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DRUGS IN PRISONS

A Clinician's Perspective

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Clinical Director, Offender Health

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1988

HMP LEICESTER

HMYOI GLEN PARVA, LEICESTER

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1988 - 2018

Leicester
Glen Parva
Stocken
Ashwell
Gartree
Nottingham
Ranby
Lowdham Grange
Whatton
IRC Lindholme

New Hall
Wakefield
Doncaster
Lindholme
Hatfield
Moorland
Lincoln
North Sea Camp
IRC Morton Hall

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Current Picture

Drugs and Mental Disorders

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Prevelance

- 81% of adult prisoners report drug use at some point prior to entering prison.
- 64% report using drugs in the month before entering prison.

- Secure setting statistics from the NDTMS
- 1st April 2016-31 March 2017,
- Public Health England & DoH & Social Care

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HMP NOTTINGHAM (Apr-June 2019)

Total receptions: **979 (82 p/w)**

MH referrals from reception: **659 (55 p/w) 67%**

SM referrals from reception: **487 (41 p/w) 50%**

∴ HIGH PREVELANCE OF BOTH MH AND SMS
(this is just those who admit having a problem)

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NOTTINGHAM = 659

Mental health contact:	**80%**
Previous prescription of psychotropics:	**70%**
H/O Self-harm:	**59%**
Near lethal self-harm (hanging etc):	**20%**
H/O Psychotic/pseudopsychotic symptoms:	**35%**
ADHD Diagnosis	**5%**
H/O Substance misuse problem:	**58%**

Most of these 659 are not just “worried well”

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DILEMMA

AND

PARADOXES

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PSYCHOTIC SYMPTOMS AND DRUGS USE

DIAGNOSIS : EASY

TREATMENT : EASY

Mr M (26 years)

INDEX OFFENCE: GBH. Stabbed an unknown person

Grandfather committed suicide

Mother : psychiatric history + alcohol

Father : substance misuse + criminality

Cousin : schizophrenia on depot

Age 6:	**“Nutter”, overactive, poor sleep, behaviour problems at home and school**
Age 10:	**ADHD (treated with Ritalin)**
Age 12:	**Cannabis use**
Age 13:	**Polydrug use**
Age 14:	**Onset of “Paranoia”**
Age 15:	**Onset of “Voices”**

Mr M (continued)

Paranoid since he was 15 years old.

Whole world is out to get him.

People sending him signals through the TV.

If people are having a conversation he believes it is about him.

TV talking to him.

People following him all the time.

Every song he hears is about him.

Sometimes recognises it as just his paranoia. Other times believes it with delusional intensity.

I can control people when I am drunk.

It is like I am a passenger in my body and not in control.

People are controlling me.

I am loads of different characters.

Feels he is distressed by the devil.

Voices since he was 11
Man and a woman
Sometimes inside his head sometimes outside
Talking to each other and to him
Derogatory and tell him to harm others

Always carries a knife or a bottle
If people cough believes it is directed at him
Sometimes rationalises it is his paranoia other times believes it with delusional intensity and acts violently particularly when under the influence
Mood instability

Presentation during recent years

- F/H of mental dis/subs misuse/ offending conduct disorder/ADHD even in pr school.
- School failure.
- Cannabis from the age of 11 or 12 years.
- Other drugs from the age of 14 or 15 years.
- Paranoid from the age of 13 or 14 years.
- Voice hearing from the age of 14 or 15 years.

- **Ideas of reference** 

Delusions

- **Pseudohallucinations** 

Hallucinations

- **Anxiety**
- **Mood instability**
- **Self-harm: parasuicidal/suicidal**
- **Violence: following violent pseudohall/hallucinations**
- **Distress/Disorder: ++**
- **Violence as a pre-emptive strike**

Diagnostic Dilemma

- **Ac. Polymorphic psychotic disorder**
- **Subst misuse related psychotic disorder**
- **ASPD + pseudopsychotic symptoms**

- **?? Schizophrenia**

Common Pattern

- **All four psychiatrists in prison treated Mr M with olanzapine 20mgs.**
- **None of the four requested hospitalisation.**
- **CMHTs not keen to provide assertive follow-up.**

Homelessness + increasing drugs use + poor compliance with medication

Deterioration + offending

Prison

After Care Paradox

More likely to receive appropriate aftercare

- **Single psychotic illness – schizophrenia**

than

- **Psychotic episodes with comorbidities such as PD and substance misuse disorders.**

Treatment Considerations

- To treat or not to treat – Prescribing off label
- This is self inflicted so not treating justified
- If only Stop using drugs you would be ok
- They are not ok even if off drugs for months
- Antipsychs reduce symptom intensity and severity but no resolution for months / years.
- Hospitalise or not to hospitalise.

Food for Thought!

- Too difficult to treat so easier not to
- Is Psychosocial model for problem drugs the right one or is a bio- psychosocial model more appropriate?

- (Parallels with obesity)

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Service Development

- **CRITICAL TIME INTERVENTION**

Six weeks post release support from our three remand prisons

- **RECONNECT**

Up to Six months post release support for "vulnerable" prisoners

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Drugs Used

- Heroin – Class A drug
- Cannabis
- Skunk Weed
- Mamba
- Crack cocaine
- Amphetamines
- NPS

Paradox of Drugs class

- **Heroin:**

Little if any, effect on psychosis

May even have antipsychotic properties

- **Cannabis:**

Far more likely to cause psychosis/pseudo psychotic symptoms for those with a genetic predisposition for mental disorders or with conduct disorder as a child.

Opiate Substitution Therapy

- **International evidence – OST very effective in stopping heroin use. Needs doses of 60-120ml of methadone for 2-5 years.**

BUT

- **Govt policy encourages abstinence rather than maintenance.**
- **SM services measure success by those detoxed.**
- **Under dosing is common increasing risk of top up use of heroin and other drugs.**
- **Under dosing leads to demand for other medication such as opiates, antidepressants, gabapentinoids, antipsychotics (combination of these far more likely to cause death due to cardiotoxicity or respiratory depression)**

Psychosocial Treatment

- **Heavy investment in Prisons since 1999**
- **CARAT (Counselling, Assessment, Referral, Advice and Throughcare)**

BUT

- ***Most psychosocial interventions are of low intensity and are of limited efficacy***

So, what can we do?

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START Service Model

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Evidence Based Treatment

- O.S.T
- Motivational interviewing
- High intensity psychological treatment

  Formulation based — Trauma

  Emotional dysregulation — Distress tolerance

  (Treatment of PD)
- UK SMART Recovery

  Mutual aid meetings — Peer mentors
- Enabling environments (recovery wings)

❖ NICE Quality Standards for drug use disorders

❖ Patel Report

❖ Advisory council on misuse of drugs (2015)

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Pillars of Recovery CSAAP Accredited

- Starting the recovery journey
- Understanding dependency
- Staying safe
- Managing cravings
- Sampling sobriety
- Building relationships and social networks
- Achieving lifestyle balance
- Understanding emotional wellbeing
- Overcoming negative thoughts
- Breaking unhelpful behaviour patterns
- Building recovery capital
- Creating a roadmap to success

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OFFENDER HEALTH DIRECTORATE

HMP Leicester	**Primary health and mental health**
HMP Gartree	**Primary, mental health and substance misuse**
HMP Nottingham	**Primary, mental health and substance misuse**
HMP Lowdham Grange	**Primary, mental health and substance misuse**
HMP Ranby	**Primary, mental health and substance misuse**
HMP Lincoln	**Primary health and mental health**
HMP North Sea Camp	**Primary health and mental health**
IRC Morton Hall	**Primary, mental health and substance misuse**
HMP Whatton	**Offender PD Service**

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