. That is the one thing which people reasonably, in my view, ask for.

Again, somebody alluded to it earlier, staff treat what they see. So rather than keep saying what drug or drugs somebody may or may not have taken, people just respond to whatever is in front

of them. And as an example of this, restraints are rarely used to manage aggressive prisoners. It is used as a last resort. Similarly people very, very rarely use sedating medication. So people are very, very measured in their responses, be it the custody staff or the healthcare staff.

Two positive spin-offs to the challenges presented by NPS are much improved practices around diagnosis to improve collaboration between mental health services, healthcare and substance misuse teams, and also a re-invigoration of harm reduction. So I would suggest that prison staff are responding frequently to a wide range of acute, long-term and other effects of NPS and that prisons and other secure

environments are a source of excellent practice and growing expertise that everyone should tap into. In the community only 1 per cent of people attending drug services will attend because of NPS use. And as you said, John, it's a very diverse pattern across the country. The prisons are a repository of expertise and everybody can and should be learning from them.

Nigel Newcomen: I endorse much of what has been said, but I do come from the perspective – Peter's perspective as well – which is that demand reduction here is the key. I gave you a little quote from a prisoner about NPS – it could be any other substance, though: "it's a bird

“

We need to use those that are using as a key resource.

”

killer.” It occupies people that don't have much else to occupy themselves with. We hope that in reform programmes, that will be addressed and there will be much more activity and so on and so forth. But at the end of the day, if we are going to encourage anything, encourage engaging education and self-education. And if you're going to manage demand down, it's going to have to come from the users and the peers.



Ben Ryan and Jan King

And I think we're going to need to be a little less risk-averse about what is allowable. We've got a couple of videos and DVDs around the system, but we haven't really got any of the open house on different ways of doing this communications exercise. I don't think the professionals will solve the problem at least until the next big issue crops up. But I do think we need to do more in demand reduction. We need to use those that are using as a key resource here.

Éamonn O'moore: Very quickly, just building on Nigel's point, I think it might be an interesting experiment to see a correlation between NPS activity and time out of cell and purposeful activity, because I think you've hit on an

important point: that the way people are using these drugs is also part of a social and cultural norm when in prison, and it is part of an activity which is occupying time which can be, in some cases, displaced by more purposeful activity.

It may be that we are seeing in some ways part of the issue is a response to some of the other pressures within the prison estate. And where we've got good education programmes, good employment and training programmes and other purposeful activity, it would be very interesting to do some work, if we had better data, to see if we can correlate that. The risk is that you can get biases in all of this because of the way you report stuff. But the point is there about using resources not only

“
There is an epidemic of misbehaviour in prisons, largely at the moment, it appears, driven by NPS.
”

on activities directed towards staff training and education, but also consider the whole prison approach. The regime in which care is delivered is as important a factor. The environment is as important a factor as other factors might be. And we shouldn't ignore that.

Martin Lomas: I don't think the battle is being won, despite the quality of staff effort, partly because they are a bit directionless at the moment. I think there are issues around the supply side that we need to take seriously. I was in Chelmsford last week where the Governor is battling to get netting up. Never mind the drones. The netting isn't even up. So I think there needs to be a determined prioritisation cutting through the bureaucracy, setting that perimeter correctly – because that is a prerequisite for supporting the more holistic approach which is to do with demand side. At the moment – again, it's difficult to be precise – but at an anecdotal level we go into prisons routinely, and safety outcomes are collapsing, with the underlying story being NPS.

Gail Jones: I think I agree with absolutely everything that has been said. The issues around staffing and so on. But I think for me one of the absolutely crucial things – alongside talking about the importance of peer support – is that we need a far more sophisticated model around how behavioural change actually comes about, because it's a very different population, the people we see in prison, to the people in community. And a health advice or a health promotion that might work outside of prison isn't necessarily going to be effective in prison.

I don't think we have a model of behavioural change that we can use in



John Shaw, Éamonn O'Moore and Dr Jo Peden

prison that has really been tried and tested. And I think we've got an awful lot more work to do if we are going to bring about fundamental changes within that population. And we can't just assume that because something works outside, it will work in prison. That goes back to something somebody said earlier, which is that people in prison are prepared to risk their lives, which means that there is a fundamental behavioural issue that we need to address and it is not a simple solution.

Anne Norman: Just going back to the training and education: there is a problem, but there is also an opportunity, because we know it's really difficult to get practitioners, when they are already strapped for staffing numbers, and then say we want you to go off for a day and go and have this training. I had conversations recently with learning disability nurses, and they were saying that actually the opportunity to have micro training sessions in the locality where they work, 20 or 30 minutes in the core day, is something that realistically is more achievable than saying we need three or four of our staff out all day.

Kate Davies: Just to say that though I completely agree – and I was the one that said it – that I think the use of NPS within a prison or secure estate setting is much more acute, it's absolutely in our communities as well. It has been in our communities for many, many years. It isn't maybe as common as heroin or crack cocaine or cannabis or the misuse of prescribed medications have been, but if you were to put a focus on the homeless community, then NPS is rife. And we need to say that the model of care needs to be across the whole population, if we are actually going to get this right. And I think that the piece of work about changing what is a good model of a substance misuse service, integrating with other healthcare services, both within the prisons and the community, is the outcome we absolutely have to achieve.

I think the other element – it's a dirty word – but actually it's also about

resource, because we are doing this in exactly the same resource envelope as we have always done, whether that is about the number of workers, healthcare providers or staff. But it is costing the prison service a fortune, not just in countable pounds and pence but also in terms of being able to do day-to-day work. This is seen as frustrating for prisoners who do not want to use and leads to more time in their cells, exacerbates the problem of having limited coping skills in prison and being left behind doors.

So that is just one element, but actually as far as being cost-effective, it does absolutely mean that we need to look at concerted, integrated partnership policy in order to get those outcomes. I am still a very strong advocate, and will remain to be, that actually some of the NPS use doesn't sit in isolation from other issues around mental health or why they are sitting in prison or a police custody suite in the first place. Those elements have to be part of an integrated healthcare approach going forward. We can't just do it in isolation from that, because then we're just asking what that means for Monday or Tuesday or Wednesday that week, but not necessarily changing a pattern of drug use earlier upstream as well as in front of us.

Linda Harris: In the range of estates I currently provide into, where I get most succour from, is where I get a feeling that I'm working within a system where NPS is everybody's business, where it isn't just seen or deemed to be the repository of one agency or another. And that, I think, gives greatest comfort to healthcare colleagues, in particular where I think there is absolutely a recruitment and retention issue, where the management of risk – and this as a further additional risk factor – is going to have an impact on being able to attract and retain good quality of staff. And I think where staff can see that there is a coherent response, that actually it is well led.

I also think that it's fantastic, George, to hear the outcome just of your early findings. As soon as that is published and put out to the sum of the whole, that will create energy. That will

create conversation just as the publication of the Public Health England toolkit did. In many ways what was contained within there was common-sense advice about good assessment, treatment, management and professional support. But actually it was well presented, and it enabled us to gather around a document which was as evidence-based as it can be, given that we are still on an early journey around research and development. And it created a whole heap of positive dialogue amongst our workforce.

We need to get timely information out to our professionals as soon as it's available in the absence of good quality research, because I think there is still a massive research agenda around this, not just in terms of its impact on our service users but its potential impact on people who work with our service users.

“
Safety outcomes are collapsing, with the underlying story being NPS.
”

Blair Gibbs: I think the point that was made about the link between this being a new challenge for the service but one that actually was encountered before in a different setting is important. We also have an ambitious prison reform agenda for this Parliament and beyond. And there is something about the importance of trying to create more regimes which are more purposeful and offer that purpose and hope. And we think that that might have a longer-term impact in terms of reducing demand.

But I think tackling supply is our immediate pressing concern, and as much as we would like to be in a position to say we are making progress, I think it's really difficult because the data is not there. We would like to know more. We're not having a discussion about a clinical problem that we can even really

define at the moment. We have a pilot for testing which we hope will give us some way in, but to craft some policy responses without really knowing the issue in its entirety and where the greatest pressures on the service are, how the substances are changing, the routes into the system – it's really difficult.

So we're certainly not complacent. We want the reform ambition not to be lost because we think it's part of the solution. But we need that foundation of security and stability which we have got a lot of work to do on. The recent levels of violence and self-harm and deaths in custody are the backdrop to this. I wish we knew more. If it's true that the prisons are uniquely susceptible to this problem,

then I think we need to understand that. But if it's also happening in the community, then this shouldn't really just be left for NOMS and the MoJ to solve. We've got to try and bring in wider government efforts, I think.

Andrew Haldenby: Thank you and, indeed, *Reform* recently produced some work trying to raise ideas about improving prison information.

Blair Gibbs: I don't want to sound despondent. We should have a reform agenda which is about empowered governors, which is about encouraging innovation, and that should extend to things like security and clinical treatment

which are about allowing new approaches.

Kate Davies: An opportunity for quite a disadvantaged group of people is where sometimes the prison health and the integration with other services really works well, because you've got 86,000 people where you can basically look at what that integration means. Though ideally you'd like to do that for probably 30 or 40 million people, actually it's knowing where you're going to get the most effect, the most value from that as well. And I think that is always important as part of reduction of crime, as well as improvement of health.

Oliver Lodge: I suppose I have one observation, listening to everything related to prison reform, which is around the potential benefits of greater autonomy and more innovation and hopefully removing barriers that may exist to better integration at a local working level and using more peer support. And that's to be lauded. I think it's clear though that there is a real need for a national approach here as well and for that best practice to be harvested, to be disseminated so that we can make improvements and these issues are tackled as quickly as possible.

The other thing is it's clear there has been a relatively rapid rise of the agenda and it's having a huge impact. The question that raises in my mind is how fleet of foot and responsive the system is, particularly around prioritising resources in a way to tackle this problem before it becomes much worse. I mean the example Martin gave of nets not being there to stop them is a stark one. But how much flexibility is there in the system to respond quickly?

Andrew Haldenby: Thank you. John?

John Mccracken: As Kate perhaps alluded to earlier, in relation to NPS the first thing people should do is just fall back on first principles. And if those first principles aren't being observed, then you will get exacerbated problems. We haven't solved the drugs problem in prisons, so that being the case, solving



Ken Everett and Oliver Lodge

the NPS problem is going to be difficult. In terms of first principles and in terms of resources, incarceration is an expensive way of trying to reduce offending – trying to reduce reoffending. And one of the good things about the prison reform agenda for the Ministry of Justice, is looking at alternatives to incarceration and how can we best prevent reoffending.

From the limited experience I have of seeing prisons, what struck me about the best prisons is the way that you've got the potential for an in-built community of individuals who are mutually supportive in tackling their substance misuse. And that is something that we should think about, how do we promote that? In terms of how we're describing prevalence, we need to be careful that we're not shooting ourselves in the foot or being counterproductive because if we're saying, on shaky evidence, that there are very, very high levels of prevalence in prisons, then that's saying there is a social norm within the incarcerated community of NPS use. And if levels of use are so very high, then by comparison the levels of harm seem not that great if we're just talking a pure numbers game.

So to fall back on Nigel's point about the equation that the prisoner was saying – am I interested in killing birds or running the risk of killing myself – then that would suggest the risk of death is not so high. Therefore perhaps the potential benefits of killing birds are the ones to emphasise.

Testing for NPS will always be difficult. I think as Angela was saying and Peter was saying, the substances are always changing. We have to be working in an environment where we can't guarantee that we know the substance. But we know the individual and the individuals. We know how they're going to react in certain situations. We hope we know how we can help them address previous miscreant behaviour and how to promote better behaviour in the future. And what we know from drugs prevention work is that a lot of the time, education does not work. We've got to find other ways of achieving behavioural change.

Nigel Newcomen: Very briefly, because I look at things through the rather mournful perspective of death, I don't want us to minimise the level of harm here because there are very few cases where I can hand on heart say the evidence says NPS was the cause. But from everything you've heard – you've heard from the Director, you've heard from the Deputy Chief Inspector – this is a really big pervasive harm impacting on all aspects of prison life. The fact that I've got relatively few deaths – and I've got too many by a long chalk – this should not be masking the fact that there is a very serious issue here. There is an epidemic of misbehaviour in prisons, largely at the moment, it appears, driven by NPS.

Angela Lennox: I think the fact that it's not drawn to your attention, the mortality, is because our teams are damn good at responding really quickly to what appears to be bizarre behaviour or collapse. And I think that's testament to the frontline staff who are really doing a brilliant job on the whole.

I think the other thing from our perspective, is that we are a really big company with a big footprint, and we would be really keen to make sure that what is coming out nationally has been tested out in a more formal way. We're very happy to be partners in looking at some of the areas and looking at some of the issues more formally than just trying a few odds and ends.

And I suppose finally – Kate, it's to you – how well does CQC [Care Quality Commission] really understand this? Because we're caught between a rock and a hard place. On the one hand, CQC is really clear on expecting us to run clinics addressing long-term conditions, and on the other hand we're running to and fro from incidents all day. And it's really making sure we're all on a level playing field and that they understand that the environment in a prison is a tough one.

Éamonn O'moore: Very quickly, I think it's important to remember the context that we're having this conversation in, which is that there is now within the prison estate a

“

It occupies people that don't have much else to occupy themselves with. We hope that in reform programmes, that will be addressed and there will be much more activity. If we are going to encourage anything, encourage engaging education and self-education.

”

very strong evidence-based approach to understanding and meeting healthcare needs which is led by NHS England, is supported by PHE [Public Health England] and delivered in the context of a NOMS commissioned service, which is about using evidence where it exists, intelligence and data where it exists, to understand health needs.

The emergent health need that this is, I would say without fear of contradiction, that had that arisen in an older system where there was less partnership work, less integration, we would have been far less responsive than we are now, even though we mustn't be complacent at all.

The other point though is about data. We are not working in an absence of data. Let's just be clear. There is more data collected in the prison system in England than anywhere else in the world at a national level which is evolving and improving all the time. While we don't have diagnostic tests, what we're looking at in PHE is an approach called syndromic surveillance, where we can consider how certain symptoms can be used to deduce that X, Y, or Z problem is happening and identify particular hotspots, for example. And there is a lot within the system that supports and enables the rapid dissemination of learning, which is what George is evidencing from his experience – that the



Dr Angela Lennox CBE, William Rial, Peter Small and Andrew Haldenby

system is actually learning from the experience of doing.

Martin Stephens: Just a few very brief points. One is the messaging thing. And we struggled with this. We have produced a range of DVDs and posters and prison radio campaigns going out next month. So we're trying to get the messaging right; at what level you pitch it and where you communicate it has been quite difficult. And both ourselves and health colleagues have struggled around that, but it's interesting. We must continue. We're trying all different mediums, all different avenues to try and get that messaging across and being clear what the message is: you don't

know what you're taking, and various issues like that.

We're clearly focusing around NPS today, but we have to recognise the vast majority of prisoners who abuse and use drugs are poly drug users, and those who have actually taken NPS are already often taking other types of traditional drugs or abusing prescribed medications. So it's not just a one-substance-takes-all. And as has already been alluded to, we're not talking about your Mars bar which is the same week in, week out. You can talk about Spice, but you know there are various themes around that week in, week out, even from the same supplier, same brand or whatever. So you need to be careful of that.

I think one of the things around dissemination, is that there are a number of mediums top-down through the NOMS hierarchy, down through staff, through governors, down that way. We try some bottom-up training, but one of the things we need to work harder on is how do we get things to the shop floor.

And whether e-learning – whilst we often don't like e-learning courses – whether we can have some e-learning package that staff have to do, even if it's an information assurance thing, at least I have to do it. I have to tick my government thing saying I've done my training. I know some places in health in Wales and other places are exploring e-learning, which would pick up some of

the 20-minute points. You can't go on a course. E-learning is not the same as engaging an individual necessarily and having that one-to-one dialogue etc., but that might be a starting point.

And on data, as we say, you do need to be careful. It's easy to bandy it around. If you ask somebody something, you'll have very high numbers of people saying this is the problem. But often you don't know. Yes, there have been a number of callouts to prison, for example, but if you ask people "could you say it's NPS?", it may have been. It may have been something else. We've also had incidents where someone has had a broken leg, for example, which is nothing to do with either assault or NPS related. Yet, oh, it's NPS because an ambulance has turned up. So we just need to be careful of some of that.

But as Éamonn was alluding to, there is some data starting to emerge, and we hope to have published some research shortly around some we've done in the north-west which gives a better indication of what is the prevalence across 10 prisons and across some prisons in the south-east. Very easy to say oh, this is the problem, that's the problem, when actually it may or may not be. We just need to keep the context of what is happening.

Andrew Haldenby: So we are reminding ourselves we will have as good data as we can, but we will look at it carefully. Let me see if I can bring it together. I'm going to take it back to our speakers with the idea that the health services and the prisons and the criminal justice services are going to work together to do this. We are going to prevent. We are going to reduce demand by working with prisoners in prisons. We've spoken a lot about peer contact and we've heard that the Government's wish to introduce more flexible regimes and more powers for governors may be a way of doing that.

We are going to have better trained staff, and it seems to me it needs both health and prisons input, and we are going to have better defended prisons to reduce the supply in that way. Taking Kate's point, we will have a stronger NHS-wide agenda, but perhaps prisons will be able to play a

part in that, because as we heard, prisons are a repository of good practice.

Peter Small: I agree wholeheartedly with something Nigel mentioned before about prisons being a lot of the answer. Supply and demand, absolutely. Legislation will come in, and that will deal with some of the issues of supply. In terms of demand, there is an untapped resource in the prisoner population. Five years ago I think it would have been unthinkable to have had a prison council in Birmingham. We've had one which does very well, produces good, well thought out proposals. We've got violence reduction representatives, and it seems to me that there is an opportunity to develop in conjunction with health colleagues – an opportunity to draw on the experience of prisoners about long-term impact of these substances and offer support and advice.

John Shaw: Three short points. Firstly, the point was made about staffing earlier and about the availability of staff. There is a chronic shortage nationally of nurses. And recruitment of nurses into a secure setting is much harder. It takes a long time to vet and clear them. By the time I've cleared them, they've moved on to something else. Putting them in the situation now where they are working with NPS and other unknown issues like this just makes it more difficult again.

So working with staff groups to make sure that they are sited on what we are doing is hugely important. I think that's a recurring theme, that we have to have more staff and more staff availability. We're paying a premium to get people to work in prisons, and we still can't recruit. There are some areas in one establishment in particular where I think we've got about 70 per cent vacancy rate, and we just can't fill those vacancies for any amount of money. It's just the nature of the work.

Secondly, I completely agree with the whole idea of behavioural change and harm reduction. But from experience that takes a long time. We've got an immediate problem now that we've got to be addressing. So both things in parallel, please, rather than saying let's

“

There is something about the importance of trying to create more regimes which are more purposeful, and offer that purpose and hope. We think that might have a longer term impact in terms of reducing demand.

”

wait for data evidence and so on at the end of the year, then we'll start to look at it. We really have to address it now because it's a massive issue right now. And I think that whole piece of going upstream to get to people earlier in the cycle, it's just a great place to do that because we see them on a revolving door there before they head off to prison in a lot of cases, only we've just divorced the whole NHS involvement from police custody, so that's gone by the wayside.

Andrew Haldenby: Thank you. Kate, if you want to comment.

Kate Davies: Well, I guess my summary is about how we look at this from the medium term and the long term. I'm really keen that we do that on a much more appropriate strategic basis, which I think is what some of my colleagues – and I've got many providers out there who are substance misuse providers, whether that is Addaction, Spectrum, Phoenix, G4S, RAPt etc., all doing some great work and developing their own models of what good practice looks like for NPS.

However, what I actually do believe, and I think my colleague in G4S said this as well, is that we should work to get national best practice. So this is a changing face of substance misuse, and we do need to recognise that as part of what a national model is. That takes time. Whether we like it or not, it does. So the immediate term is about prison-by-prison, provider-by-provider, commissioner-by-



Nigel Newcomen CBE and Angela Norman

commissioner with service users, as John was alluding to, looking at what you're doing and how you're doing it alongside security but also alongside demand. Then the medium term, with the prison reforms but particularly with police custody and earlier upstream, we can start to look at what some of that good practice really starts to look like.

My concluding remark is, and I've said this once – I'm going to say it again – there was funding that was actually put in as part of national good practice about what good looked like for substance misuse when we knew there was a changing face around heroin and crack cocaine. We need to do the same at government level to achieve an integrated outcome. Otherwise everyone is just going to think it's someone else's problem, and we won't get good practice and good evidence and research as part of that.

Nigel Newcomen: I've found the discussions helpful. I came to this, as I

say, my particular mournful perspective of looking at deaths which may or may not be specifically related to NPS in a rather depressed state of mind because I only have bad news and then worse news to present. But I made five points about learning earlier on. We're all agreed that supply reduction has got to be addressed, and Martin has come up with a salutary message about the way to go on that. There was some quite good news on staff awareness and training which I thought was positive.

I didn't hear a lot about one of the other points I made which was about bullying and debt management – the very criminal aspects of the NPS trade. And Martin made a point that this is big business inside. It's big criminality in a criminal world. But there is a very serious and significant issue which comes through to me but also comes through in your VP units and everywhere else, vulnerability being exploited here.

Drug treatment services – I was impressed to hear about some of the

“
I go away with a little bit more hope than I came with.
”

need for learning across boundaries and through prison walls. Prisons aren't always very good about knowing what is going on on the other side of the wall. You've got lots of lessons which I think we can pick up on. But finally, where I started, I think the answer lies with prisoners. The more innovative we can get, the more innovative directors and staff can get in terms of designing or allowing, encouraging and engaging communication from those that have got experience of it, is the one hope of getting this addressed. So thank you for the invitation, and I go away with a little bit more hope than I came with.

Reform
45 Great Peter Street
London
SW1P 3LT

T 020 7799 6699
info@reform.uk
www.reform.uk
[@reformthinktank](https://twitter.com/reformthinktank)