Drug testing in prisons

There are 131 prison establishments in Britain with a current inmate population of over 53,000. Recent research has estimated that around 15 per cent of prisoners are dependent drug users at the point of reception, though this percentage is commonly believed by drugs specialists to be a considerable underestimate. It is likely that as many as 70 per cent of all prisoners will use a controlled drug at some time during their time in custody.

For many years drug workers have been drawing attention to the alarming levels of drug use in prison. Primarily, this has been related to concerns over HIV transmission, but there has also been great concern over the chances of leading a drug-free lifestyle after custody being undermined by increasing (or even, new) drug use while in prison.

The links between problem drug use and crime — particularly acquisitive crime — are now generally acknowledged through the criminal justice system and increasingly in the public eye. Many of the most chaotic drug users end up in custody, often continuing to use drugs problematically. The view that prisons are rife with illicit drug use has become commonplace and it appears to be this that finally galvanised the Home Secretary, Michael Howard, into action.

Past interventions have tended to focus on attempts by the prisons to control the use of drugs — particularly heroin — in custody. More recent awareness of the numbers and degree of chaotic, problematic and at-risk drug users in custody and the opportunities for intervention at this point have led to various treatment initiatives in the custodial setting, often involving outside drug specialists.

For the last couple of years, the Prison Service has been preparing a strategy for tackling drugs which was finally published in May last year. This strategy is founded on the combination of security measures to reduce supply and deter use, and the provision of advice and treatment.

As of April, all Britain's prisons are carrying out mandatory drug testing. But what does this really mean and is it viable if there's not enough money for prison-based treatment services?

by

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Mandatory Drug Testing
The core element of the prison drug strategy is Mandatory Drug Testing (MDT), and for better or worse, MDT has arrived in all British prisons. Early last year MDT was piloted in nine prisons and 37 per cent of inmates who were tested were found to be positive. Following the ‘success’ of this pilot, the Prison Service guaranteed that by April every prison would be testing, and it seems that this undertaking has been met.

Leaving aside for now the questions of ethics and effectiveness, it is quite clear that a lot of thought has gone into the testing process itself, resulting in a very careful and thorough testing protocol. (See What happens? box.)

Testing can be carried out either when the prisoner arrives at the prison or on a random basis, but the key to the whole programme is that of random testing. Ten per cent of each prison’s monthly roll is randomly selected by computer at Prison Service HQ, and the names and numbers forwarded to the drug testing unit in the prison. Anyone who tests positive is placed on report — given notice that they will be formally charged under the relevant prison rules. Of all the types of drug testing, random testing will place the greatest strain on a prison’s resources.

Testing on reception
The next biggest strain is likely to be that of testing all prisoners on reception. If all inmates cooperated (which seems unlikely) this wouldundeniably provide very useful statistics, but the main purpose is to draw a baseline against which performance can be measured. In practice, each prison can decide for itself whether and how to test on reception, and most choose not to test. Such flexibility is designed to meet the different needs of different prisons and to avoid the logistical problems which would otherwise face prisons which receive large numbers of prisoners.

SUMMARY
All prisons must now carry out mandatory drug testing of their inmates. Each month, ten per cent of a prison’s population is randomly tested and a positive test can result in harsh disciplinary penalties. Prisoners can also be tested on arrival or if they are known drug users. However, there are a number of ethical and practical problems which mandatory testing raises but does not satisfactorily address — chief among these are the potential for abuse of testing and the relationship between testing and treatment.

The author is writing in a personal capacity and is no longer working in the prison field.
Those testing positive on reception cannot be placed on report as the “offence” was committed prior to custody, and testing positive for illicit drugs in the outside community is not yet an offence. At least one of the open prisons plans to identify and screen out all drug users by testing on reception, though this is likely to annoy staff at prisons to which such prisoners will be diverted.

**Frequent testing**

Another component is the frequent testing programme – which has both mandatory and voluntary elements. In the mandatory programme, known drug users are tested randomly, and at a much greater frequency than the rest of the prison population. The urine samples are tested on site, though if the inmate wishes positive results can be confirmed by an outside laboratory. As with the general random testing programme, all positives are placed on report.

Testing can only work as part of a comprehensive strategy to tackle drug use in prisons.

Despite this punitive starting point given by the Home Office, the Prison Service is attempting to implement a more supportive regime, accepting that testing alone is doomed to failure without support systems. As part of this, most prisons are developing substance-free areas to help people overcome drug problems and stop drug use. But despite staff goodwill, a lack of resources and the confines of prison culture are likely to limit the degree to which they can offer the support they would like.

One version of this frequent testing programme involves the inmate’s punishment being suspended for six months while they volunteer to go on the programme, though prison trainers advise staff not to suspend adjudication in this way.

Drug testing units are keen to emphasise the benefits of such a voluntary frequent testing programme. At Bristol Prison they have offered to write reports for bail, sentencing, parole, lifer review boards, and so on, providing evidence that the person has been totally drug free.

**What Happens?**

The prisoner is taken immediately to the sample collecting site by two staff. They are then searched (by officers of the same sex) and supervised while providing a urine sample. If unable to comply the inmate can be detained for up to five hours before being charged under prison rules with refusing to provide a urine sample.

The sample is then tested for opiates, cocaine, amphetamines, methadone, benzodiazepines, cannabinoids and barbiturates, though only a random sample are tested for LSD as these tests are very expensive.

At every stage the protocol is explained to the prisoner, and so far there appears to be confidence both in the accuracy of the test and in the difficulty of cheating the test, at least for male prisoners.

**Drug testing abuse?**

Despite the consumption of alcohol being against prison rules and the existence of alcohol-related violence, alcohol is not tested for, further reinforcing the perception that drug testing has a political rather than a practical agenda.

Its most unpopular aspect is likely to be that of testing on the grounds of “reasonable suspicion”. It is hoped that the potential for abuse of this power will be minimised by the condition that testing must be approved by someone on a governor grade.

Also unpopular is testing in relation to temporary release. The granting of home leaves, “town visits”, outside work, change of labour, change of security category and so on involves an assessment of the risk to the inmate and to others, and is likely to be tied in to proving negative on drug tests. This is particularly poignant for long-termers and lifers, many of whom may have their sentences “extended” by years, perhaps just for smoking cannabis.

**Sanctions**

There are a wide variety of possible sanctions, levied at the governor’s discretion. A current example is 28 days loss of remission for refusing a test, 21 days for testing positive for class A drugs and 14 days for cannabis. Other sanctions involve fines, re-categorisation, transfer within the prison, the stopping of privileges and closed visits. In fact, Michael Howard has just announced a pilot programme in three prisons where closed visits will be the sanction for every positive test.

The prison service is still unclear about how to respond to persistent “offenders”, those who will not stop their drug use. A handful of prisoners will be repeatedly punished for something many believe is not a problem and in a manner which is often disproportionate to the punishment outside prisons. Others will be repeatedly punished for what could be viewed as an illness.

The few prisons that have considered this have said they will refer these persistent users to treatment. But what if they don’t want treatment, or are unhappy with the treatment that is being offered? To the service’s credit, it realises that control measures cannot work in isolation, but there still remains the question over the degree to which this willingness to tackle the drug problem can be effectively translated into practice.

**Treatment**

As well as being a tool of control, MDT is meant to involve a supportive response. It is this area that is generally missing and there are fears that will continue to be the case. The overall emphasis is clearly on control, and the ineffectiveness of such a one-sided approach is already well known in the outside world. Even where there is an awareness of this, drug testing units are struggling with limited support and resources and are unable to provide support and the access to support that they would like. So far no additional resources have been provided, effectively sabotaging the strategy. Unfortunately, this approach is little changed from the one that has led to the current inadequate situation.

It is questionable to reward people just because they have not broken prison rules.

Treatment in prison (if it exists at all) has always been very under-resourced and over-stretched. Referrals from MDT programmes are threatening to overwhelm already shaky services. Many prison treatment services are provided by outside agencies which – because they were not consulted in the development of testing regimes – feel disinclined to help deal with the problems that testing creates.

Where treatment is available it is usually meant to be available to all prisoners, and the outside agencies are understandably unhappy about prioritising referrals from the testing units, many of who may just be casual
cannabis smokers. On top of this, fear of being identified as a target for testing is discouraging some inmates from utilising what treatment there is.

Considering that security will always be of paramount consideration in custody settings and that political will is behind testing as a control strategy, it is unlikely (though perhaps unsurprising) that the prison service will get significantly involved in the provision of treatment, despite indications to the contrary in the new prison service strategy.

**Outcomes**
The full implications of mandatory testing are still unclear. The widespread boycott anticipated by some prison drug workers has not materialised, though anecdotal evidence suggests that testing is antagonising the inmate population. The great majority of prisoners feel they are either being disproportionately punished, or are being punished for a condition (addiction) that arguably they should be receiving help for.

Between February last year and this January, over 8300 random tests were carried out in English and Welsh prisons. There were over 3000 positive results. The vast majority of these positives – 2417 – were for Class B drugs, mainly cannabis. There were only 470 positives for Class A drugs. Given the indications that the impact of mandatory testing will mainly be felt by recreational cannabis users, it is likely that some will be deterred from using by the potential to lose remission. This will be viewed as a success in terms of the Key Performance Indicator of reducing the overall level of use, but it is unlikely to influence the behaviour of more committed or dependent users, which is more closely associated with control and health problems.

The inmate population is well aware of the mechanics of urine testing and already there is an alarming degree of anecdotal evidence of drug misusers favouring heroin over cannabis in certain situations, as it does not show up in tests so long after use. While this is often likely to be an excuse for using such drugs, the fact that the mechanics of testing do provide the opportunity for such an excuse is regrettable. Similarly there is an increase in the use of alcohol.

One potentially worrying development is that of differential regimes on the basis of drug use alone. If the only difference is the enforcement of a drug-free environment then this is not a problem, but plans for other incentives are more problematic. There is something questionable about rewarding people simply because they have not broken the law or prison rules. While fully developed and well thought out systems of differentiated regimes based on a variety of relevant factors could be appropriate, some of the ideas currently being aired could result in a determinedly recidivist armed robber who has never taken illicit drugs being considerably better treated than an ex-heroin user who has had successful treatment but who occasionally smokes cannabis.

**Testing's political dimension**
It is clearly essential not only to control the drugs trade in prison, but also to provide education about drugs and treatment and help for those who want and need it. But it seems unlikely that the MDT programme in its current form will significantly achieve any of these goals without significant resources being channelled into support and treatment. What it will do is to satisfy current political agendas. It will do nothing for drug work in prison, which may in turn be heading towards a critical point.

Just as the issues are at last being acknowledged, the Department of Health is tiring of funding most of the little work that goes on.

Mandatory drug testing can only work as part of a more comprehensive strategy to tackle the problem of drug use in prison. Perhaps it is time for the prison service to resurrect the abandoned concept that rehabilitation in the widest sense is a key component of a custodial sentence.