Home Office Research Study 267

Prisoners' drug use and treatment: seven research studies

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Home Office Research Studies

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Foreword

In the last few years, the Prison Service has developed a substantial programme of drug treatment. Much of this has been aimed not only at meeting the health needs of prisoners but also at helping them to curtail their consumption of prohibited drugs both in prison and on release. Regular consumption of such drugs, particularly heroin and/or cocaine or crack, is often associated with high levels of offending. For prisoners with drug habits of this kind, successful resettlement is dependent on tackling their drug use, as many of them recognise.

This report brings together seven studies which are all directly or indirectly concerned with the progress of the Prison Service drug strategy. This strategy is sufficiently new that relatively little has been published about it, until now. In an era when policy is increasingly informed by research evidence, and is assessed against achieved outcomes, these studies shed useful fresh light both on the issues facing the Prison Service drug strategy and on the extent and value of prisoner engagement with treatment.

Some of these studies provide further confirmation of the links between drug use and offending. Others review the effectiveness of treatment, both in the prisons of England and Wales, and internationally. A major theme of those bearing on effectiveness is the importance of aftercare. Without good-quality aftercare, both in prison and on release, drug treatment is much less likely to be successful. Another key theme is for treatment to be geared to the needs of different kinds of prisoners, for instance in terms of gender and ethnicity. In short, this set of studies has much to say on how drug treatment in prison can contribute to crime reduction. It should be of interest to those concerned with both policy and practice, particularly given the limited amount of other published material on the drug strategy for the prisons of England and Wales.

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Acknowledgments

This set of seven studies has taken time to assemble. It is good to be able to look back, and thank those involved. Editorial work first began in earnest in 2001, under the sponsorship of Maureen Colledge, as head of what was then the prisons research and statistics part of Offenders and Corrections Unit, in RDS (Research, Development and Statistics). From the outset, the Drug Strategy Unit of the Prison Service was involved in the planning of this collection of studies. Both Sarah Liriano and Tony Bullock contributed to early discussions about the planning of this collection. Chris Lewis, as head of the former Offenders and Corrections Unit, took a close interest.

Originally, there were to have been six studies, but Pat Dowdeswell (who replaced Maureen Colledge in 2002) rightly pressed the case for a seventh, concerned with the substance use and treatment needs of white and black/mixed race female prisoners. As it was not quite complete, there was a longer gestation for the work as a whole.

These studies benefited from comments by colleagues in the Home Office (including the then Drugs and Alcohol Research Unit) and the Prison Service. In addition, various peer reviewers were involved. Trevor Bennett (then at the University of Cambridge, currently at the University of Glamorgan) reviewed Chapter 2; Paul Turnbull (of South Bank University) reviewed Chapters 3 and 4; Norman Hoffmann (of Evince Clinical Assessments and Brown University) reviewed Chapter 5; and Mary McMurran of Cardiff University reviewed Chapter 6. Their inputs are gratefully acknowledged.

Malcolm Ramsay

Contents

Summary

This report brings together seven studies concerned with prisoners' drug use and treatment, in England and Wales. This is a field where policy and practice have been developing rapidly in the last few years. Up to now, there has been relatively little research bearing on these developments. While prisoners' drug use and treatment are health issues, the primary focus of the studies published here is mainly on the links with offending. This echoes the fact that, to a significant degree, drug policy for prisons is ultimately geared to the reduction of reoffending or, in other words, what happens after people leave prison. Brief outlines of the seven studies, particularly their main conclusions and policy implications, are provided below. Finally, some crucial overarching points are presented (more detailed overviews are given in Chapter 1).

Prisoners' drug use before prison and the links with crime

Chapter 2 summarises key results of the Criminality Survey 2000, as carried out by BMRB (British Market Research Bureau) with a large sample of newly arrived prisoners.

- The main conclusions emphasise the high levels of drug use by prisoners in the year before they were in custody, together with links between drug use and patterns of offending behaviour. Nearly three-quarters had taken an illegal drug in the 12 months pre-prison; of these, over half (55%) reported that they had committed offences connected to their drug taking. The need for money to buy drugs was the most commonly cited factor. Findings of this kind lend weight to the potential value of delivering drug treatment to prisoners, before they return to the community.

Changing levels of drug use and treatment before, during and after imprisonment

Chapter 3 is linked to the previous chapter, in that drug users identified in the Criminality Survey were followed up through further interviews later in their sentences and, in some cases, on release.

- This tracking study points to changes in the level of drug use, before, during and after imprisonment. During imprisonment, there was less use of drugs than before or afterwards. In particular, there was relatively little use of stimulants such as cocaine or crack. Substantial minorities of prisoners received various types of treatment, with

a range of objectives. On release, those prisoners who continued to use drugs tended to be relatively prolific offenders, liable to reconviction. This study too indicates that prison can be an opportune setting for delivering drug treatment.

Substance misuse among white and black/mixed-race female prisoners

Chapter 4 assesses the treatment needs of women prisoners, focusing on whites as the largest ethnic group and also on black/mixed-race women (specifically of Afro-Caribbean rather than Asian origin, as there are still relatively few such women in prison).

- Key conclusions include the fact that white women prisoners had particularly high rates of drug dependency, usually involving opiates, and quite often crack as well. The black/mixed-race women prisoners had lower rates of dependency, which tended to involve crack (but not usually heroin). In general, the prevalence and frequency of pre-prison drug use on the part of female prisoners matched or even exceeded that of male prisoners. Overall, for women prisoners, such findings point to the need for, proportionately, similar levels of drug treatment to those for male prisoners. There is also a need for treatment to take into account different patterns of drug use, particularly crack as consumed by some black/mixed-race prisoners.

Key findings from the literature on the effectiveness of drug treatment in prison

Chapter 5 reviews the English-language literature on drug treatment for prisoners, much of it American in origin.

- The main conclusion is that good-quality treatment can be effective in reducing reoffending, particularly when it is of adequate length, meets individual needs and, above all, is followed through by aftercare, both in prison and following release. The need for high-quality, seamless aftercare is an important issue for both the prison and probation services, together with the wide range of other relevant organisations.

Results of evaluations of the RAPt drug treatment programme

Chapter 6 brings together both previously published and also new work, all of it focusing on the first major drug treatment programme set up in various English prisons during the 1990s. RAPt, which stands for Rehabilitation of Addicted Prisoners Trust, is a 12-step, abstinence-based model, ultimately of American origins.

- The conclusions from the various studies presented here consistently show RAPt graduates achieving reductions in both drug use and offending on their release. This is an important finding as RAPt is the longest-accredited drug treatment programme for prisoners.

A process evaluation of drug treatment in English and Welsh prisons

Chapter 7 summarises the results of a substantial evaluation, originally carried out between 1996 and 1998, of the initial process of setting up the Prison Service drug strategy.

- The conclusion was that, even then, useful progress was being made. External contractors were helping to deliver the new services, in the face of (diminishing) reluctance on the part of some prison staff. The more intensive treatment programmes in prison, with their emphasis on community-based and self-directed change through peer involvement and confrontation, were impacting positively on ingrained aspects of prison culture and inmate behaviour. This is further testimony to the value of providing drug treatment in prison, albeit more in terms of the process of delivery, rather than of outcomes.

Management of drug-using prisoners in Leicestershire

Chapter 8, based on a case study involving three prisons in Leicestershire, was originally carried out in 1996-7, at a time when drug treatment provision for prisoners was 'extremely limited'.

- The recommendations, which helped to shape the Prison Service drug strategy, include endorsement of the role of specialist external providers of treatment; the setting up of a continuum of courses and support for those receiving treatment; and the involvement of prisoners' families. All of these remain highly relevant. The third recommendation may still represent a particular challenge.

Conclusions: policy implications and lessons for practitioners

Three main sets of implications are highlighted in Chapter 9:

- First, many prisoners are interested in drug treatment, and that treatment can help to bring about reductions in drug use and offending.

- Secondly, drug treatment is inevitably many-faceted, and needs to be kept under regular review. Similarly, different types of prisoners may have distinct needs.

- Thirdly, good-quality aftercare (both for the remainder of the period of imprisonment and also on release) is absolutely vital to the success of drug treatment in prison.

Finally, while drug use and its treatment or control poses a real challenge for prisons, it can also help to re-focus managers, staff and inmates on how prisons should operate, and on their place in society.

Introduction

Malcolm Ramsay

In the last few years, a substantial, multi-strand drug strategy for prisons has been put in place. This largely follows the publication of a strategy document, Tackling Drugs in Prison, in 1998, which built on an earlier initiative, in 1995. Although the Prison Service drug strategy is sometimes viewed rather narrowly, in terms of slightly older measures such as Mandatory Drug Testing and supply reduction, there is now an increasingly extensive programme of treatment, in different shapes and forms. These include detoxification (particularly but not exclusively of those arriving in prison with withdrawal symptoms); a screening and assessment service known as CARAT (counselling, assessment, referral, advice and throughcare); and some distinct treatment programmes (therapeutic communities or rehabilitation units). Their purpose is not only to meet health needs but also to address drug use as an adjunct of crime. Treatment currently accounts for around 60 per cent of the direct costs of the drug strategy in prisons, with the remainder split relatively evenly between supply interdiction and mandatory/voluntary drug testing. This is almost certainly a more 'balanced' effort than is true of the strategy as a whole, where law enforcement looms much larger than treatment, costwise.

The seven studies presented here are primarily concerned with drug treatment in prisons, and with the prevalence of drug use before, during and after imprisonment. After this introduction (Chapter 1), the report is structured as follows:

Chapter 2, entitled 'Prisoners' drug use before prison and the links with crime', draws on the Criminality Survey, carried out in 2000, which involved some 1800 recently arrived male prisoners. They were asked about their patterns of drug use, and possible links with offending, over the last year when they were at liberty. Finally, just briefly, the chapter addresses the differing levels of drug use on the part of novice and serial prisoners before their entry into prison. For a variety of reasons, which may include institutionalised social exclusion, serial prisoners tend to have been more heavily involved in drugs than novice prisoners. Many of them fall into the 'revolving door' category of short-sentence prisoner, with a high probability of reconviction, as highlighted in a recent report by the Social Exclusion Unit (SEU, 2002).

Chapter 3, entitled 'Changing levels of drug use before, during and after prison', draws on follow-up surveys carried out with drug users identified in the 2000 Criminality Survey. Follow-up groups included both prisoners and ex-prisoners. The main focus of this chapter is, as its title suggests, on the changing nature and extent of these men's drug use before, during and after prison. Drug use was lowest in prison, although there was still consumption of cannabis and heroin in particular. Use of stimulants was relatively uncommon in prison. Respondents were exposed to a range of drug treatment and testing provisions while in prison. For instance, nearly a quarter had participated in a detoxification programme, and nearly a third had had a consultation with a drug treatment worker. Well over a third of those interviewed in prison were housed in voluntary testing units (where extra privileges are enjoyed, subject to the results of regular drug testing). Over half the respondents had been subjected to mandatory tests, which carried the threat of serious sanctions, including extra time in prison. However, respondents tended to ascribe their decreased use of drugs to limited availability, rather than concerns about punishment. Finally, the chapter discusses links between post-release drug use and offending. Those ex-prisoners still using drugs extensively tended also to be relatively prolific offenders, and were more liable to be caught reoffending.

Chapter 4, entitled 'Substance misuse among white and black/mixed-race female prisoners', draws on a wider study of the 'Differential Substance Misuse Treatment Needs of Women, Ethnic Minorities and Young Offenders' (Borrill et al., 2003). An important component of that study was a survey carried out in 2001, exploring patterns of drug use before and during custody, among 301 white and black/mixed-race women. Not only was there widespread drug use among the female prisoners in the year prior to their imprisonment, but it was of remarkable severity, with half the sample drug dependent. There were clear ethnic differences. Opiate use was most apparent among white women, whereas black/mixed-race women were more likely to have problems with crack cocaine. The survey also found that female inmates' drug use in prison was broadly similar to that of male prisoners: levels of use were low in relation to pre-prison prevalence, and there was a tendency to use depressants rather than stimulants in custody. Finally, the chapter reviews the extent to which factors such as education, experience of violence and mental health are associated with drug use: some tentative observations are made.

Chapter 5, entitled 'Key findings from the literature on drug treatment in prisons', discusses the British and international literature in this field. This literature is primarily North American, as is so much work concerned with drug use and crime. So, unsurprisingly, the major studies reviewed here are mostly from the United States. Evaluations of prison-based interventions, in terms of recidivism rates, have long been a classic field of scholarly debate (Pawson and

Tilley, 1997). There is now sufficient research to show that good-quality treatment can be effective, particularly when it is of adequate duration, matched to the individual and followed through with aftercare.

Chapter 6, entitled 'Results of evaluations of the RAPt drug treatment programme', brings together the results of published and unpublished studies into the effectiveness of one particular treatment programme in prisons. RAPt (Rehabilitation of Addicted Prisoners Trust) operates a '12-step' approach based on an American model. This advocates complete abstinence from drugs and alcohol. There is also a strong emphasis on aftercare. RAPt's pioneering programme at Downview and other prisons is the first to have been instituted and evaluated in this country. Previously published studies have had process and outcome components, the latter including both relapse and reconviction results, albeit with relatively modest numbers. The recently completed and so far unpublished study is a fresh reconviction analysis, based on larger numbers. All of the outcome analysis, published and unpublished, points to the RAPt programme achieving significant gains for programme graduates.

Chapter 7, entitled 'A process evaluation of drug treatment in English and Welsh prisons', assesses the initial delivery of the drug strategy in prisons. Given the pace of change since the research was carried out in 1996-8, this chapter serves almost as a historical record, going back to a time when 'service provision [of treatment for prisoners] was extremely limited', and when 'most services were within the first year of implementation'. Unlike the previous chapter, the focus is not on outcomes, but on the early delivery of treatment services for prisoners. A survey of over 1,000 prisoners about to enter treatment was carried out, while extensive use was made of other data on those involved in treatment. The research sheds light on a range of issues that are still relevant, including costs and completion rates. The chapter concludes that 'an ambitious project of expanding drug treatment in prisons was making good progress at a time when population pressures were reaching unprecedented levels' – pressures that have continued to increase since the late 1990s.

Chapter 8, entitled 'Management of drug-using prisoners in Leicestershire', is a case study of three male prisons in Leicestershire. Based on data collection including surveys of staff and prisoners carried out in 1996-7, it too is in some sense a historical record, although once again the issues discussed are still highly relevant. It links up with the previous chapters by considering the need for prisoners to be able to receive drugs treatment. It highlights the fact that the men's prevalence and frequency of drug use was lower in prison than when they were in the community. However, those using drugs most heavily in prison tended also to have been most dependent on drugs while still at liberty. In addition to discussing issues relating to the delivery of treatment (and aftercare), the chapter also examines Mandatory

Drug Testing, implementation of which by the Prison Service began in 1995. It notes: 'we have already shown that some prisoners may begin or return to the use of heroin and other substances in prison but it takes a conceptual leap to attribute these changes, solely, to MDT.'

Taken together, these seven studies provide clear testimony to the rapid development of the drug strategy within prisons. The potential need for this kind of intervention is suggested by the high levels of drug use of many prisoners, prior to their imprisonment, which are associated with high levels of offending. The actual value of interventions with drug-using prisoners is demonstrated both by the review of the international literature and by early results from treatment programmes in English and Welsh prisons.

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2. Prisoners' drug use before prison and the links with crime

Sarah Liriano and Malcolm Ramsay

What do we mean by drug use before prison? How can we measure it? Why does it matter? The main data source deployed here to answer these questions is a survey in 2000 of 1884 males who had recently been sent to prison in England and Wales. They were asked about their earlier drug use, and also about their previous offending. Good reasons for discussing prisoners' pre-prison drug use, at the start of a report on prisoners and their drug treatment in prison, include the following:

- Efforts to reduce prisoners' levels of drug use constitute a primary focus of the Prison Service drug strategy. Prisoners' levels of drug use prior to their incarceration constitute a baseline against which the effectiveness of the drug strategy in prisons can be measured.

- Drug use is widely believed to be at the root of a considerable amount of crime, although it is also fair to say that the nature of the relationship remains under debate. The Prison Service, together with other agencies of the criminal justice system, has an important role in tackling crime as well as drug use. Crime reduction is a focus for the Prison Service drug strategy. The aim of drug treatment in prison is partly to help reduce subsequent reoffending, in addition of course to improving prisoners' health (or at least minimising any harm). Investigating prisoners' own perceptions of the links between their drug use and their offending behaviour before they were imprisoned is, in research terms, a convenient way of starting to explore the drugs/crime relationship. Not only are prisoners literally a 'captive' group, fairly straightforward to survey, but they are at the serious end of the spectrum of offenders processed by the criminal justice system.

- Any survey of a sample of all newly incarcerated prisoners necessarily covers both 'novice' prisoners and those who have experienced earlier periods of imprisonment. While there is a large and growing literature on the association between drug use and crime, it pays surprisingly little attention to longitudinal issues, including possible effects of imprisonment, both positive and negative. By

> comparing the pre-prison behaviour of first-time prisoners with those previously imprisoned, it is possible to broaden our understanding of an enormously complex set of issues.

This chapter develops these three strands in the same sequence. After providing some basic details about the Criminality Survey of male prisoners (or the Prsioners Criminality Survey), it begins in earnest by discussing their pre-prison drug use. The next section relates this to their offending behaviour during the same phase of their lives. Finally, there is a brief discussion of differences in drug use between 'novice' and 'serial' prisoners.

The Criminality Survey and its participants

A prison sentence contributes to reductions in crime partly by removing criminals from the communities in which they operate. However, the amount of crime that is prevented, both at the level of the individual criminal and across society as a whole, is not fully known. The Criminality Survey conducted in English and Welsh prisons during April and May 2000 was a major attempt to throw systematic light on the number of crimes committed by individual offenders, whilst in addition examining the relationship between offending and social, economic and lifestyle factors. This chapter focuses in particular on pre-prison drug use.

A representative sample was drawn of recently arrived male prisoners who had been sentenced during February and March 2000. Sex offenders were excluded (on interviewer safety and other grounds). The eligible prisons were those of medium or large size (those with, collectively, 95% of all offenders). Of these, 34 were selected to take part in the survey (with stratification by sample size). At each selected prison 49 prisoners were randomly chosen. In addition, there was a booster sample, selected from the same 34 prisons, which comprised all offenders not in the main sample who had been convicted of TDA (taking and driving away), burglary, or theft from a vehicle (these 'high-volume' offences were of particular concern to the Home Office when the survey was being planned).

The overall response rate for the survey was 90 per cent (a sufficiently high level to rule out any weighting for response bias). There was a small proportion of refusals (5%) whilst a further five per cent were classed as other unsuccessful outcomes comprising: prison recommended not to interview the respondent, respondent transferred to another prison, authorised absence i.e. home leave or admitted to hospital, or absconded.

The survey consisted of a main questionnaire and a more complicated Life Events Calendar. The first part of the interview was concerned with lifestyle factors prior to coming into prison and covered:

1. Domestic situation before prison.
2. Education and employment.
3. Income from legal and illegal sources.
4. Alcohol and drugs consumption.
5. Whether previously convicted of offences.

The Life Events Calendar was then used to collect in-depth information about the respondents' lives for up to 18 months prior to the survey, to construct a more complete picture of their lives and behavioural patterns. There was a particular focus on numbers and types of offences committed. Work is still continuing on this aspect of the Criminality Survey, although some details can be found in Lewis and Mhlanga (2001).

A merged data file covering both the main sample (n=1,330) and the booster sample (n=584) was created (in total, 1884). This merged file was weighted in order to be representative of all male prisoners sentenced in February/March 2000 (except sex offenders). The weighting was applied both to correct for the over-representation of TDA/burglary/vehicle theft cases in the merged file and so that there was appropriate representation for prisoners in different establishments.

Respondents' personal characteristics and their representativeness

As in any sample survey, it is important to delineate respondents' personal characteristics and, as far as possible, to compare them with recently sentenced prisoners in general or, if necessary, with the better-documented prison population as a whole.

- Respondents had a mean age of 28 years, ranging from 15 years to 70 years. The age distribution is consistent with the male population sentenced in February and March 2000 from which the sample was drawn and with the general prison population (Home Office, 2001). The majority of respondents were white (86%), the second largest ethnic group being black (9%).
- In the four weeks prior to coming into prison just one-tenth of respondents were living in accommodation they owned.

- Almost half, 47 per cent were living in self-contained rented accommodation. A small proportion, two per cent, were living on the streets, with the remainder in bedsits, hostels, bed and breakfast accommodation or hospital or residential treatment.
- Nearly half the respondents, 47 per cent, were living with a wife or partner whilst one-fifth were living alone and a further 22 per cent were living with parents or in-laws.
- Approximately half (51%) of the sample were unemployed for the four weeks prior to coming into prison with a further 11 per cent unable to work as a result of illness or disabilities. Nearly a third (30%) were working full-time, with a further four per cent working part-time. Just three per cent were in full-time education in the four weeks prior to coming into prison. Of those working, 30 per cent were self-employed and over half (54%) were in semi-skilled/unskilled or casual work. One-quarter of those in employment were in unofficial or black economy jobs.
- Almost half (47%) of the sample had left education before the age of 16 and only five per cent had continued their education after the age of 18. This is reflected in the educational qualifications gained; only 21 per cent had passed any GCSEs (or SCEs) and 59 per cent had no educational qualifications at all. None of those interviewed had any A level or degree level qualifications.
- Approximately one-fifth of respondents (19%) stated they had not been convicted previously. Almost a quarter of respondents (23%) had appeared in court and been convicted on four or less occasions and a further 21 per cent had been convicted on five to ten occasions. One-third of respondents (34%) had been convicted on ten or more previous occasions. Of the 1884 survey respondents, one third (34%) stated they had not previously served a custodial sentence.

In terms of age, the survey sample is consistent with the prison population (Home Office, 2001). The ethnic breakdown of the Criminality Survey respondents was broadly similar to the prison population as a whole, although white prisoners were slightly over-represented and those of other ethnic groups were slightly under-represented.

Prisoners' drug use before their imprisonment

One of the key issues when looking at offending behaviour is the misuse of drugs and alcohol. By way of prelude to tackling the complex issue of drug use and crime, this section examines the nature and frequency of drug misuse on the part of the Criminality Survey respondents prior to their incarceration. The focus is on drug use within the last year; lifetime use was not recorded in this survey, and is in any case less informative.

Drug use by age

The sample has been split into two main age groups, 17-24 year olds (n=747) and 25-59 year olds (n=1089), while 47 respondents fall outside this age range: 37 were aged under 17 and ten were over 59.

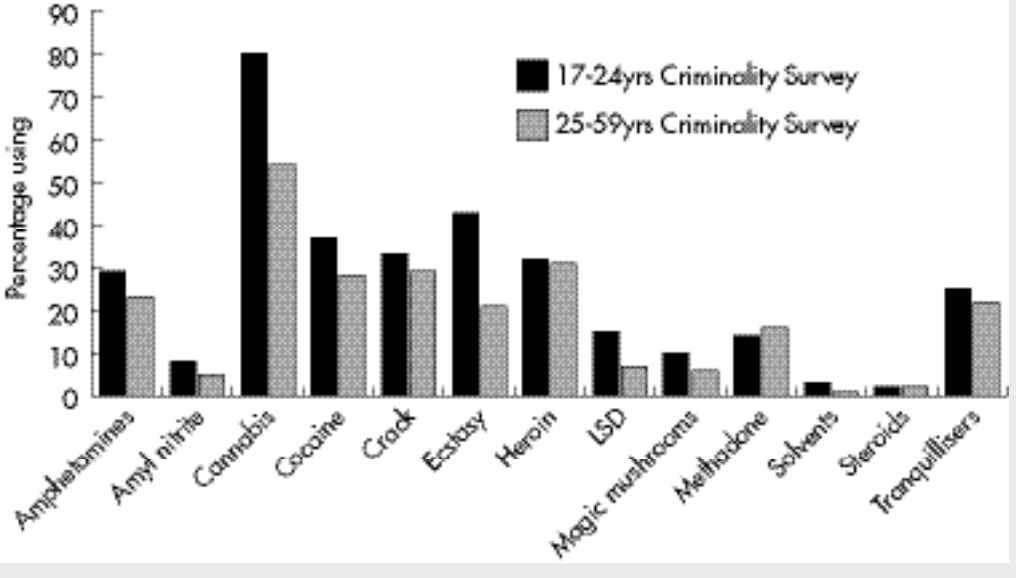
These two groups were selected because previous research has tended to point to a contrast between younger drugs users (those in their teens and early twenties) and those who are older, with more damaging patterns of consumption. As shown in Figure 2.1, younger prisoners were significantly more likely than older ones to have used cannabis within the last year (significant results reported in this chapter are based on chi-squared tests, meeting the standard 5% criterion). Of those aged 17 to 24, 80 per cent had done so, while the equivalent figure for those aged 25 to 59 was significantly lower, at 54 per cent.

Cocaine usage was also more widely reported by the 17 to 24 year old age group, with 37 per cent reporting some use compared with 28 per cent of the older age group (a significant difference). Similarly, one-third of 17 to 24 year olds reported using crack compared with 29 per cent of 25 to 59 year olds (although this was not a significant difference). Also, ecstasy use was twice as prevalent in the younger age group, with 43 per cent reporting its consumption within the last year, compared with 21 per cent of 25 to 59 year olds.

Similar proportions of both the younger and older respondents reported using heroin: 32 per cent of those aged 17 to 24 years old compared with 31 per cent of those aged 25 to 59 years old. Furthermore, usage of methadone (a synthetic analogue of heroin, used in treatment and also illicitly) was only slightly higher amongst the 25 to 59 years olds, at 16 per cent compared with 14 per cent of the 17 to 24 year olds.

In the Criminality Survey, the absence of any drug use was recorded more often for the older age group, 36 per cent of 25 to 59 year olds reporting abstention compared with 14 per cent of 17 to 24 year olds. Examining this further, the use of drugs diminishes progressively with age; just under one quarter (24%) of 25 to 29 year olds, 29 per cent of 30 to 34 year olds and almost half (48%) of 35 to 39 year olds reported not using any drugs in the past year before imprisonment.

Figure 2.1 Percentages of prisoners reporting use of different drugs in the 12 months prior to imprisonment, by age group



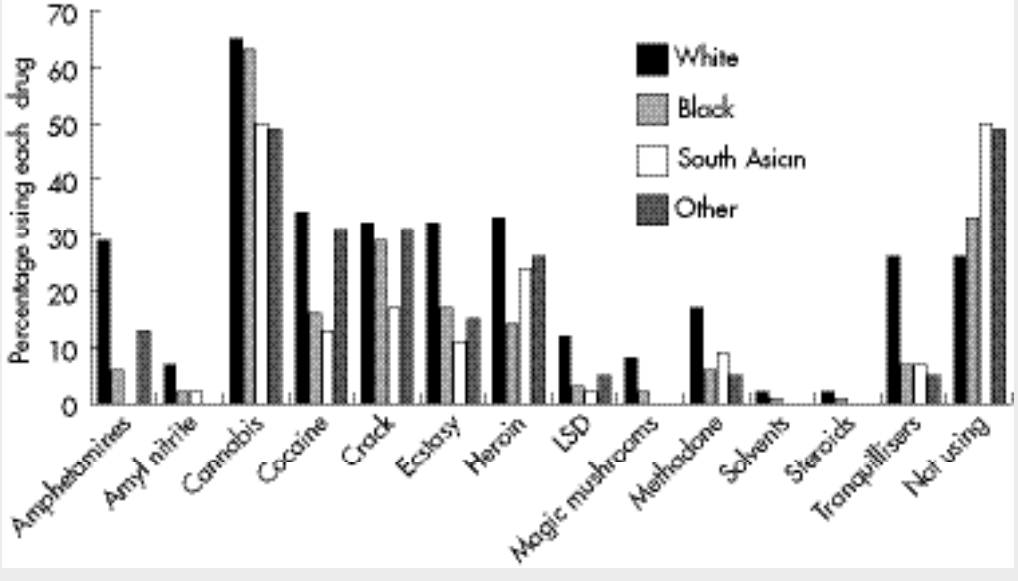
Note: Source is Criminality Survey 2000. The Criminality Survey results presented in charts, tables and text for this chapter are, consistently, weighted data.

Finally, where age is concerned, what is particularly interesting is that, for the prisoners in the Criminality Survey, levels of use of heroin (and of methadone) were similar for older and younger respondents. Heroin in particular is consistently found at the centre of any discussion of the links between drug use and crime, at least so far as this country is concerned. While there is probably no simple explanation as to why the younger prisoners had levels of heroin use matching those of their older peers, the finding is an important one, with potential implications for treatment policy in prisons.

Drug use by ethnicity

The graph in Figure 2.2 shows drug use by ethnicity in the twelve months before prison. Drug use is broadly defined to include one-off consumption.

Figure 2.2 Percentages of prisoners reporting use of different drugs within the last twelve months, prior to imprisonment, by ethnicity



Note: Source is Criminality Survey 2000. The 'South Asian' group comprises those of Indian, Pakistani and Bangladeshi origin.

In general, for most drug types except cannabis and crack, there were significantly higher prevalence rates for white respondents than for those in other ethnic groups. One-third of white respondents reported having used heroin, whilst only one in seven black respondents (14%) reported having used it. Similarly, cocaine was used by one third of white respondents (34%) but only 16 per cent of black respondents reported using cocaine. There is a significant difference in the use of cocaine and heroin between the white and black respondents. Cannabis was the most popular drug among all ethnic groups, with almost two-thirds of white and black respondents reporting that they used cannabis (65% and 63% respectively). Half (50%) of South Asian respondents (those of Indian, Pakistani and Bangladeshi origin) and 46 per cent of other respondents reported taking cannabis. All South Asian drug users reported using cannabis. South Asian respondents were most likely not to use any drugs, with 50 per cent reporting no use of any drugs over the past twelve months.

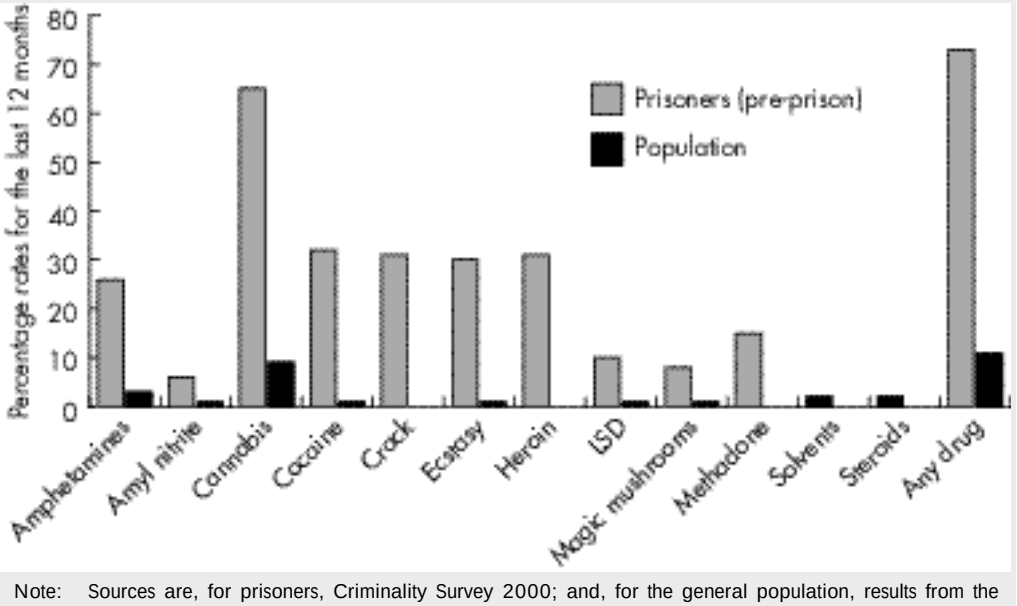
Drugs used in the past year

Almost three-quarters (73%) of respondents had taken an illegal drug in the twelve months prior to imprisonment. While this is broadly consistent with other published work, it is a

slightly higher proportion. Burrows et al. (2001), in reviewing published work on drug misuse prior to imprisonment, found consistently that about 60 to 70 per cent of prisoners had used drugs. Swann and James (1998) found that 63 per cent of prisoners had misused drugs in the 12 months prior to imprisonment and the most popular drug was cannabis, consumed by almost two-thirds (65%) of drug misusing respondents.

Figure 2.3 compares drug use by prisoners, as reported by the Criminality Survey, with that of the general population from British Crime Survey data for 16 to 59 year olds. This illustrates the substantial contrast in the levels of drug use of the two groups.

Figure 2.3 Percentages of prisoners and general public reporting use of different drugs in the previous twelve months



Note: Sources are, for prisoners, Criminality Survey 2000; and, for the general population, results from the drugs self-report component of the British Crime Survey, as reported in Ramsay et al., 2001. The figures for specific drug are those covered in both surveys, whereas the 'any drug' figures embody slightly different sets of drugs.

Figure 2.3 shows that prisoners' levels of drug use prior to their imprisonment are far greater than those of the general population. While the comparison is not altogether a fair one, in that prisoners are disproportionately younger than the equivalent general-population group, a very large gap would still have remained even if the comparison had been restricted to, say, those aged under 29.

Heroin and crack / cocaine use

Almost half of the Criminality Survey respondents (47%) had used heroin, crack or cocaine in the last twelve months. Prevalence rates for each of these drugs were 31 per cent, 31 per cent and 32 per cent respectively. These are costly and addictive drugs, consumption of which has been shown in other research to be associated with a propensity to commit high levels of property crime. Of those reporting consumption of heroin in the Criminality Survey, almost all (95%) were using it at least once a month, 85 per cent were using at least four to five times in the last week, and 82 per cent were using it at least once a day. Many of those consuming heroin also reported use of other drugs. Two-thirds of heroin users (66%) were in addition consuming crack at least monthly and 43 per cent cocaine at least monthly. Cocaine and crack are powerful stimulants, which can be used to offset the depressant effect of heroin.

Similarly, crack, a fast-acting 'cooked' form of cocaine, was also consumed on a regular basis by most of those reporting its use in the last year. Indeed, 86 per cent of crack users were using it at least once a month, two-fifths (41%) were using it at least every other day and 37 per cent were using it at least daily. Half of those using crack also used cocaine at least monthly and one-tenth reported use of crack and cocaine at least five times per week.

Of those using cocaine within the last year, 82 per cent were taking it at least monthly. However, only 16 per cent were using at least five times a week and just over one-tenth (11%) were using at least daily. These frequency rates are lower than those for crack.

Frequency of use

The drugs used most frequently prior to imprisonment were cannabis and heroin. One-fifth of respondents reported use of cannabis more than once a day, with a further 17 per cent using daily. One-quarter of respondents reported at least daily use of heroin, including one in seven respondents (14%) using it more than once a day. Similarly, almost a third of those using cannabis (31%) did so more than once a day, with a further 27 per cent using it daily. Likewise, nearly one-third of methadone users were consuming it once a day. LSD, magic mushrooms, amyl nitrite and glues and solvents were generally only used occasionally.

Overall, over half of respondents (54%) reported taking an illegal drug daily or nearly every day, with almost one-third (31%) using more than once a day.

Injecting behaviour

Almost one quarter (23%) of respondents said they had injected drugs in the twelve months prior to coming into prison. Heroin was the most popular drug injected with 19 per cent of respondents saying they had injected it (83% of those who said they injected drugs injected heroin). The injection of more than one than one drug was reported by 12 per cent of the respondents, roughly half of those who reported any injecting.

Drug use by type of offence leading to conviction / imprisonment

The main offence for which the respondent was sentenced to prison was classified into eight standard categories: violence against the person (VATP), sex offences, burglary, robbery, theft and handling, fraud and forgery, drug offences and other offences. Sex offenders were however excluded from the survey and therefore no sex offences are recorded.

Comparing those who reported use of any drug (including once-only use) with those who reported not using an illegal drug in the twelve months prior to prison, the former group were more likely to be convicted of burglaries, robberies, theft and handling, and drug offences. Those not using drugs were more likely to be convicted of VATP, fraud and forgery and 'other' offences. A similar pattern is seen when comparing those using a drug at least daily, except for those sentenced for drug offences, the majority of whom were not daily drug users. Almost half of all those using a prohibited drug on a daily basis (48%) were convicted of burglary or theft or handling.

Drug use by sentence length

Drug use varied with sentence length. To explore this issue, respondents were categorised into short-term, medium-term and long-term prisoners, based respectively on sentence lengths of less than twelve months (n=1068), twelve months to four years (n=664) and more than four years (n=151 including 36 lifers).

Drug use was more prevalent among the short-term prisoners. One-third of short-term prisoners had used heroin in the twelve months before coming into prison compared with less than a quarter of long-term prisoners. This possibly reflects the fact that many short-term prisoners were sent to prison for relatively small-scale property offences – offences which can be associated with the purchase of heroin in particular, as discussed below. Cocaine and crack use was not related to sentence length, with approximately one-third of those on short, medium and long-term sentences using cocaine (31%, 33% and 31% respectively) and similarly for crack (30%, 32% and 28% respectively).

Respondents' views on drug use and on treatment in prison

Over half those using drugs (53%) during the last year and almost two-fifths of the total sample (38%) considered themselves to have a drug problem. Of these, 41 per cent stated that they would like to receive some form of treatment whilst in prison (but were not) and a further ten per cent were already receiving some kind of treatment in prison. This signifies a high level of potential interest in treatment on the part of prisoners, with clear relevance for policy.

Prisoners' drug use and crime before their imprisonment

Since the late 1980s or early 1990s, there has been a lot of debate about the links between drug use and crime. On the one hand, the need to tackle drug-related offending has become a key tenet of Government policy. This mission is probably accepted by many criminal justice practitioners (Gravett, 2000), and finds considerable if not universal support in the media. Academic researchers have perhaps been more divided, with at least some expressing their reservations. In a recent review, Tony Seddon has cautioned against any simplistic or mechanistic assessments of the relationship between drug use and crime (Seddon, 2000). Even non-recreational drug use comes in different shapes and forms, as he rightly observes: "Relationships are better described in terms of tendencies or probabilities rather than as determined or inevitable."

In reality, however, even those researchers criticised by Tony Seddon are themselves cautious – perhaps more so than he allows. Thus Trevor Bennett, the author of various NEW-ADAM publications largely devoted to exploring the connections between drug use and offending, has offered his own caveats (Bennett, 2000). Bennett concludes one discussion of drugs and crime by noting that, despite his own clear evidence that high-rate offenders tend to be regular consumers of drugs such as heroin, crack and cocaine, "it cannot be assumed from this that drug use causes offending or that offending causes drug use". Instead, he prefers to talk of "the likelihood that one of these variables causes the other". Another possibility, of course, is that the close links between drug use and offending ultimately reflect deeper, underlying factors, common to both (Seddon, 2000).

One of the important missing elements in much of the drugs-crime literature is the longitudinal dimension. It is insufficient to assess the relationship between drug use and offending simply on the basis of recent events, perhaps largely over the last year or just the last month. On the other hand, even knowing whether offenders' careers in deviancy began with drugs offences or non-drugs offences, as is discussed in various studies, may not advance our understanding all that far. It is the interaction, over time, of a wide range of personal choices and external

influences, that shapes people's lives. The Criminality Survey offers only some limited insights into the past lives of the respondents. One important aspect that is covered in the survey, and is discussed in the final section, is any imprisonment prior to the current sentence, as experienced by many but not all of the respondents. In this section, that particular factor is ignored. Now that various caveats have been mentioned, this should help to pave the way for some preliminary analysis of the links between drug use and offending.

Prisoners' own assessments of the links between drugs and crime

Respondents were asked whether they thought their drug use and crime were connected. Those that responded positively to this question were asked for further details on how they felt their offending and drug taking were linked. These questions were only asked of those stating that they had taken drugs in the twelve months before prison.

Over half of those who had taken drugs in the twelve months before prison (55%) stated that they had committed offences that were connected to their drug taking. The table below shows the more detailed reasons given (by those accepting the connection between taking drugs and crime).

Table 2.1 Responses to questions on ways in which drug taking and crime were connected

Links between drug use and crime	Percentage reporting each factor
Through the effect of drugs on your judgement	35
Through the need for money to buy drugs	82
Because drugs were one of the things you could buy with the money from crime	22
Through stealing drugs	4
Other connection	8

Notes: Source is Criminality Survey 2000. Respondents indicated all those factors that were relevant (hence column sums to more than 100%).

The need for money to buy drugs was most often cited as a link between drug use and crime. It was reported by 82 per cent of prisoners accepting a drugs-crime connection. The second most popular response was the effect of drugs on personal judgement, reported by just over a third of prisoners (35%).

Respondents who stated that there was a link between their offending and their drug use were also asked what proportion of their offences was linked to their drug taking. Roughly two-thirds (66%) stated that all their offending was linked to their drug taking whilst a further fifth (19%) said that most of their offences were connected to their drug taking.

These self-assessments are not by themselves conclusive evidence of the importance of the drugs-crime connection. Further work is underway to assess the interaction of patterns of drug use and offending. The main points highlighted here are still important ones. First, over half (55%) of those respondents who had used drugs pre-prison reported that they had committed offences connected to their drug taking. Secondly, 82 per cent of these respondents stated that 'the need for money to buy drugs' contributed to their drug-related offending. This was a higher proportion than those citing all other factors linking drug taking and crime, and lends further emphasis to the importance of the drug-crime association.

Contrasts in patterns of drug use between novice and serial prisoners

There was an important variation on the part of the Criminality Survey respondents, in their previous experience of imprisonment, which was in turn associated with differences in drug use. With the limited data available from the Criminality Survey, it is only feasible to probe indirectly, in this final section, into longitudinal issues. The potential importance of this perspective has been highlighted in other research (Seddon, 2000). Our starting point, as mentioned before, is the fact that one-third of respondents (34%) had not previously served a custodial sentence. The patterns of drug use of those that had been in prison previously and those that had not are compared below.

We need to start by considering how far we are comparing generally similar groups. Those who had not been in prison previously had a mean age of 27.8 and a range of 15 to 71 years. Those who had previously experienced a prison sentence had a mean age of 28.3 and a range of 15 to 63 years. These are broadly comparable. However, a greater proportion of those who had not had a prison sentence before were aged under 25 (46%, compared with 39% who had previous prison experience), which could help to account for some differences in the drug use of these two groups.

There were some clear contrasts between 'novice' and 'serial' prisoners, in terms of drug use. Of those that had never been in prison before, 43 per cent had not used any drugs in the last twelve months, whereas only 19 per cent of those that had been in prison before had not used any drugs in the last twelve months. Almost two-thirds (63%) of those that had been in prison before were using drugs at least daily compared with 36 per cent of those

that had not been in prison previously. Over half (56%) of those that had been in prison before used heroin, cocaine or crack at least once in the last twelve months compared with less than a third (30%) of those that had not been in prison before. Overall, drug use was less prevalent amongst those serving their first custodial sentence, with significantly lower levels of drug use reported for most drugs including heroin, crack and cocaine. Those serving their first custodial sentence also reported a significantly lower prevalence of cannabis. Just over half had used cannabis (53%) compared with 70 per cent of those incarcerated before. It is possible that prior experience of prison could have contributed to these differences in drug use between novice and serial prisoners. Research suggests that there is a small group of prisoners who widen their drug use repertoire in prison by turning to heroin (Edgar and O'Donnell, 1998; Singleton et al., 1999; Swann and James, 1998 and also Chapters 3 and 7 in this publication).

It is likely, on the basis of the drugs-crime literature, that prisoners who have developed heavy-end drug habits will also be relatively prolific offenders. However, further research will be needed to help tease out answers to the complex questions about how patterns of drug use and offending develop over time.

Conclusion

Knowledge of prisoners' drug use prior to prison is a possible benchmark against which effectiveness of the Prison Service drugs strategy can be monitored. It also gives an indication of the level of treatment provision required by prisoners. The data from the Criminality Survey has shown that almost three-quarters (73%) of respondents had used an illegal drug in the twelve months before prison, just under half (47%) had used heroin, crack or cocaine and 31 per cent had used heroin. Of those reporting consumption of heroin, almost all (95%) were using it at least monthly and 82 per cent were using at least daily. This is indicative of the scale of the drug problem faced by prisoners and consequently the Prison Service.

Crime reduction is a focus for the Prison Service drug strategy, and the importance of the link between drug use and offending has once again been highlighted here, at least in terms of prisoners' own perceptions. Of those who had used drugs in the previous year (and nearly three-quarters of all respondents had done so), over half reported that their drug use and offending were connected. Most often, they cited 'the need for money to buy drugs'. While such findings are in one sense worrying, they also raise the possibility that, by addressing problem drug use inside prisons and helping prisoners to lead a drug-free life

once discharged, this may lead to a reduction in offending. There is however a caveat: much of the offending associated with heroin-using offenders, particularly theft (including shoplifting) and handling stolen goods, is of a kind that is massively under-recorded. Any reductions in recorded crime are likely to be correspondingly more modest.

Finally, as discussed in subsequent chapters, much can be done to help change the lifestyles of those individuals with high levels of drug use and offending, by providing treatment, whether within the prisons or elsewhere under the auspices of the criminal justice system. It is possible to bring about reductions in these two forms of deviant behaviour, and recent efforts in this country to enhance drug treatment for prisoners are at least starting to make a difference.

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3. Changing levels of drug use before, during and after imprisonment

Tony Bullock

Introduction

A series of studies has shown that drug use in prison is now commonplace and that many inmates come into custody with severe drug use problems (Maden et al., 1991; Turnbull et al., 1994; Singleton et al., 1999). Drawing on the findings of the Prisoners Criminality Survey: Drugs Follow-up, this chapter assesses the impact of imprisonment on drug use, particularly through the following themes:

- Drug use before, during and after custody: the chapter tracks respondents' drug use as they move through custody and on release, and discusses how the extent and nature of drug use changes over these periods.
- Drug testing: respondents' experiences and perceptions of voluntary and mandatory drug testing are explored.
- Drug treatment: the chapter also assesses respondents' experiences of the different types of treatment provided by the Prison Service.
- Recidivism: the relationship between prisoners' post-release drug use and rates of re-conviction and reoffending is discussed.

The original Prisoners Criminality Survey (see Chapter 2) investigated sentenced male prisoners' pre-prison drug use and offending. Using two sub-samples of drug-using respondents identified from this survey, the Follow-up study tracked their drug use through a series of interview sweeps in custody and following release, in 2000 – 2001 (see the Methodology section following).

After outlining the study's methodology, the chapter begins by describing the high levels of problematic drug use in the year prior to custody among the sample. The next section shows how, while there is fairly widespread occasional use of some drugs in prison, levels of use inside are substantially lower than in the community. The study also found a marked tendency towards the use of depressants – particularly cannabis and heroin – in custody, and the reasons for this are discussed. This is followed by assessments of the respondents' experiences of drug treatment and testing, and the final two sections discuss post-release drug use and (re) offending.

Methodology

A group of drug-using male prisoners was identified from the 2000 Prisoners Criminality Survey (73% of respondents admitted to drug use in the year prior to their incarceration). These were divided into two samples, based on their sentence length, and two[1] sweeps of interviews were conducted:

Sample 1 (interviewed in prison)

Sample 1 consisted of 302 interviews with prisoners, most of whom had been in custody for between four and nine months. Respondents were asked about their drug use and experiences of treatment and testing during their current terms of imprisonment.

Sample 2 (interviewed in the community following release)

Sample 2 involved a separate sample of 227 ex-prisoners who were interviewed in the community following their release. This group consisted of shorter sentence prisoners (most had served four months or less), most (90%) of whom had been in the community for between four and eight months since release. Respondents were asked about drug use, treatment and testing during their last term of imprisonment and about drug use and reoffending since release.

All pre-prison data are taken from the original Prisoners Criminality Survey (Lewis and Mhlanga, 2001; see also Chapter 2), and refer to the twelve months before imprisonment when respondents were at liberty (i.e. excluding any previous periods in custody).

Both the Prisoners Criminality Survey and the Follow-up study were conducted by the market research company BMRB International. Fieldwork for the first sweep (Sample 1) of the follow-up took place during July and August 2000 and involved face-to-face interviews in 33 prisons geographically spread across England. Fieldwork for the second sweep (Sample 2) of the study took place during November 2000 and January 2001 and again involved face-to-face interviews with ex-prisoners throughout the country.

It is important to note a number of methodological caveats. Firstly, only sentenced male prisoners took part (sex offenders were also excluded), and only prisoners admitting in the Prisoners Criminality Survey to drug use in the year before custody were eligible for the study. Furthermore, the combined samples contain a disproportionately high number

1 A third sweep, Sample 3, was also conducted but is not reported here.

of short-sentence prisoners. The combination of these factors means that the sample is not representative of the wider prison population. Secondly, the results come from different sweeps of interviews and the variations in the methodologies (see above) could impact on the results. Lastly, the study addresses the periods before, during and after custody. These periods of time vary and so any conclusions based on comparisons between them need to be made with caution. These caveats are reiterated where necessary throughout the report.

Also, while not wishing to underplay the harm caused by alcohol and its relationship to drug use, this issue is not considered by this report, primarily because very few respondents (4% of the combined samples) had drank alcohol while in prison.

Sample profile

A large proportion of the combined samples display many of the characteristics usually associated with offenders: deprived backgrounds with considerable criminal histories.

Over half (60%) the respondents were unemployed immediately prior to custody. A similar proportion (54%) left school before the age of 16, and nearly a third (32%) had been taken into local authority care as a child. Respondents had been imprisoned for a wide range of offences, the most common of which was 'burglary' (40%), followed by 'theft and handling' (14%). Almost half (48%) of the respondents were sentenced to a year or less, while just eleven per cent had been sentenced to over three years. However, nearly three-quarters (72%) had been in prison before, most of whom (69%) had previously been in custody three times or more.

White inmates are slightly over-represented, in relation to the overall sentenced male prison population, as are younger prisoners: 89 per cent were white and seven per cent black; while 29 per cent of the sample were 20 years old or under, 47 per cent were between 21 and 30, while a further 24 per cent were aged over 30. The disproportionate number of young prisoners reflects the high proportion of short-sentence inmates in the combined samples (there are disproportionately more young offenders among short-sentence prisoners in the wider prison population). Also, young respondents in the Prisoners Criminality Survey were more likely than older prisoners to state that they had used drugs.

Drug use before prison

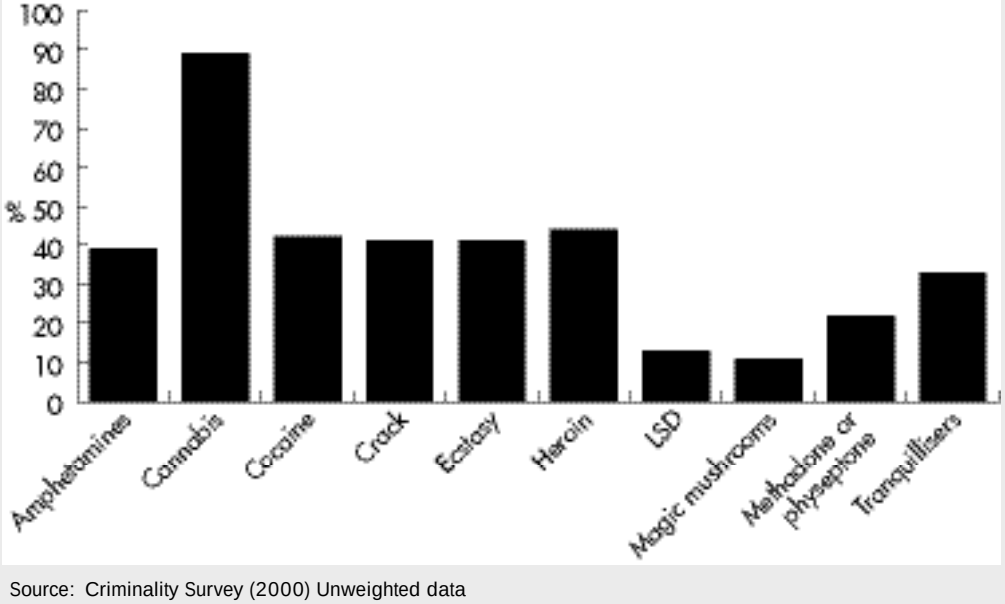
The following two sections are concerned with the levels and types of drug use in the periods before and during custody (post-release use is discussed after the treatment and testing sections). The severity of respondents' drug use before custody is assessed and this is then used as a baseline against which subsequent patterns of use are measured.

Pre-prison drug use among sentenced male prisoners is discussed in greater detail in Chapter 2. However, this section is included to illustrate the high levels of pre-custodial drug use among the Follow-up group and, later, to contrast this with in-prison use. All data refer to Samples 1 and 2 combined, and were collected shortly after sentencing as part of the original Prisoners Criminality Survey. It is essential to reiterate that the samples are not representative of the wider prison population – see the caveats in the Methodology section.

Prevalence rates before custody

Figure 3.1 illustrates the prevalence rates (irrespective of frequency or quantity) for the ten main substances studied.

Figure 3.1 Prevalance of drug use in the twelve months prior to custody (Samples 1 and 2)



Source: Criminality Survey (2000) Unweighted data

Cannabis was the drug used by the largest proportion (89%) of respondents in the twelve months prior to custody, followed by heroin (44%). Around 40 per cent of the sample had used each of the other main Class A drugs – cocaine, crack and ecstasy – and amphetamines.

The study also found considerable poly-drug use. Most Class A drug users used cannabis as well. There were also high levels of use of more than one Class A drug. For example, a large majority of those using heroin during this period had also used crack (72%), and around half had taken methadone (51%) or cocaine (49%).

Frequency of use before custody

The frequency with which drugs were taken is also striking. Respondents were asked to characterise the level of their drug use by stating how often they had used drugs during this twelve month period. However, it is highly likely that drug use will fluctuate over a twelve month period, and so the results should be viewed as simply a broad indication of respondents' level of use.

Almost three-quarters (74%) of the sample were using a drug on a daily or near-daily basis in the twelve months before their imprisonment (this figure falls to 51% when cannabis is excluded). Table 3.1 below illustrates how often the users of the ten main drugs studied were taking the drug.

Prevalence rates for each of the main Class A drugs – cocaine, crack, ecstasy and heroin – were all relatively comparable (between 39% and 44%, see Figure 3.1). However, the different frequencies with which these substances were used provide a clearer indication of the drug-using characteristics of the sample. Over four in five (82%) heroin users were taking the drug on a daily or near-daily basis, compared with just four per cent of ecstasy users. Equivalent figures for cocaine (12%) and even crack (39%) were also considerably lower than that for heroin. Thus suggesting that, in addition to cannabis, heroin was the main drug of choice for a considerable number of respondents.

Table 3.1 Frequency of drug use in the twelve months prior to custody (Samples 1 and 2 combined)

	Percentages of users of the specified drugs			
	Daily or near-daily	At least weekly but not daily or near-daily	At least monthly but less than weekly	Less than monthly
Amphetamines (n=203)	20	30	23	28
Cannabis (n=467)	59	28	7	6
Cocaine (n=218)	12	45	21	21
Crack (n=211)	39	32	19	10
Ecstasy (n=218)	4	48	28	21
Heroin (n=232)	82	11	2	5
LSD (n=65)	2	11	23	65
Magic mushrooms (n=57)	0	5	14	81
Methadone or physeptone (n=116)	31	29	18	22
Tranquillisers (n=170)	31	35	15	18

Source: Prisoners Criminality Survey (2000) Unweighted data.

Injecting before custody

Nearly a third (32%) of the combined samples had injected a drug in the twelve months pre-prison: the majority of these (82%) had injected heroin, while 32 per cent had injected amphetamines and 23 per cent crack.

Severity of drug use before custody

The prevalence and frequency data suggest widespread and heavy drug use. However, while respondents were not tested for dependence, they have been grouped into three categories, based on the frequency of their use:

1. 'Non-problematic users': respondents fell into this group if they were using cannabis on a less than daily or near-daily basis, or any other drug weekly or less.

2. 'Problematic users': respondents using cannabis on a daily or near-daily basis or any other drug two or three times per week.

3. 'Acutely problematic users': respondents using cannabis more than once a day or any other drug four times per week or more.

Using these classifications, two-thirds (65%) of the respondents were acutely problematic users in the year prior to custody, 18 per cent problematic users and a further 18 per cent non-problematic users.

Drug use in prison

All in-prison data come from Samples 1 and 2 of the Follow-up study. Much of this section compares drug use in prison with pre-prison use (where the data were taken from the original Prisoners Criminality Survey). However, the periods of time respondents spent in custody (both on remand and after sentence) are generally shorter than the twelve month pre-prison period covered by the Prisoners Criminality Survey. Respondents' time in custody varied from under a month to over a year and a half – although most (70%) had spent between one and seven months inside. Therefore, any comparisons between the two periods need to be made with caution.

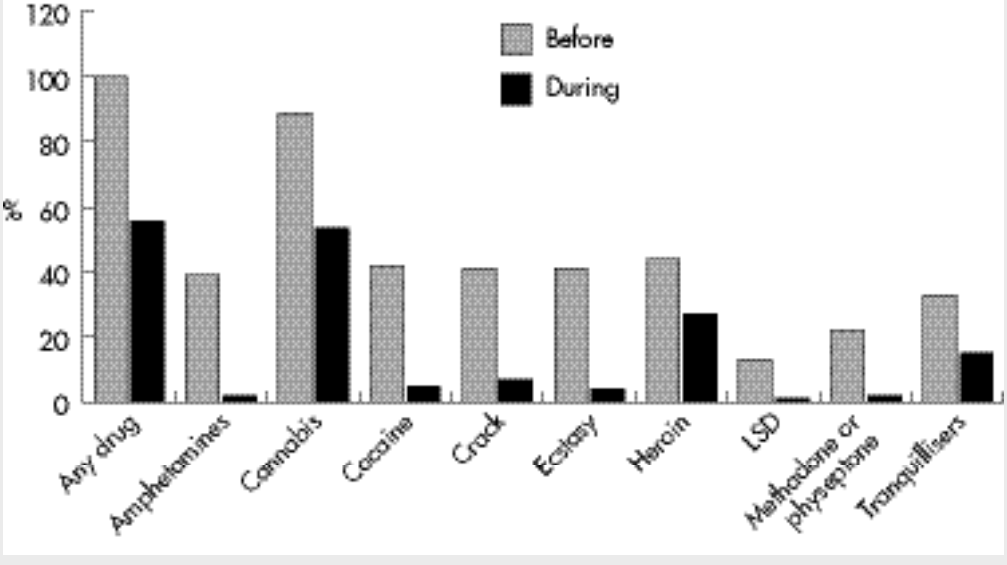
Despite this qualification, the prevalence, frequency and other results combine to present a persuasive argument that the level of drug use in prison is substantially lower than in the community and that depressants, particularly cannabis and heroin, are preferred in prison to stimulants such as amphetamines and cocaine.

Prevalence rates in prison

Figure 3.2 (overleaf) displays both the pre- and in-prison prevalence rates for the ten main drugs studied. A little over half the sample (56%) had used at least one illicit substance while in custody.

Cannabis is the drug used by the largest proportion (54%) of prisoners; there are twice as many users of cannabis than of the second most popular drug, heroin (27%). Next most popular is the illicit use (i.e. not prescribed) of tranquillisers (15%). Despite their widespread usage outside prison, other drugs appear to only have a limited following in prison: just seven per cent of respondents had used crack; five per cent cocaine; four per cent ecstasy and two per cent amphetamines.

Figure 3.2 Prevalance of drug use before and during custody (Samples 1 and 2)



Source: Criminality Survey (2000); Criminality Survey: Drugs Follow-up Samples 1 (2000) and 2 (2000-01) All unweighted data. Methodological Note: Pre- and in-prison time periods differ, see Methodology section.

Frequency of use in prison

Frequency of use, as shown in Table 3.2, tended to drop even more steeply than prevalence rates.

Table 3.2 Frequency of use before and during custody (Samples 1 and 2)

	Percentages of users of the specified drugs			
	Pre-prison		In prison	
	Daily or near-daily	At least weekly but less than daily or near-daily	Daily or near-daily	At least weekly but less than daily or near-daily
Cannabis	59	28	14	30
Cocaine	12	45	4	16
Crack	39	32	3	11
Heroin	82	11	3	36

Source: Prisoners Criminality Survey (2000); Prisoners Criminality Survey: Drugs Follow-up Samples 1 (2000) and 2 (2000-01). All unweighted data. Methodological Note: pre- and in-prison time periods differ, see the Methodology section.

Over half (59%) of cannabis users were using the drug on a daily or near-daily basis prior to their imprisonment, compared with just 14 per cent in prison. An even more dramatic decline can been seen in the daily or near-daily use of heroin: from 82 per cent pre-prison to three per cent in prison[2].

Intravenous drug use in prison

Similarly, intravenous drug use is substantially lower in prison compared with pre-prison rates. Just five prisoners (2% of those using drugs in prison, compared with the 35% pre-prison rate) said that they had injected in prison (four had injected heroin and one amphetamines – two stated that they had shared needles). This level of IV use is similar to that found by Singleton et al. (1999) and several other studies (see Hough, 1996 for an overview of the literature concerning prisoners' injecting behaviour). However, Swann and James (1998) suggest that there remains a stigma attached to intravenous use in prison. If this is so, this stigmatisation could lead respondents to under-report their injecting behaviour.

Factors impacting on the levels of drug use in prison

The comparatively lower levels of reported use in custody are supported by respondents' own assessments of their in-prison use. They were asked how their drug use differed in prison compared with in the community, and the overriding difference concerned their levels of use: most (81%) said that their use had decreased, whereas very few (6%) reported an increase in use since coming to prison. The main reason provided for the reduced levels of use was the relative lack of availability in prison (mentioned by 61% of those reporting reduced use), followed by attempts to stay off drugs (14%) and not being able to afford drugs (13%). Just six per cent of those reporting reduced use said that this was due to concerns about punishment.

The finding that drug use in custody is mainly curtailed by a lack of availability reflects the findings of the Shewan et al. (1994) study in Scottish prisons. They point to the security measures in Scottish prisons which, they argue, are successful in reducing the supply and consequently the use of drugs.

Prisoners' efforts to reduce their consumption were the second most frequently cited reason for using less drugs in prison than in the community. Swann and James (1998) suggest that the very act of imprisonment may encourage inmates to address their use. The authors

2 The proportions of prisoners using cocaine and crack on a daily basis may be somewhat misleading due to the relatively small numbers of users (irrespective of frequency) of these drugs in prison, 19 and 33 people respectively.

describe a process of 'spontaneous remission' whereby users are able to modify their behaviour without the assistance of formal treatment. They suggest that one of the factors that can initiate this process of self-change is the hitting of a personal 'bottom' such as the death of a relative or even the impact of imprisonment.

Severity of drug use in prison

The reduced levels of drug taking described above are reflected in the classifications of use outlined in Table 3.3 below. The changing levels of drug use in prison compared with community rates can be characterised by a shift from problematic use to non-problematic use and abstinence (see the Severity of drug use before custody section for definitions of the different classifications of use). While all respondents admitted to drug use in the twelve months prior to custody (during the original Prisoners Criminality Survey), 44 per cent stated that they had abstained from use in custody. And while three-quarters (65%) of the combined samples could be described as acutely problematic users in the year prior to custody, just six per cent of respondents displayed this level of use in prison.

Table 3.3 Classification of respondents' drug use before and during custody (Samples 1 and 2 combined)

	Percentages	
	Pre-prison	In-prison
Abstainers	0	44
Non-problematic users	18	38
Problematic users	18	12
Acutely problematic users	65	6
Total	101 *	100

* Percentages may not always sum to 100 due to rounding

Source: Prisoners Criminality Survey (2000); Prisoners Criminality Survey: Drugs Follow-up Samples 1 (2000) and 2 (2000-01). All unweighted data. Methodological Note: Pre- and in-prison time periods differ, see the Methodology section.

Types of drugs used in prison

The different types of drugs used before and during custody are instructive. Cannabis is the most widely taken substance during both periods. However, while the pre-prison results show fairly comparable prevalence rates for heroin, cocaine, crack and amphetamines (between 39% and 44%), of these, only heroin was used by a substantial proportion (27%)

of respondents in prison. Crack was used in prison by just seven per cent of respondents, cocaine five per cent, ecstasy four per cent and amphetamines two per cent.

The types of drugs prevalent in prison (heroin, cannabis and to a lesser degree tranquillisers) and those with much lower levels of use (crack, cocaine, ecstasy and amphetamines) clearly fall into two distinct groups – stimulants and depressants – based on their physiological and psychological effects. And while other factors (price and availability, for example) will inevitably impact on the level of use, this observation suggests an apparent tendency towards the use of depressants in prison (see also Dillon, 2001; Hassan, 1996; Pitt, 1997; Shewan and Gemmell, 1994; Singleton et al., 1999; Swann and James, 1998; Turnbull et al., 1994).

Reasons for the use of drugs in prison and the tendency towards the use of depressants

The finding that depressants are preferred in prison is consistent with respondents' own stated reasons for their drug use. Table 3.4 shows the most frequently cited reasons for the use of cannabis, heroin and tranquillisers.

Table 3.4 Reasons for use of the three main drugs of choice in prison (Samples 1 and 2)

	Percentage of users of the specified drug		
	Cannabis	Heroin	Tranquillisers
Relaxation	54	28	38
To relieve boredom	43	40	27
Calming effects	27	19	19
Easily available	19	26	22
Enjoyment	29	19	17
To block out current situation	22	28	18
Depression	12	12	4
Less chance of detection	2	10	1

Source: Prisoners Criminality Survey: Drugs Follow-up Samples 1 (2000) and 2 (2000-01). All unweighted data.

'Relaxation' and the 'relief of boredom' are the two most frequently cited reasons for the use of each of the three substances. 'Enjoyment' is also frequently cited, particularly by cannabis users, as is the need to 'block out their situation', particularly by heroin users.

The fact that the 'relief of boredom' and the ability to 'block out the current situation' are often cited as reasons for the use of drugs in prison is in line with other studies. Swann and James (1998) cite 'boredom' and the 'need to escape from the reality of the prison experience' as factors encouraging use, while Dillon (2001) suggests that heroin offers prisoners a 'day out' from prison life, and Hassan states:

> "Heroin is the greatest painkiller known to humanity and it is the ideal drug to mask the harsh realities of prison life." (1996, p.35)

The levels of heroin use (which are high in relation to the other Class A drugs) in prison are of particular concern. One reason for the popularity of heroin is likely to be the high levels of its use before prison (see the previous section). Excluding cannabis, heroin appears to be the main drug of choice for many of the respondents when in the community. This in turn could foster a considerable demand for the drug in prison. A high level of demand is also likely to encourage, if not generate, a supply of heroin (Hunt and Chambers, 1976) and could lead prisoners with a peripheral interest in the drug (i.e. those using it on an occasional basis in the community) to use it in custody in the absence of their usual drug of choice. As Swann and James (1998) note, many prisoners appear to be poly-drug users, willing to take whatever drugs are available.

Swann and James (ibid.) also suggest that heroin use has become a 'cultural' aspect of prison life. They argue that it is important for drug users to be part of a group in prison, both for protection and to ensure a more consistent supply (see also Dillon). Using the same drug as one's peers facilitates entry into a group and encourages trust. Similarly, Rogers (2000), an ex-prisoner, suggests that some vulnerable prisoners engage in heroin use 'to be part of a group, to feel safe and protected' (p.34). Furthermore, he states that, around 1994, heroin became more popular and increasingly acceptable, when previously it had been frowned upon by inmates.

The prison environment is clearly less conducive to the use of some drugs than others. The heightened mental awareness associated with stimulants such as amphetamines, cocaine, and ecstasy, is likely to be exacerbated by the physical confinement of imprisonment and this is liable to result in increased paranoia, anxiety and related mental stresses (Pitt, 1997). Similarly, Keene (1997) notes that prisoners attach a degree of importance to the 'calming effects' of certain drugs – particularly cannabis and tranquillisers – as they lead to better behaviour, a better atmosphere and improved psychological health. The potential for stimulants to induce insomnia is also likely to deter their use.

Drug treatment in prison

This section briefly outlines Prison Service treatment programmes and respondents' experience of them. However, it is important to note that very few respondents had received therapeutic interventions and even fewer had completed their treatment. This is at least partly because the study was conducted at a time when services were in their early stages of development and also because of the high proportion of short-sentence prisoners among the sample (many intensive programmes are only suitable for prisoners serving at least six months). Consequently the scope for analysis was extremely limited, and the results described below simply address prisoners' overall assessment of their treatment. It is also worth noting that the fieldwork was conducted at a time (2000-01) when treatment interventions were in their early stages of development, and that there has been considerable expansion of, and increased investment in, the services since then.

The Prison Service has developed a treatment service framework to meet the needs of prisoners with drug problems of all degrees. The framework stems from the 1998 drug strategy, Tackling Drugs in Prison (HM Prison Service, 1998), which replaced a system of somewhat piecemeal, locally based, interventions. The main components of the new service are detoxification, CARATs (Counselling, Assessment, Referral, Advice and Throughcare) and intensive treatment programmes.

Detoxification

Clinical detoxification programmes are available to facilitate the withdrawal from opiate, alcohol and benzodiazepine use. Treatment for prisoners withdrawing from other drugs, such as crack cocaine, is directed at the individuals' specific withdrawal symptoms rather than through detoxification.

Nearly a quarter (23%) of those surveyed had entered a detoxification programme, with 97 per cent completing the treatment. However, only half (49%) of those using opiates, alcohol or tranquillisers on a daily or near-daily basis prior to prison were detoxified. A large majority (85%) of those receiving detox were being treated primarily for heroin withdrawal, although many of these had problems with numerous substances.

The type of medication used to detoxify prisoners varies between establishments and many prisoners stated that they had been given more than one drug. The length of time prisoners spent on detox also varied: nearly a third (31%) spent between three and four days in treatment, slightly more (34%) spent five days to a week and a further quarter (26%) spent

between one and two weeks. Nearly two thirds (61%) of Sample 2 respondents (i.e. short-sentence prisoners) receiving detox felt that the duration of their treatment was too short (Sample 1 were not asked this question).

Prisoners' assessments of their treatment also varied: 20 per cent thought their programme was 'very beneficial', 30 per cent thought theirs was 'fairly beneficial', 25 per cent 'not very beneficial' while 24 per cent thought theirs was 'not at all beneficial'. Generally, the longer the programme lasted, the more likely participants were to find it beneficial.

Most (81%) respondents completing a detoxification programme felt that it could be improved. The main issues were: length (it needs to last longer); medication (wrong type or amount) and therapy (the need for more complementary therapeutic measures such as counselling and group work).

CARAT (Counselling, Assessment, Referral, Advice and Throughcare) service

The CARAT service is a multi-agency approach to tackling prisoners' drug problems. CARAT workers conduct assessments, develop care plans and make referrals to appropriate interventions in prison. They can also provide up to eight weeks post-release support as a safety net when it proves difficult to link prisoners with community service providers.

Nearly a third (31%) of all respondents had received a CARAT assessment. However, this figure represents just over a third (36%) of respondents with problematic or acutely problematic levels of use before prison. Most of Sample 1 respondents given an assessment (Sample 2 were not asked this specific question) agreed with the resultant care plan: overall nearly nine in ten (87%) either agreed with it or had no strong opinion.

Therapeutic interventions

CARAT teams treat prisoners with low-level drug problems using one-to-one counselling, group work or relapse prevention. Other complementary therapies, such as acupuncture, are also available, as is information concerning the impact of drug use. Prisoners with moderate to severe problems are eligible for intensive treatment programmes, either therapeutic communities or services that employ the 12-step or cognitive-behavioural approaches. There are currently around 50 programmes. Most employ cognitive-behavioural treatment while there are around eight 12-step and six therapeutic communities.

One-to-one counselling was the most common form of intervention received by the sample. Eighty-seven respondents received this (see Table 5 below), and nearly two thirds (64%) of those who had completed it found it beneficial (38% of those completing treatment thought it could have been improved).

Table 3.5 Types of treatment received in prison and recipients' assessments of the service (Samples 1 and 2 combined)

	Number starting treatment	Number completing treatment	Very beneficial (%)	Fairly beneficial (%)	Not very beneficial (%)	Not at all beneficial (%)
1-to-1	87	52	27	37	25	10
Group work	38	25	20	60	12	8
Rehabilitation programme	36	25	36	16	24	24

Source: Prisoners Criminality Survey (2000); Prisoners Criminality Survey: Drugs Follow-up Samples 1 (2000) and 2 (2000-01). All unweighted data

Just 38 respondents received group therapy, and of these 25 had completed the course of treatment at the time of interview. Again most (80%) of those who had completed the treatment felt that it was beneficial. However, just over a third (36%) of this group thought that this treatment could be improved.

Slightly less respondents (n=36) had entered an intensive treatment programme, although it is not possible to break this figure down into the three forms of therapy as many participants were unsure of the precise nature of the treatment they had received. Just over a half (52%) of those who had completed their programme felt that it was beneficial.

Drug testing in prison

The Prison Service has implemented schemes of voluntary and mandatory drug testing, and while the aim of both procedures is to deter drug use, this is achieved in quite distinct ways.

Voluntary testing

Prisoners submitting to voluntary testing are required to make a written commitment, or 'compact', to remain drug-free. Those testing positive under this scheme are subject to administrative sanctions, such as loss of certain privileges, and, where necessary, they may also be referred to treatment. Voluntary testing is now available in 93 per cent of prisons and programmes often involve Voluntary Testing Units (VTUs). These are discrete units, normally with restricted access to other inmates, which aim to provide a supportive environment for prisoners wishing to remain drug-free.

Prisoners' experiences of VTUs

At the time of interview 40 per cent of Sample 1 were housed on a VTU, and a further eight per cent had been on one previously; nearly a quarter (23%) of Sample 2 had been on a VTU at some time during their previous sentence. However, it is worth noting that some respondents mentioned that they had no choice whether or not to stay on a VTU. The frequency of testing on units appears to vary considerably. Around a quarter (27%) of prisoners who could recall how often they were tested reported a weekly or more than weekly rate; 30 per cent stated a rate of every two or three weeks, while 44 per cent stated a rate of monthly or less.

Over two-thirds (70%) of those who had been on VTU found it beneficial: 39 per cent finding it 'very beneficial'; 31 per cent 'fairly beneficial'; while 15 per cent felt that it was 'not very beneficial' and 16 per cent said that it was 'not at all beneficial'. Just over half (54%) felt that 'their' VTU could be improved. The most frequently cited suggestions for improvements were: more frequent testing; more advice and counselling; greater isolation from the rest of the prison and more positive incentives.

Mandatory Drug Testing

Mandatory Drug Testing (MDT) was introduced in 1995 and is designed to deter drug use by punishing prisoners found to be using drugs. MDT figures are also used to assess trends in prisoners' drug use, and the procedure is also a means of identifying prisoners in need of treatment or support. Each establishment is required to test ten per cent of prisoners (or 5% depending on the level of the prison population), chosen at random, on a monthly basis. Inmates may also be tested if there is a reasonable suspicion that they are using drugs. Penalties for testing positive include the imposition of 'additional days', 'closed visits' or 'loss of privileges'.

Experiences of MDT

A little over half (56%) of all respondents had been selected for a mandatory test (again the disproportionate number of short-sentence prisoners among the combined samples is likely to affect this result – figures include both random and on suspicion tests). This figure represents three-quarters (75%) of respondents admitting to using drugs in prison. The majority of these men had been selected once (48%) or twice (22%), while a small number had been selected five times or more (12%).

Most (73%) of those who had been selected for a mandatory test had never tested positive, while a fifth (19%) had tested positive once and just seven per cent had tested positive more than once. Four in ten (40%) respondents who had used drugs in prison and had been tested had tested positive. Positive tests among Sample 1 (Sample 2 were not asked this specific question) were most frequently made for the use of cannabis.

Just five men (3% of those selected for testing), again solely from Sample 1, had refused to provide a sample for a test but 23 (12% of those selected for a test) admitted to having attempted to subvert a test. The main methods for subverting tests were by diluting the drugs in their bodies by drinking lots of water, or by using someone else's urine.

The impact of MDT

Sample 2 respondents (i.e. short-sentence prisoners) were asked whether the threat of random testing influenced their drug use. And around a third (32%) of this sample stated that the threat of punishment from MDT did deter them from using drugs. The main reasons provided by those respondents who said that MDT did not deter them from using drugs centred on their lack of concern about the potential punishments. This lack of concern ranged from a general dismissiveness – 'I don't care about the punishments' – to more subtle reactions, such as feeling that the temptation to use drugs when readily available was simply too great, while some felt that it was simply 'worth the risk'. Other respondents suggested that they were undeterred because there are ways around the tests, or that there are no 'real' punishments.

'Switching'

A common accusation (Gore et al., 1996) levelled against the MDT scheme is that it encourages prisoners to use 'hard' rather than 'soft' drugs. Cannabis is detectable by urine tests for between around ten and 28 days, depending on the level of use, whereas opiates are only detectable for up to around five days. This disparity, critics suggest, leads prisoners

to reduce their use of cannabis whilst maintaining or increasing their use of hard drugs in order to continue their habits and reduce the likelihood of detection.

Respondents were specifically asked about this issue and a small proportion (eight respondents or 3% of those using drugs in prison) stated that they had changed to harder drugs in order to avoid detection.

However, it has also been suggested that accusations of 'switching' are based on anecdotal evidence. The possibility that 'switching' is more myth than reality was explored by asking whether MDT had forced prisoners to use hard drugs, and nearly two thirds (65%) of all respondents agreed with this proposition (50% agreed strongly and 15% agreed slightly). Nearly all (98%) of those in agreement said that MDT encouraged people to use heroin.

Post-release drug use

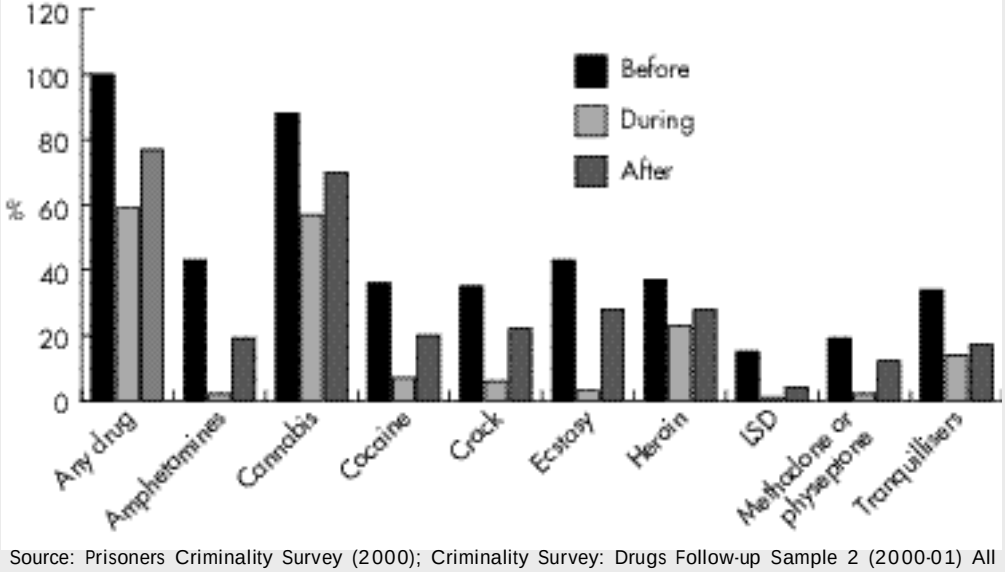
This section discusses the levels and types of drug used by Sample 2 following their release. The tables display comparable data for the pre and in-prison periods to show the significance of and provide the context for the post-release drug use. However, any comparisons between these stages need to take into account the different time periods involved. The majority (90%) of Sample 2 had been in the community for between four and eight months, which is generally longer than they had been in prison: 73 per cent had been in custody for less than four months. Both these periods are considerably lower than the twelve month pre-prison period, and so comparisons between these three stages need to be made with caution.

The findings do, however, suggest that post-release use, while greater than levels in prison, is not generally as high as respondents' pre-prison usage.

Prevalence of use post-release

Figure 3.3, below, represents the prevalence rates of drug use before, during and after custody for Sample 2.

Figure 3.3 Prevalence of drug use before, during and after custody (Sample 2 only)



Source: Prisoners Criminality Survey (2000); Criminality Survey: Drugs Follow-up Sample 2 (2000-01) All unweighted data. Methodological Note: the pre-, in-prison and post-release time periods differ, see the Methodology section.

During the post-release period, cannabis is the drug with the most widespread use: 70 per cent of Sample 2 had used cannabis since their release, compared with 28 per cent using heroin and ecstasy, 22 per cent using crack, 20 per cent cocaine and 19 per cent amphetamines.

The prevalence of use is greater for all drugs post-release compared with in-prison rates. However, the extent of this change varies between the individual drugs. The respondents appear to be reverting to drugs used before prison: there is a relatively small increase in the use of heroin (probably because of the relatively widespread use inside) while the increase in use of the other Class A drugs is considerably greater. The prevalence rate for heroin increases by just five percentage points, from the in-prison level of 23 per cent to 28 per cent post-release, while the percentage point increases for stimulants are considerably greater: a 25-point increase for ecstasy; 17 for amphetamines; 16 for crack and 13 for cocaine.

Frequency of use post-release

Table 3.6, below, illustrates the frequency of use before, during and after custody for four of the main drugs used (Sample 2 only). Considering the generally infrequent use in prison, it is perhaps to be expected that in each case the rate of daily or near-daily use is greater in the post-release period compared with the in-prison rates.

Table 3.6 Frequency of use before, during and after custody (Sample 2 only)

	Percentages of users of the specified drugs					
	Pre-prison		In prison		Post-release	
	Daily or near-daily	At least weekly to less than daily or near-daily	Daily or near-daily	At least weekly to less than daily or near-daily	Daily or near-daily	At least weekly to less than daily or near-daily
Cannabis	57	31	20	38	42	39
Cocaine	10	48	0	20	4	20
Crack	38	26	0	14	10	27
Heroin	77	11	4	54	51	27

Source: Prisoners Criminality Survey (2000); Prisoners Criminality Survey: Drugs Follow-up Sample 2 (2000-01) All unweighted data. Methodological Note: The pre-, in-prison and post-release time periods differ, see Methodology section.

The daily or near-daily use of heroin increases from four per cent of in-prison users to 51 per cent of the post-release users, while the daily or near-daily use of cannabis doubles from 20 per cent to 40 per cent of users. The increases in consumption following release are reflected in the severity classifications of respondents' use.

Severity of post-release drug use

While just eight per cent of Sample 2 could be regarded as acutely problematic users in custody, this figure rises to 29 per cent following release (see Table 3.7, and the Severity of drug use before custody section for definitions of the different classifications of use).

The three time periods in question are different and this will inevitably impact on the results. However, given the size of the increase in use following release, it appears fair to assume that drug use among short-sentence inmates does increase in the short-term in the post-release period; but not to pre-prison rates.

Table 3.7 Classification of respondents' drug use before, during and after custody (Sample 2)

	Percentages		
	Pre-prison	In prison	Post-release
Abstainers	0	41	23
Non-problematic users	22	33	24
Problematic users	21	18	24
Acute users	57	8	29
Total	100	100	100

Source: Prisoners Criminality Survey (2000); Prisoners Criminality Survey: Drugs Follow-up Sample 2 (2000-01) All unweighted data. Methodological Note: The pre-, in-prison and post-release time periods differ, see Methodology section.

Drug use and (re) offending

The relationship between drug use and offending is explored in greater detail in Chapter 2. However, the findings of this study show a definite relationship between post-release drug use and (re) offending.

Over half (57%) of the combined samples felt that at least some of their offending in the twelve months prior to coming to custody was related to their drug use. Moreover, two-thirds (66%) of this sub-group stated that all of their offending during this period was drug-related and a further 19 per cent said most of their offences were. The need for money to buy drugs was the most frequently cited factor (81% of the sub-group) relating drug use to offending, while 40 per cent stated that the effect of drugs on their judgement was also a factor.

The results concerning post-release reoffending pertain to Sample 2 (i.e. short-sentence prisoners) only. They had been in the community following release for between four and nine months and all results stem from their reported behaviour and are not validated by any official sources. However, the results, as shown in Table 3.8, do suggest a clear relationship between post-release drug use and recidivism.

Both reconviction and reoffending rates were lower for those respondents abstaining from drugs since release than for those using drugs. The rate of self-reported reconviction (9%) among the abstainers was less than half of that (20%) of the drug-users, although this difference does not reach statistical significance. Moreover, while a little over a third (36%)

of the abstainers admitted to reoffending since release, almost two-thirds (62%) of the drug users stated that they had reoffended, and this difference is significant.

Table 3.8 Post-release drug use and self-reported recidivism / reoffending (Sample 2 only)

	Percentages	
	Reoffended	Reconvicted
All of Sample 2 (n=227)	56	17
Abstainers (n=53)	36	9
Drug-users (n=174)	62	20
Non-problematic users (n=54)	52	22
Problematic users (n=54)	63	15
Acutely problematic users (n=66)	70	21

Source: Prisoners Criminality Survey: Drugs Follow-up Sample 2 (2000-01) All unweighted data.
Methodological Note: the pre-, in-prison and post-release time periods differ, see Methodology section.

Furthermore, the rate of reoffending is also related to the rate of post-release drug use. Half (52%) of the non-problematic users admitted to reoffending post-release, compared with 63 per cent of problematic users and 70 per cent of acute users (although not displayed in the table, this figure rises to 86 per cent for those respondents using Class A drugs on a daily or near-daily basis).

Conclusion

The aim of this study was to assess how imprisonment impacts on drug use; specifically, how respondents' use changes as they come into, move through and out of prison, and which factors, including treatment and testing, influence their use. And, while bearing in mind the caveats cited throughout the chapter, the results suggest a number of significant findings:

- Respondents' drug use, and intravenous use in particular, is considerably lower in prison than in the community, partly reflecting lower levels of availability in custody;
- There is an apparent tendency towards the use of depressants rather than stimulants in custody;

- Only a minority of short-sentence respondents stated that MDT deterred them from using drugs in custody;
- Again, only a minority of respondents with treatment needs had received either a CARATs assessment or detoxification, at the time of the study (2000-01, when these services were in their early stages of development); and
- Post-release reoffending is significantly related to post-release drug use.

While many respondents were poly-drug users before coming into custody, the study shows an apparent tendency towards the use of depressants in prison. This is likely to stem from, among other things, the high number of hardcore cannabis and heroin users coming into custody, and because the effects of depressants are clearly more suited to the prison environment than stimulants.

The results of this, and numerous other studies (Maden et al., 1991, Turnbull et al. 1994, Singleton et al., 1999; Dillon, 2001, Farrell et al., 2000, Joyce, 1996, Shewan and Gemmell, 1994, Swann and James, 1998), confirm that a high proportion of people entering prison do so with severe drug problems. However, while occasional use is widespread inside, frequency rates are relatively low and few prisoners maintain problematic levels of use. Given the caveats associated with the study, it is difficult to assess the significance of the post-release levels of use. These are lower among short-sentence prisoners than pre-prison levels in the short-term (although it is impossible to assess whether this is true of the longer-term).

The main reason for the relatively low level of use in prison appears to be the lack of availability. Some respondents also reported a conscious desire to reduce their drug use, which may, in part, be due to a process of 'spontaneous remission' caused by the shock of imprisonment (Swann and James, 1998).

Only a minority of respondents stated that MDT was an effective deterrent against the use of drugs. Very few of those respondents whose drug use in custody was lower than in the community said that this reduction was because of concerns about punishment, and only a third of Sample 2 (227 short-sentence prisoners) said that MDT deterred them from using drugs. The study found little evidence of 'switching' from soft to hard drugs because of MDT – this topic is to be covered in greater depth by another study specifically exploring the impact of MDT. And while the number of inmates housed on Voluntary Testing Units is encouraging, the significance of this is tempered by the suggestion that some inmates may be housed on such units without the necessary desire to remain drug-free.

It is difficult to assess the effectiveness of treatment services as very few respondents had completed treatment, and because the study was conducted at a time when these interventions were in their early stages of development. However, the finding that many respondents displaying problematic use did not receive CARATs assessments or clinical detoxification is of concern, even if this may be somewhat outdated given the developments in treatment services since the study period. Likewise, the finding that detoxification services are commonly perceived to be too short is also of concern and is consistent with a forthcoming study covering the female estate (Borrill et al., forthcoming).

In conclusion, imprisonment does appear to reduce drug use while inmates are in custody, and post-release rates of use among short-sentence prisoners seem to be lower than pre-prison levels. The study has also shown that while there is still room for improvement, the Prison Service has made progress in terms of treatment and testing since the introduction of the 1998 drugs strategy. A thorough assessment of these interventions went beyond the remit of this study. However, Chapters 4 and 5 show that treatment can lead to a reduction in post-release drug use and reoffending. Furthermore, the need to effectively address inmates' drug use is reinforced by the finding that reoffending is significantly related to levels of post-release drug use.

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4. Substance misuse among white and black/mixed race female prisoners

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Introduction

Following on from the discussions in the last two chapters of male prisoners' drug use, this chapter addresses substance misuse among female prisoners and highlights a number of factors associated with this use.

Female inmates represent an increasingly large proportion of the overall prison population. Between 1991 and 2001 the average female population rose by 140 per cent from nearly 1,600 to more than 3,700 (during the same period, the male population rose by 41 per cent from just over 44,000 to 62,500). And, while drug users often share similar characteristics, such as employment problems and poor mental health, the literature concerning drug-using female prisoners suggests that they have a number of needs that are quite distinct from those of their male counterparts (see Chapter 3).

Consequently, to help ensure that their drugs interventions meet the needs of all inmates, the Prison Service commissioned a study, 'The Differential Substance Misuse Treatment Needs of Women, Ethnic Minorities and Young Offenders in Prison' (Borrill et al., 2003a). The research comprised three inter-related studies: one, just mentioned, involved in-depth assessments of prisoners from the three groups with substance misuse problems, while a second elicited the opinions of practitioners concerned with drug treatment in prison: see Home Office Development and Practice Report 8, Borrill et el., 2003b The third component, which is reported here, was a survey of 301 white and black/mixed race women. Its aims were to:

- obtain an estimate of the prevalence and nature of substance misuse among female prisoners, both before and during their imprisonment;
- examine associations between substance misuse and a range of social, psychological and psychiatric factors which may be of particular relevance to women offenders;
- assess the different patterns of, and factors associated with, use among white and black/mixed race women; and
- enable comparisons with studies of drug use by male prisoners.

After a brief summary of the study's methodology, the chapter outlines the respondents' pre-prison drug use; several distinct ethnic differences in the respondents' patterns of drug use are highlighted, and comparisons are drawn with male prisoners and with a 1997 study of female prisoners' drug use. The following section describes patterns women's drug use in prison. The third section looks at a range of factors – such as education, experiences of violence and mental health – and their association with substance use. Although the precise nature of the relationship between such factors and substance use is beyond the remit of the study, a number of tentative observations are made. The chapter ends with a short discussion of the findings.

Methodology and sample composition

The sample of women was drawn from both remand and sentenced populations, in proportion to their relative numbers, from ten female establishments in England. In order to fully investigate substance misuse in the black/mixed race female population, a stratified sampling method was used, with the aim of interviewing sufficient numbers of black and mixed race women to enable meaningful comparisons to be made with the white population (see Table 4.1).

Table 4.1 Ethnic and sentence status composition of the sample

	Remand	Sentenced	Total
White	31	159	190
Black/mixed race	34	77	111
Total	65	236	301

Foreign national women were excluded from the study, as were women of Asian, Chinese or other ethnic backgrounds as their numbers would be too small for meaningful comparisons. (The study only addresses white and black/mixed race British women and is not representative of the female prison population as a whole.) Within these parameters the women were selected randomly from Home Office statistical records and/or local prison databases.

At the time of interview, which was in 2001, a little over half (54%) of the sample had been in custody for six months or less, 18 per cent had been inside for over six months to a year, while 28 per cent had been in prison for over a year.

A structured interview was used which incorporated items from a variety of standardised measures of substance misuse and health status, including: the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993); the Severity of Dependence Scale (SDS) (Gossop et al., 1995); the Hospital Anxiety & Depression Scale (HADS) (Zigmond and Snaith, 1983); and elements of the Mini International Neuropsychiatric Interview (MINI) (Sheehan et al., 1998). Further information concerning sentence length and offence type was collected from prison records.

Substance use

The underlying aim of the 'Differential Needs' study was to assess the substance misuse treatment needs of the three groups in question, namely women, young offenders and inmates from ethnic minority groups. However, while baseline levels and patterns of substance misuse by male prisoners – which necessarily inform any assessment of treatment needs – had been explored in other recent studies (see Chapters 2 and 3), there had been no comprehensive study of female prisoners' drug-taking behaviour since a study conducted by the Office for National Statistics (ONS) in 1997 (Singleton et al., 1999).

This section redresses that situation. Firstly, pre-prison drug and alcohol use is discussed: drug use and, moreover, dependence was widespread among the sample. Comparisons are made between the two ethnic groups, as are comparisons with equivalent data for male prisoners and with relevant results from the 1997 ONS study. Secondly, the sample's use of illicit drugs while in custody is described. This was significantly lower than pre-prison rates and there appears to be a concentration on the use of depressants rather than stimulants in custody. Comparisons are again drawn with in-prison use by male and by female prisoners in 1997.

Illicit drug use in the twelve months prior to custody

Prevalence rates

The proportion of women reporting drug use in the twelve months prior to prison was significantly higher among white women (77%) than black/mixed race women (63%).

Table 4.2 Prevalence of illicit drug use in the year prior to custody, by ethnicity

	White (n=190)	Black/mixed race (n=111)
Any drug	147 (77%)	70 (63%) *
Amphetamines	48 (25%)	6 (5%) ***
Cannabis	108 (57%)	61 (55%)
Cocaine	53 (28%)	15 (13%) **
Crack	91 (48%)	40 (36%) *
Ecstasy	41 (22%)	15 (13%)
Heroin	112 (59%)	21 (19%) ***
LSD	9 (5%)	0 (0%)
Methadone•	56 (30%)	9 (8%) ***
Other opiates•	45 (24%)	9 (8%) ***
Solvents	7 (4%)	0 (0%)
Tranquillisers	81 (43%)	16 (14%) ***

• Numbers for methadone and other opiates include those prescribed
* Indicates that the difference between prevalence rates among the two ethnic groups in the year prior to custody was statistically significant at p<.05;
** difference p<.01;
*** difference p<.001 (chi square tests were used to assess statistical significance throughout the paper)

Prevalence rates for each of the drugs illustrated in Table 4.2 were greater for white than black/mixed race women (although these differences were not significant for the use of cannabis, ecstasy, LSD and solvents).

Drug dependence

In addition to the widespread use of various drugs, the severity of many respondents' drug use was high: half (49%) of the women were dependent on at least one drug (using the score of seven or more on the SDS scale as the cut-off point for dependence). There was a significant ethnic difference in the rates of dependence: 60 per cent of white women were dependent, compared with 29 per cent of black/mixed race women. However, there was no overall difference in dependence rates for remand and sentenced prisoners.

Heroin dependence was most common (33%), while nearly a quarter (23%) of the women were dependent on crack, and five per cent on tranquillisers. There were marked ethnic differences in dependence on heroin, with 47 per cent of white women dependent on it compared with only ten per cent of black/mixed race women. However, rates of crack dependence were similar for white women (25%) and black/mixed race women (21%).

Demand for treatment was extremely high among drug-dependent respondents: 87 per cent said that in the twelve months prior to their incarceration they would have liked some form of help with their drug problems. During the same time period, a quarter (26%) of drug-dependent women had received maintenance medication, 20 per cent had received counselling, 15 per cent reduction detoxification and 17 per cent needle exchange.

Injecting drugs

Nearly a third (31%) of the respondents said they had injected drugs at some time. A significantly greater proportion of white women (45%) had injected drugs compared with black/mixed race women (9%) – which is probably a reflection of the higher levels of heroin use among the white women. Of those women who reported injecting outside prison, 90 per cent were injecting heroin.

Alcohol misuse

A third (34%) of the sample reported harmful or hazardous levels of alcohol consumption (i.e. they scored eight or more on the AUDIT questionnaire) in the year prior to their imprisonment. While white women had slightly higher rates of harmful drinking (37%) than black/mixed race women (29%), there was no significant association between ethnicity and drinking status, or between drinking status and sentence status. Women reported drinking primarily to cope with negative emotions, stress and painful memories, and crack users in particular referred to using alcohol as a sedative – to balance the stimulant effects of the drug.

Forty-nine women (16%) were assessed as both harmful drinkers and dependent on at least one drug (see Table 4.4). Nearly one in five (18%) of white women were dependent on drugs and also had harmful levels of drinking, compared with 13 per cent of black/mixed race women. It is also worth noting that 55 per cent of black/mixed race women were not dependent on either drugs or alcohol, compared with 21 per cent of white women.

Table 4.4 Association between drug dependency (SDS score =>7 any drug) and harmful alcohol use (AUDIT 8+) during the twelve months before prison by ethnicity

	Harmful drinking	
	No	Yes
All		
Not drug-dependent	101 (34%)	53 (18%)
Drug-dependent	98 (33%)	49 (16%)
White		
Not drug-dependent	40 (21%)	35 (18%)
Drug-dependent	80 (42%)	35 (18%)
Black / mixed		
Not drug-dependent	61 (55%)	18 (16%)
Drug-dependent	18 (16%)	14 (13%)

Comparisons with other studies[1]

One of aims of the survey was to enable comparisons with other similar studies. This section again looks at drug use in the year prior to custody and compares female prisoners' prevalence rates with the results of a survey of male and female use conducted in 1997.

Gender differences in prisoners' drug use in the year prior to custody[2]

The Criminality Survey (Lewis and Mhlanga 2001, see also Chapter 2) explored the prevalence of drug use in the year prior to custody by sentenced male prisoners. Table 4.5 below compares the results of this survey with those for sentenced women from the current study.

1 First note of caution: unlike the Criminality Study or the Psychiatric Morbidity survey, the Differential Needs study included a 'mixed race' category in its ethnic classification question. Therefore, the ethnic composition of the 'black/mixed race' group, as used in the Differential Needs study, may differ slightly from the 'black' group used by the other two surveys.

2 Second note of caution: while the two studies are comparable, it is essential to be aware of the different sampling techniques used during the Differential Needs study and the Criminality Survey. The Differential Needs study selected sentenced white and black/mixed race respondents at random (in proportion to their relative numbers in terms of their remand or sentenced status), while the Criminality Survey over-sampled certain prisoners and then weighted the data to represent the actual sentenced male prison population.

Table 4.5 Prevalence of male and female drug use in the twelve months prior to prison by ethnicity

	Differential Needs study – females (2001 – sentenced only)		Criminality Survey – males (2000 – sentenced only)	
	White (n=159)	Black/mixed race (n=77)	White (n=1614)	Black (n=162)
Any drug	120 (76%)	48 (62%)	1198 (74%)	103 (64%)
Amphetamines	40 (25%)	4 (5%)	461 (29%)	8 (5%)
Cannabis	92 (58%)	42 (55%)	1053 (65%)	100 (62%)
Cocaine	43 (27%)	10 (13%)	543 (34%)	24 (15%)
Crack	73 (46%)	26 (34%)	506 (31%) ***	48 (30%)
Ecstasy	34 (21%)	11 (14%)	521 (32%) **	26 (16%)
Heroin	88 (55%)	16 (21%)	539 (33%) ***	24 (15%)
Tranquillisers	68 (43%)	14 (18%)	417 (26%) ***	13 (8%)*

* difference between gender groups (eg white males compared with white females), p<.05;
** difference, p<.01;
*** difference, p<.001.

Patterns of drug use in the twelve months prior to custody were broadly similar for black (or mixed race) sentenced men and women (as reported in the Criminality Survey and Differential Needs study, respectively). Among black (or mixed race) respondents, cannabis was the drug used by the largest proportions of both sexes, while crack was the 'hard' drug most widely used by both black (or mixed race) men and women. The prevalence of 'any drug', cannabis, cocaine and ecstasy was higher among the black (or mixed race) men than for black (or mixed race) women (although none of these differences were statistically significant), while the prevalence of crack, heroin and tranquillisers was higher among black (or mixed race) women (only the difference in the rates of tranquilliser use was statistically significant).

Although similar proportions of white men and women (74% and 76%, respectively) had used at least one illicit drug in the twelve months prior to custody, there appear to be distinct gender differences in the use of individual substances. Cannabis was again the drug most widely used by both sexes of white respondents. However, while the prevalence rates for amphetamines, cocaine, crack, ecstasy and heroin were broadly similar among the white men (from between 29% and 34%), there were noticeable differences in the rates of use of these drugs by the white women. The prevalence of heroin and crack was higher than for the other Class A drugs among the white women. Moreover, the prevalence of these two drugs –

as well as tranquillisers – was significantly higher among white women than white men, whereas there was more widespread use of each of the other drugs among the white men (although only the difference in the rates of ecstasy use was statistically significant). This appears to suggest that pre-prison recreational use of drugs is more common among white men, while the use of the two drugs most often associated with problematic use – heroin and crack – is more widespread among white women.

Female prisoners' drug use in the year prior to custody in 1997 and 2001[3]

The Psychiatric Morbidity Survey (Singleton et al., 1999) conducted by the Office for National Statistics (ONS) in 1997 produced a comprehensive study of prisoners' drug use. Table 4.6 displays prevalence rates (broken down by ethnicity) for female prisoners in the year prior to custody, taken from the ONS study, and compares these with the equivalent results taken from the current study.

Table 4.6 Prevalence of female drug use in the twelve months prior to prison in 1997 and 2001 by ethnicity

	Differential Needs Study (2001)		ONS[4] (1997)	
	White (n=190)	Black/mixed race (n=111)	White (n=575)	Black (n=124)
Any drug	147 (77%)	70 (63%)	357 (62%) ***	54 (44%)**
Amphetamines	48 (25%)	6 (5%)	128 (22%)	2 (2%)
Cannabis	108 (57%)	61 (55%)	267 (46%) *	44 (35%)**
Cocaine	53 (28%)	15 (13%)	93 (16%) ***	3 (2%)**
Crack	91 (48%)	40 (36%)	138 (24%) ***	22 (18%)**
Heroin	112 (59%)	21 (19%)	206 (36%) ***	10 (8%)*

* difference between the two studies (eg white women in 2001 compared with white women in 1997), p<.05;
** difference, p<.01;
*** difference, p<.001

3 Note of caution: again, the Differential Needs and ONS studies are comparable, but it essential to note the different sampling techniques used. The Differential Needs study used a stratified sampling method: respondents were drawn from both remand and sentenced populations, in proportion to their relative numbers. Whereas, the ONS study over-sampled remand prisoners and then weighted the data to represent the composition of the wider prison population.

4 The data from the ONS survey illustrated in Tables 4.6 and 4.8 exclude foreign national prisoners and therefore differs slightly from results of the same survey published elsewhere.

Comparisons between the two studies show some statistically significant differences between rates of drug use in the year prior to custody by both white and black (or mixed race) prisoners. These differences provide evidence of a possible increase in the prevalence of drug use between 1997 and 2001. More than three quarters (77%) of white inmates in the 2001 study had used at least one illicit substance during this period, compared with 62 per cent of white prisoners in 1997, while the equivalent rates for black (or mixed race) prisoners were 63 per cent and 43 per cent, respectively (both increases are statistically significant). Furthermore, rates of use of each of the individual drugs studied were higher in 2001 than 1997 and these differences were significant for both white and black (or mixed race) prisoners for each substance except amphetamines.

Drug and alcohol use in prison

Prevalence rates

Just eight women (3%) reported drinking alcohol in prison. However, there was considerably wider use of other substances. Nearly half (45%) of the sample had used an illicit drug while in custody, while the main drugs women reported using were heroin (27%), cannabis (21%) and tranquillisers (17%) (Table 4.7).

A significantly greater proportion (54%) of white prisoners had used an illegal substance in custody compared with black/mixed race respondents (31%). Similarly, prevalence rates were higher among white prisoners for each individual drug except crack, the prevalence of which was the same for both groups. However, the only statistically significant differences were for heroin and other opiates – which is likely to be, at least in part, due to the higher levels of heroin use among white respondents prior to their imprisonment.

The more widespread use of depressants compared with stimulants in prison partly reflects the patterns of use of these drugs in the twelve months prior to custody. However, while the prevalence of crack use by the overall sample was roughly equal to heroin use in the year prior to prison, the proportion of the sample using crack in custody was significantly less than the population using heroin. This disproportionate use of depressants in custody mirrors the patterns of use among male prisoners (see Chapter 3) and the findings of several other studies (Singleton et al., 1999 and Dillon, 2001, for example). The prevalence rates for each of the drugs illustrated in Table 4.7 are significantly lower in prison than in the year prior to custody (except for LSD, where the difference was not significant). This is again consistent with the findings of other studies of female prisoners (Singleton et al., 1999) and use by male prisoners (see Chapter 3).

Table 4.7 Prevalence of illicit substance use in prison by ethnicity and compared with the twelve months prior to custody

	In prison			Year prior to prison
	White	Black/mixed race	All[5]	All
Any drug	102 (54%)	34 (31%) ***	136 (45%)	217 (72%) •••
Amphetamines	3 (2%)	1 (1%)	4 (1%)	54 (18%) •••
Cannabis	44 (23%)	20 (18%)	64 (21%)	169 (56%) •••
Cocaine	5 (3%)	1 (1%)	6 (2%)	68 (23%) •••
Crack	16 (9%)	10 (9%)	26 (9%)	131 (43%) •••
Ecstasy	4 (2%)	0 (0%)	4 (1%)	56 (19%) •••
Heroin	67 (35%)	15 (14%) ***	82 (27%)	133 (44%) •••
LSD	1 (1%)	1 (1%)	2 (1%)	9 (3%)
Methadone	20 (11%)	4 (4%)	24 (8%)	65 (22%) •••
Other opiates	31 (16%)	4 (4%) **	35 (12%)	54 (18%) •
Tranquillisers	36 (19%)	14 (13%)	50 (17%)	97 (32%) •••

* difference in prevalence rates between the ethnic groups (i.e. white women compared with black/mixed race women in prison) p<.05;
** difference p<.01;
*** difference p<.001
• difference in prevalence rates between the period in custody and the twelve months before, for the whole sample p<.0.5,
•• difference p<.01;
••• difference p<.001

Comparisons between rates of drug use in custody and in the year prior are complicated by the different time periods in question; the length of time respondents had spent in custody at the time of interview varied greatly, from just a few days to several years. Most (72%) of the sample had been in custody for a year or less (n=218). Among this group, the prevalence of 'any drug', cannabis and heroin was significantly (p<.001, in each case) lower in prison compared with the twelve months before. However, comparisons between prevalence rates in and before custody for respondents who had been in prison for over a year (n=81) suggest a slightly different outcome. While rates of use in custody were lower than in the twelve months before for 'any drug', heroin and cannabis, only the reduction in cannabis use was highly significant (p<.001); the reduction in 'any drug' use was less significant (p<.05) and the reduction in heroin use was not significant (although some of this reduced statistical power may be due to the smaller sample size of prisoners in custody for over a year). Furthermore, among respondents who had been in custody for a year or more, 74

5 Black/mixed race prisoners were over-sampled. Therefore, the overall sample was not representative of the wider female prison population – these figures are included to illustrate the different rates of use in the periods before and in custody.

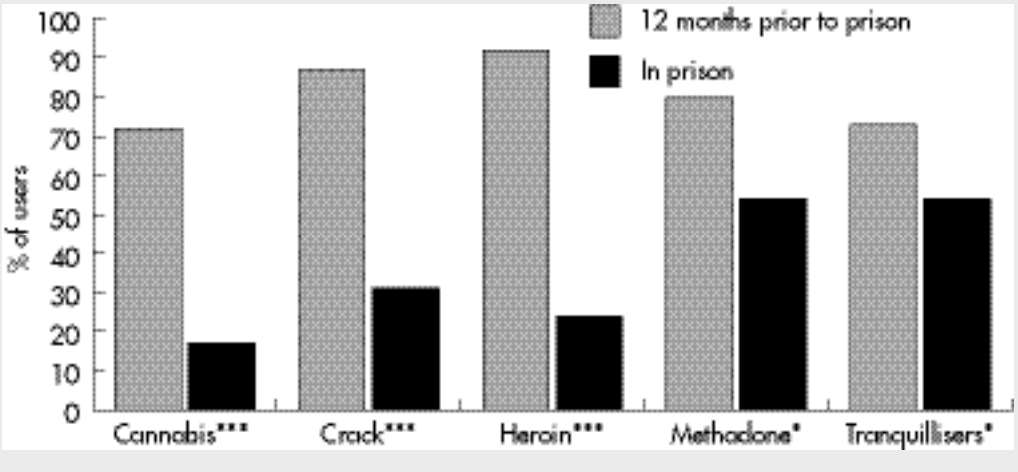
per cent of this group who had used drugs in the year before their imprisonment also used drugs in custody. The equivalent rate among those who had been in custody for less than a year was 59 per cent (the difference between the two rates was not statistically significant).

The combination of these findings therefore suggests a number of broad conclusions. Firstly, the prevalence of drug use among the sample was lower in prison than in the year before irrespective of time spent in custody. However, the reductions in prevalence rates were more pronounced among prisoners who had served less than a year, and prevalence rates were higher among prisoners who had served a year or more. Therefore, conclusions drawn from comparisons between drug use in custody and in the year before – as illustrated in Table 4.7 – need to be made with caution, as the length of time spent in custody appears to impact of the prevalence of drug use in prison.

Frequency of drug use

The frequency with which women reported using drugs in prison is also considerably lower than in the pre-prison period. Figure 1 below illustrates the percentages of users of five drugs who reported taking them on a weekly or more frequent basis during both the twelve months prior to custody and in prison. The weekly or more frequent rate of use is significantly lower in prison than in the twelve months before for each of the five drugs.

Figure 4.1 The use of drugs on a weekly or more frequent basis in the 12 months prior to custody and in prison by drug type



* difference between weekly use in prison and the twelve months before p<.05;
*** difference p<.001

Almost three-quarters (72%) of those respondents using cannabis in the year before their imprisonment were using the drug at least once a week, compared with 17 per cent of cannabis-users in prison (this difference was highly significant, p<.001). Similarly, the proportion of users of each of the substances illustrated in Figure 4.1 who were taking the drug on a weekly or more frequent basis is significantly lower in custody than in the previous twelve months.

However, as when looking at prevalence rates, comparisons between frequencies of use before and in prison are complicated by the different time periods in question (most, 72%, respondents had been in custody for a year or less). Despite this note of caution, separate analyses for prisoners who had been in custody for less than a year and those who had been inside for a year or more reveal that the rates of weekly or more frequent use of 'any drug', cannabis and heroin were significantly (p<.001, in each case) lower in custody than in the year before for both groups.

Comparisons between the prevalence of female prisoners' drug use in custody in 1997 and 2001

This section again compares the findings of the current study with the results of the ONS Psychiatric Morbidity Survey (Singleton et al., 1999). Table 4.8 below compares prevalence rates in custody for both white and black (or mixed race) prisoners in 1997 and 2001.

Table 4.8 Prevalence of female drug use in prison in 1997 and 2001 by ethnicity

	Differential Needs Study (2001)		ONS (1997)	
	White (n=190)	Black/mixed race (n=111)	White (n=574)	Black (n=123)
Any drug	102 (54%)	34 (31%)	208 (36%) ***	24 (20%)
Amphetamines	3 (2%)	1 (1%)	19 (3%)	0 (0%)
Cannabis	44 (23%)	20 (18%)	179 (31%) *	24 (20%)
Cocaine	5 (3%)	1 (1%)	9 (2%)	0 (0%)
Crack	16 (9%)	10 (9%)	46 (8%)	2 (2%)*
Heroin	67 (35%)	15 (14%)	136 (24%) **	5 (4%)*

* difference between the two studies (eg white women in 2001 compared with white women in 1997), p<.05;
** difference, p<.01;
*** difference, p<.001

Higher proportions of both white and black (or mixed race) prisoners had used at least one illicit substance in prison in 2001 than in 1997: 36 per cent of white inmates had used drugs in the 1997 survey, compared with 54 per cent in the 2001 study – a statistically significant difference. Similarly, the prevalence rate among black (or mixed race) prisoners rose from 20 per cent in 1997 to 34 per cent in 2001, although this difference is not statistically significant. The rate of cannabis use among black (or mixed race) prisoners is roughly the same in 1997 and 2001, but among white women there is a significant fall from 31 per cent of respondents using the drug in 1997 to 23 per cent in 2001. In contrast to the use of cannabis, the prevalence of heroin increased significantly from 24 per cent to 35 per cent of white prisoners and four per cent to 14 per cent of black (or mixed race) prisoners. The use of crack is also significantly more common among black (or mixed race) prisoners in 2001 than in 1997, rising from two per cent to nine per cent.

Mandatory Drug Testing (MDT) was introduced by the Prison Service in 1995 and was designed to deter drug use by punishing prisoners found to be using illicit substances (establishments are required to test a proportion of prisoners, chosen at random, on a monthly basis). Critics of the scheme suggest that this encourages the use of hard drugs as they are detectable by urine tests for shorter periods of time than cannabis (see Gore et al., 1996, and Chapter 3). The fall in the prevalence of cannabis and the rise in the use of heroin among white women is consistent with these suggestions. However, the impact of MDT was not specifically explored by this study and so it is not possible to attribute these changes in drug use to the scheme (other factors, such as changes over time in community-based drug use, may also impact on levels of prison-based use). Having said this, these changes are clearly an area of concern irrespective of the precise reasons why they have occurred.

Demographic and social and psychological factors associated with substance misuse

One of the primary aims of the study was to investigate a number of factors that may be associated with substance use. Several key topics were identified from the previous literature (see Chapter 5) including: education; employment; relationships with family and friends; children; physical health; mental health and illness; self harm and attempted suicide. Each topic was studied using a variety of standardised instruments (see the methodology section); associations with ethnicity, drug use and dependence were tested, and the key findings are summarised here.

Education

Two-thirds (64%) of the women interviewed had left school with no educational qualifications at all, while 30 per cent had achieved one or more passes at GCSE/CSE/O level. Significantly more drug-dependent women left school without qualifications (76%), compared with non-dependent women (52%). Similarly, there was a significant association between drug use in the twelve months before prison and women who had been assessed as having special educational needs: 19 per cent of women who used drugs had been assessed as having special educational needs, compared with five per cent of non-drug users.

Families, children and relationships

Half of the white women who were living with a partner prior to their imprisonment said their partner had a drugs problem, compared with less than a quarter of the black/mixed race women. Moreover, a quarter of the white women with partners said their partner had alcohol problems, compared with nine per cent of the black/mixed race women. Similarly, 29 women (10%) said that most or all of their family/friends had a problem with alcohol, with similar rates for white women (11%) and black/mixed race women (8%). Fifty-nine women (20%) said that most or all of their family/friends had a problem with drugs, with higher rates for white women (22%) than for black/mixed race women (9%).

A large majority (70%) of the respondents had children. Of the women who reported having children currently under the age of 16 (n=179) only 62 per cent (n=110) lived with their children at home prior to their imprisonment, while 13 per cent (n=24) reported having children 'in care'. Drug-dependent mothers were less likely than non-dependent mothers to anticipate that they would live with children when released from prison, were more likely to have a child living with other family members before prison and more likely to anticipate that their children would live with other family members once they were released.

Experiences of violence

Over half (54%) of the women stated that family members or friends had been violent towards them, with higher rates for white women (62%) than for black/mixed race women (41%). A quarter of women (26%) said that their partner/spouse had been violent towards them, with higher rates for white women (34%) than black/mixed race women (12%). Of those women who had experienced violence, almost half (48%) thought that it was related to drug or alcohol use at the time.

Although black women overall reported lower rates of family violence, black women with drug dependence had the highest proportion of women reporting violence. There was a significant association between drug dependence and categories of family violence for black/mixed race women.

Employment

There was a significant association between drug use, drug dependence and employment status: 73 per cent of women who had used any drug in the twelve months before prison were unemployed immediately before coming into prison, as were 78 per cent of drug-dependent women. In comparison, 50 per cent of non-drug users and 56 per cent of non-dependent women were unemployed before coming to prison.

Mental health

Previous contacts with mental health services outside prison

One hundred and seventy-seven women (59%) said that they had visited their GP or another health professional at some time for emotional or mental health problems, although black/mixed race women were significantly less likely to have done so than white women (47% compared with 66%). The rates of GP attendance for mental health problems were not significantly higher for women with drug dependence (64%) or harmful drinking (62%) than for non-dependent women (54%) or non-harmful drinkers (57%). The majority of those who had visited their GP for a mental health problem said it was for depression (82%).

Anxiety and depression in prison

Current levels of anxiety and depression in prison were measured using the HADS scale. Thirty-nine per cent of women reported moderate or severe levels of anxiety in the past week, compared with 19 per cent experiencing moderate or severe levels of depression. Anxiety levels appear higher for drug-dependent women and those with harmful levels of drinking, although these differences were not statistically significant. There were also no significant differences in mean scores for depression between drug users and non drug-users, or between harmful and non-harmful drinkers.

Self-harm and suicide

Half (51%) of the sample reported at least one act of self-harm at some time in their lives, most often through taking an overdose or cutting themselves. There was a significant association between harmful drinking and lifetime self-harm. Around half (47%) of the sample also said that they had made a suicide attempt in their lifetime. A significantly higher proportion (52%) of white women had made a suicide attempt in their lifetime compared with black/mixed race women (38%). However, there was no significant association between drug dependence and lifetime suicide attempts in either black or white women. And current suicide risk was not significantly associated with drug dependence or ethnicity.

An association between family violence and self-harm was found for both white and black/mixed race women. Family violence was associated with drug dependence for black/mixed race women but not for white women, and drug dependence was associated with self-harm for black/mixed women but not for white women. Further analysis provided tentative support for the association between ethnicity, dependence and self-harm, but the possibility that drug dependence may be an important risk factor for self-harm in black/mixed race women requires further investigation.

Stressful life events

Most of the women (71%) said that they had been physically assaulted in their lifetime and two in five (42%) said they had witnessed someone else being assaulted. A similar proportion (43%) said they had been sexually assaulted and a quarter (24%) said that they had had other unwanted sexual experiences. White women were slightly more likely to have experienced physical assault than black women (76% compared with 62%), but there was no association between ethnicity and other stressful events.

These experiences were also examined in terms of drug and alcohol use. There were significant associations between experiencing or witnessing a physical assault and all three of the substance misuse variables (reported drug use before prison, dependence on one or more drug during this time, and harmful use of alcohol pre-prison). Other unwanted sexual experiences (excluding sexual assault) were associated with both drug dependence and harmful use of alcohol during the twelve months before coming to prison. Causing serious harm or death to someone else was significantly associated with harmful drinking.

Psychotic experiences

Nearly a quarter of the sample (22%) reported that they had experienced one or more psychotic symptoms in their lifetime and 57 per cent of these women said that they had been using drugs or alcohol at the time. There was an association between reported psychotic symptoms and with both reported drug use in the twelve months before prison and drug dependence. However, no significant relationship was found between the presence of psychotic symptoms and ethnicity, or between psychotic symptoms and the harmful use of alcohol.

Manic episodes

Women were also asked about experiences of feeling high, or unusually full of energy. Nearly a quarter (23%) of the sample reported experiences of feeling high, or being unusually full of energy. A greater proportion of drug users (32%) and, in particular, drug-dependent women (37%) reported an episode of this kind, and the association between drug use and dependence and manic experiences was highly significant. However, no association was observed between harmful drinking and reported manic experiences.

Physical health

Altogether nearly two-thirds (61%) of the women rated their health as good or as very good to excellent. Women who were drug-dependent or reported harmful drinking did not perceive their physical health as any worse than women without a history of drugs or alcohol misuse (although it is worth bearing in mind that interviews were conducted in custody where respondents' levels of substance misuse were considerably lower and the lifestyles more stable). There were also no differences between ethnic groups in subjective perception of physical health.

Overall, nine per cent of women had contracted hepatitis at some time, though rates were higher amongst women who injected drugs (23%). Epilepsy and diabetes were more commonly reported by women who injected drugs.

Summary and conclusions

The findings of a series of studies (Turnbull et al., 1994; Singleton et al., 1999; Chapters 2 and 3) have illustrated the extent of substance misuse problems experienced by people coming into prison. And the results of this survey not only confirm the high levels of these problems among female prisoners – 66 per cent of the sample were either drug-dependent

or reported harmful/hazardous levels of drinking in the year prior to custody – but also suggest that 'hard' drug use – heroin and crack – is actually more common among white women compared with white men coming into prison. Furthermore, drug use among women coming into custody appears to be increasingly widespread: between 1997 and 2001 the pre-prison prevalence rates for both crack and heroin significantly increased among both black and white women.

The study also found distinct ethnic differences among women prisoners in the year prior to custody. Dependence rates were significantly higher among white (60%) than black/mixed race women (29%). While heroin was the drug on which white respondents were most often dependent, the drug on which black/mixed race women were most often dependent was crack.

Women's drug use in prison mirrors that of male inmates: the prevalence and frequency of use rates are significantly lower than in the year prior to custody and there is more use of depressants rather than stimulants in prison (see Chapter 3 for a discussion of these issues). Comparisons between the prevalence of drug use in custody in 1997 and 2001 highlighted a number of interesting changes. The overall prevalence of drug use among white women increased significantly. And, while the rate of cannabis use by white women fell during this period, the prevalence of heroin increased for white and black (or mixed race) women, as did the rate of crack use among black (or mixed race) respondents.

The findings suggesting that there have been changes over time in the extent and nature of female prisoners' drug use clearly raise questions concerning why this has occurred – particularly in the light of criticisms (Gore et al., 1996) suggesting MDT may encourage the use of hard drugs. However, a further study has been commissioned specifically to assess the impact of MDT on prisoners' drug use and is to be published shortly, also by the Home Office (Singleton et al., forthcoming).

Assessing the associations between substance use and social and psychiatric problems is less straightforward. The reasons why people use drugs and why some people become dependent on them are clearly complex and beyond the remit of this study. Having said that, the results of the study do suggest a number of interesting findings.

Educational attainment was significantly lower among drug-dependent women, while women who used drugs in the year prior to custody were significantly more likely to have been assessed as having special educational needs. However, there was no association between drug dependency or harmful drinking and rates of GP attendance for mental health

problems (although these were high for all groups). And while anxiety levels in custody appear higher for drug-dependent women and those with harmful levels of drinking, these differences were not statistically significant, nor were there significant differences in average depression scores between drug users and non drug-users, or between harmful and non-harmful drinkers. Anxiety and depression were presented by many women as a response to the experience of imprisonment but the high levels of symptomatology prior to imprisonment suggest that this explanation is an oversimplification.

Psychotic experiences were more common amongst women who were dependent on drugs, and manic experiences were also associated with dependence on heroin or crack cocaine. However, causality is complex. Both cannabis and stimulants have been clearly shown to cause psychosis like symptoms (Mathers and Ghodse, 1992; McLellan et al., 1979) and may be one factor that triggers psychosis amongst those with a pre-disposition (Murray and Fearon, 1999). More controversially it has been argued that drug use may be a 'self-medicating' response to the positive symptoms of psychosis (Khantzian, 1985). Although it is now generally argued that most drug use consequent upon psychotic experiences tends to be a response to negative symptoms or related social deficits (Mueser et al., 1998; Phillips and Johnson, 2001) this may still have the effect of undermining a woman's ability to manage or control her drug-taking.

Women reported drinking primarily to cope with negative emotions, stress and painful memories, and crack users in particular referred to using alcohol as a sedative – to balance the stimulant effects of the drug. Much of the literature from the USA has suggested that women's drug-taking is linked to family influences, abuse, violence, low self-esteem and mental health problems. And the results of this study are consistent with this picture, to the extent that both alcohol and drug misuse were associated with the experience of being physically assaulted (unwanted sexual experiences, other than sexual assault, were also associated with drug dependence). However, the picture is more complicated than these statistical associations suggest. Alcohol problems were also associated with causing physical harm to others, suggesting that the association may result from underlying personality or lifestyle characteristics, rather than a causal link between victimisation and substance misuse. This is a complex issue that is probably not amenable to a simple explanation. However, it is sufficient to note that female drug users are more likely to report problems of victimisation.

The study on which this chapter is based formed part of a wider programme of research that aimed to explore the substance misuse treatment needs of minority prisoner groups, including women. The underlying aim was to inform the Prison Service's drug strategy. The

results of the survey provide a clear picture of the extent of substance misuse among female prisoners and highlight a number of ethnic differences among women in terms of both prevalence rates and choice of drugs. White women are more likely to require treatment for the use of heroin, while treatment services for black/mixed race women need to be more focused on crack.

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5. Key findings from the literature on the effectiveness of drug treatment in prison

Tony Bullock

Introduction

The publication, in 1998, of the Prison Service's drug strategy, Tackling Drugs in Prison, brought about fundamental changes in the treatment of prisoners with substance abuse problems in England and Wales. Before the introduction of the strategy, services for drug-involved prisoners were primarily locally organised; consequently, the type and standard of services varied considerably across the prison estate. In addition to new and more coordinated measures to reduce the supply of drugs and to discourage substance abuse indirectly, such as drug testing, the strategy led to the introduction of a service-wide programme of counselling, assessment, referral, advice and throughcare (CARATs) and the expansion of treatment services. There are now over 40 rehabilitation programmes and seven Therapeutic Communities treating inmates with a range of drug and alcohol problems.

This paper was originally commissioned by the Prison Service's Drug Strategy Unit as part of their efforts to develop their treatment services. The aim of the review was to summarise and assess the literature concerning drug[1] treatment in prisons and, in particular, to draw from this body of knowledge what works in treating prisoners with drug problems.

The primary objectives of the prison drug strategy are to reduce prisoners' drug use and offending. Therefore, for the purposes of this review, the effectiveness of treatment is assessed in terms of its impact on post-release relapse and recidivism. Consequently, the main source of data stems from outcome evaluations of individual treatment programmes. However, as methodologies differ, the results of the separate evaluations are not directly comparable, and, significantly, the validity of most of these evaluations has been criticized. It is difficult, therefore, to form firm conclusions – which modalities are most effective and to what degree – on the basis of these results.

1 The treatment of alcohol problems, unless conducted in conjunction with other substances, is not addressed by this paper.

Every effort has been made to ensure that the report objectively reflects the available English-language literature. However, this literature is not fully representative of international practice as a large proportion of English-language papers come from the United States, and this dominance is evident throughout the paper (although a broader international perspective has been drawn on as far as possible). The American prison population, substance abuse problems and treatment services are distinct from those in Britain and Continental Europe. It is necessary to be aware of these differences when drawing conclusions about British treatment issues in terms of the literature presented here.

This literature review, while providing an overview of key reports on drug treatment in prisons, can usefully be supplemented by turning to systematic reviews of related topics. For instance, there are Cochrane reviews of methadone treatment, and of drugs/mental illness (accessible through the internet, on www.nelh.nhs.uk); however, these tend not to be directly relevant to prisoners. While a Campbell review of prison-based drug treatment is being prepared by Doris MacKenzie, David Wilson and Ojmarrh Mitchell, it is not complete at time of writing (www.aic.gov.au/campbellcj/reviews/titles.html).

Much of the relevant literature focuses on individual treatment modalities or specific programmes in prisons. The three most commonly discussed treatment modalities are: therapeutic communities (TCs), cognitive-behavioural and methadone prescription (reduction and maintenance programmes)[2]. The paper starts by outlining these approaches. Despite scant attention in the international literature, a further modality, '12-step', is also reviewed. 12-step services – as used prolifically through the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) organisations – are employed in several UK prisons and the only substantial British outcome research in this field involves an evaluation of some of these programmes (Martin and Player, 2000b; see also Chapter 6). A summary of the US Bureau of Prison's TRIAD evaluation is also included. In the interests of brevity, few details are provided about the precise nature of progammes or research methodologies[3].

There follows a summary of the literature concerning the differential substance abuse treatment needs of female and juvenile prisoners (an issue of particular concern to the Prison Service). While drug users often share similar characteristics – such as poor mental health and employment problems – this section outlines how these are often manifested quite distinctly among women and juvenile prisoners. This is followed by a brief discussion of three themes which recur throughout the body of literature – client matching, time in treatment and throughcare.

2 In practice, the three styles are not absolutely distinct and sometimes employ overlapping approaches.
3 A fuller paper is available from the author.

Approaches to treatment: Therapeutic Communities

There are several types of Therapeutic Communities, each with different philosophies and practices, and so a simple definition is not possible (see De Leon, 2000). However, most TCs share several fundamental qualities. They are usually hierarchically structured, intensive residential programmes that invariably last for at least a year. Treatment is achieved by addressing the individual's personal, social and moral development through a process of self-help, mutual self-help and encounter groups.

The assertion that the treatment of drug-dependent prisoners 'works' (Lipton, 1998a and 1998b; NIDA, 1999) is often made with reference to one or more of the evaluations of five TCs conducted during the 1980s and 1990s. Each of these five studies is outlined individually below and, as a collective body of work, account for a large proportion of the empirical evaluations conducted in this field.

The results of these studies show similarly encouraging results in terms of recidivism and relapse, to a degree that Lipton suggests is:

> "[H]ighly unusual in social science research. Consistency of this level is rarely seen. It may well be that the level of consistency achieved across programs … demonstrates that the overall effect of this form of programming is stable and replicable."
>
> (Lipton, 1998a, p.20)

The Amity Therapeutic Community, California

Treatment at the Amity TC lasts for around twelve months and has three components: an initial assessment stage, the main treatment stage and a period of community re-entry and aftercare treatment in a community facility following release.

Wexler and colleagues (1995) evaluated the programme by comparing the recidivism rates of four prisoner cohorts: inmates who completed both the in-prison and aftercare programmes; inmates who had just completed the in-prison programme; 'drop-outs' and a control group of prisoners who had received no treatment. The re-incarceration rates twelve months after release are presented in Table 5.1(ibid. p.19).

Table 5.1 Re-incarceration rates at the Amity TC

	In-prison and after-care graduates	In-prison graduates	Drop-outs	No-treatment group
Re-imprisoned after 12 months	26%	43%	50%	63%

The results suggest an inverse relationship between the level of treatment at the Amity programme and recidivism rates: the more treatment a prisoner received the less chance he had of being re-incarcerated. A quarter (26%) of graduates who completed both the in-prison and aftercare treatment were re-imprisoned within twelve months, compared with 43 per cent of those who had simply completed the in-prison programme. Re-incarceration rates were slightly higher among the drop-out group (50%) and higher still for those not receiving any treatment (63%).

The validity of the results is, however, questioned by the Preventing Crime meta-analysis (Sherman, 1997). The meta-analysis used a scale of one to five to summarise the scientific rigor of the studies examined. Wexler's evaluation of the Amity programme was awarded a score of three, which, by the author's definition, indicates:

> "...problems with the research design such as limited information on the subjects and comparison groups so that it was impossible to determine how similar the groups were before the study began."
>
> (ibid.)

The Kyle In-Prison Therapeutic Community, Texas

Residents at the Texas ITC receive a six- to twelve-month intensive in-prison treatment programme followed by further treatment in the community. Knight and colleagues (1997) conducted an evaluation of the programme that took measures of recidivism and drug use six months after release. As with the Amity programme, the Texan TC appears to impact positively on recidivism rates: seven per cent of treatment graduates had been re-arrested within six months compared with 16 per cent of the non-treatment sample. Furthermore, the treatment group also displayed less drug use at the six-month follow-up point (ibid. pp.91-93).

However, Knight's findings are also called into question, this time by the authors of the TRIAD report (Federal Bureau of Prisons, 1998, pp.35-37). The TRIAD report (which is covered in more detail later in the paper) reviews a number of evaluations and suggests that

the findings from Kyle may, like those from Amity, be partially due to selection bias: in relation to the comparison group, the treatment group may have been composed of individuals with characteristics that render them less likely to reoffend – such as increased motivation to change.

Stay'N Out, New York

The Stay'N Out programme is a prison-based TC in New York. An evaluation of the programme was conducted by Wexler (1990) where the re-arrest rates (after three years) of treatment graduates were compared with those of three other groups: prisoners receiving a less intensive programmme (milieu therapy), a group who only received counselling, and prisoners receiving no treatment.

Table 5.2 Re-arrest rates at the Stay'N Out treatment programme

	Treatment graduates	Milieu therapy	Counselling only	No treatment
Re-arrested after 3 years	27%	35%	40%	41%

Like the Californian TCs, the results of the Stay'N Out evaluation suggest a relationship between the level of treatment and recidivism rates: 27 per cent of graduates were re-arrested within three years compared with 35 per cent of those received the milieu therapy, 40 per cent of those just receiving counselling and 41 per cent of those receiving no treatment. However, the Stay'N Out evaluation is also heavily criticized by the TRIAD authors, who suggest that the results probably were, like those from the Californian and Texan TCs, "attributable to differences in background characteristics of the groups and not to a treatment effect" (Federal Bureau of Prisons, 1998 p.30).

Cornerstone, Oregon

Two evaluations have been conducted at the Cornerstone TC in Oregon (Field, 1989 and 1992). The first study found positive outcome measures in terms of recidivism: 29 per cent of programme graduates were re-imprisoned within three years compared with 74 per cent of programme drop-outs (Field, 1989). The second study produced similarly encouraging results, prompting Lipton to claim:

> "Cornerstone clients showed, as a function of the research program, enhanced self-esteem, reduced psychiatric symptomatology, increased knowledge in critical treatment areas, reduced criminal activity, and reduced criminal recidivism."
>
> (Lipton 1998a, p.31)

The precision of the findings is, however, questioned by the Sherman meta-analysis which found 'serious flaws' in the 1989 study's research design.

Key-Crest Programme, Delaware

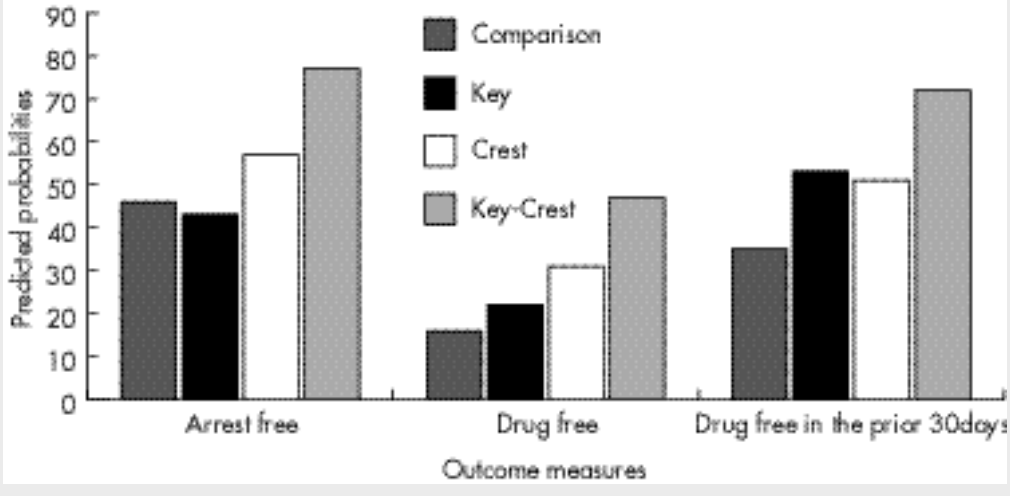
Inciardi describes the Key-Crest programme as a 'Multistage Therapeutic Community Continuum' that involves three components: treatment while in prison (KEY), treatment during 'work release' and again while on parole (CREST). The evaluation of the Delaware model used an 18-month follow-up of four groups:

(i) A 'Comparison' group was composed of inmates who received no treatment in prison or in the community;
(ii) The 'KEY' cohort received primary treatment in-prison but no community treatment;
(iii) The 'CREST' cohort received no in-prison treatment but got secondary and aftercare services in the community; and
(iv) KEY-CREST, both in-prison and community aftercare treatment.

The outcome measures taken 18 months following release for both relapse and recidivism are presented in Figure 5.1.

Drug users receiving both in-prison (Key) and post-release (Crest) treatment were much more likely to have remained drug- and arrest-free 18 months after release from prison: 77 per cent of this (Key-Crest) group were likely to remain arrest-free, compared with a 57 per cent likelihood for the Crest-only group, while the Key-only sample (43%) actually has a lower arrest-free rate than the comparison group (46%). Similarly, drug-free rates after 18 months are also highest among the Key-Crest group: 47 per cent were predicted to be drug-free at this stage, compared with 31 per cent of prisoners just receiving the Crest component, 22 per cent just receiving Key and 16 per cent of the comparison group.

Figure 5.1 18 month follow-up results at the Key-Crest programme



The Key-Crest sample again displays the best results in terms of being drug-free in the 30 days before the 18 month follow-up point. Seventy two per cent of this group were likely to be drug-free during this period, compared with 51 per cent of the Crest group, 53 per cent of the Key group and 35 per cent of the comparison group, leading the authors to observe:

> "[T]he most striking effect is the consistent benefits of the transitional TC treatment in a program like CREST and the even greater benefits for those who have both primary and secondary treatment (KEY-CREST). Both the CREST and the KEY-CREST groups do significantly better on the five outcome measures examined here [two of which are not discussed in this paper], relative to the COMPARISON group. However, for none of the five outcome measures is the KEY group statistically distinguishable from the COMPARISON group."
>
> (ibid. p.274)

The TRIAD authors endorse the Key-Crest findings; describing them as the 'clearest findings' from any of the TC evaluations (Federal Bureau of Prisons, 1998 p.39). However, this praise is qualified by the suggestion that the results may not be fully attributable to the intervention but may in part be due to the research design (ibid. pp.33-34).

Conclusions: Therapeutic Communities

As Lipton notes, the results of the evaluations of the five major TCs show remarkably consistent results. Therapeutic Communities do appear to reduce rates of recidivism and relapse. Moreover, where aftercare services are also provided, as with the Key-Crest and Amity projects, the outcome results are even more encouraging. However, the criticisms made by the Sherman and TRIAD studies highlight a series of flaws – mainly sample bias – in the evaluations' methodologies. Therefore, the positive outcomes may, at least in part, be due to the different characteristics of the treatment and comparison groups rather than the impact of the treatment services.

Cognitive-behavioural approaches

Long et al. (1998) suggest that perspectives on substance abuse and treatment have evolved from a position where drug-users were viewed as morally bankrupt to one where abuse is now seen as either a 'chronic and progressive' disease or a result of 'learned behaviour' (ibid. p.102). The authors suggest that seeing abuse as a disease lacks theoretical backing and empirical evidence – although this is not the case with dependency, see below – but that preliminary research has shown that cognitive-behavioural techniques can be effective.

The cognitive-behavioural perspective is based on the notion that behaviours – such as drug use – are often a product of prior experiences, thoughts and emotions. Research evidence and results from meta-analytic reviews appear to support the view that interventions designed to teach substance-users skills to modify and manage their behaviour can be effective.

It is essential here to note the distinction between substance abuse and dependency. The term 'substance abuse', as used throughout this chapter, encompasses a range of degrees of misuse. However, dependency is a chronic, severe and distinct disorder that often has a genetic or biological foundation. This does not negate the argument that addictions can be developed through experiences. Rather it explains why some people become addicted and others do not despite comparable experiences. That is, the biologically predisposed may have stronger or more profound reactions to alcohol or drugs than those without such a predisposition, leading, in some cases, to dependency. Teaching skills, as part of a cognitive-behavioural or similar programme, can still effect change and achieve the long-term management of substance abuse problems even with dependent users in much the same way as equivalent techniques have been used to manage conditions such as diabetes, asthma and hypertension.

Lipton and colleagues (1998) state that evaluations of cognitive-behavioural programmes (whether for the treatment of drug abuse or otherwise) generally show positive results and that the quality of these evaluations is typically better than studies of other modalities. Further support for this approach to treatment is provided by the results of a study conducted by Lightfoot and Boland (1993).

Millson et al. (1995) evaluated the pilot Offender Substance Abuse Pre-Release Program (OSAP), set up by Correctional Service of Canada, which used a cognitive-behavioural approach. The study found that, after completing the programme, inmates had a better understanding of the consequences of drugs and alcohol, how substances affect people, how to decline offers of substances and that inmates had an enhanced ability to communicate to others their wish to stop using drugs.

Further support for the cognitive-behavioural approach to in-prison drug treatment is provided by Gendreau and Goggin's (1991) evaluation of the Correctional Service of Canada substance abuse programmes. The evaluation studied 112 programmes, using a variety of approaches to treatment, concluding that: "cognitive behaviour modification programs have been shown to be the most effective" (ibid.p.15). Sherman et al. (1997) also support the use of cognitive-behavioural treatment: "more effective programs follow a cognitive behavioral and social learning" (ibid. p.17).

In conclusion, the cognitive-behavioural approach to in-prison substance abuse treatment has strong theoretical foundations and academic support. Moreover, while the number of outcome evaluations of cognitive-behavioural programmes with prisoner populations is limited, each of those conducted has shown positive treatment effect results. However, the exact extent of the effects and the parameters of what can account for improvements are yet to be definitely determined.

Methadone prescription

Methadone is used to treat, as well as to detoxify, prisoners with drug problems (primarily heroin-users) either as part of reduction or maintenance programmes. Reduction programmes involve the prescription of gradually reduced amounts of methadone while maintenance programmes provide a stable dose.

Dolan et al. (1998) review the relevant literature and outline the rationale for methadone prescription as a form of drug treatment. The authors argue that the provision of

methadone to prisoners nearing release can be justified on the grounds that it leads to a reduction in injecting behaviour and a consequent reduction in both post-release overdoses and the illegal activities committed to fund intravenous heroin habits. Similarly, the authors argue that methadone maintenance programmes also reduce levels of injecting behaviour and, consequently, the transmission of blood-borne infections through needle sharing.

The same authors argue that there are two main arguments against the prescription of methadone: pharmaceutical prescription reduces drug users' motivation to take part in other types of treatment, and that it renders users less likely to remain abstinent. The possibility of creating methadone-dependent prisoners is a further concern.

Dolan et al. report the evaluations conducted at the methadone maintenance programmes at Rikers Island, New York and at a prison in New South Wales, Australia. The Australian programme "appears to have benefited some inmates who reported a lower frequency of drug use in prison", and staff there believe that the programme has reduced blood-borne infections (ibid. pp.386-387). Graduates of both progammes have the same recidivism rates as other ex-prisoners. However, the authors note that graduates had a higher risk of reoffending and contend that evidence from community-based methadone programmes indicates that such treatments do reduce criminality (ibid. p.387).

Further support for the use of methadone is provided by the literature review conducted by the Correctional Service of Canada (1996); this study concludes that methadone treatment can be an effective way of reducing drug use and offending.

The Saughton Drug Reduction Programme

The Saughton Drug Reduction Unit at Edinburgh Prison is the only in-prison methadone treatment programme to have been evaluated in the UK. Prisoners receiving treatment were assessed and prescribed methadone at a level that was reduced over a four-week period. Counselling and advice were also provided.

The evaluation (Shewan, 1994) looked at the levels of drug use in the month following treatment and again around two months later, for a group of 30 programme graduates and a control group of the same size. Drug use was found to be less among the treatment group at both stages. However, the sample sizes are small and the background characteristics of the two groups do not appear to have been taken into account, thus rendering the validity of the results questionable.

Other Methadone Initiatives

McGuigan (1995) describes how the methadone maintenance treatment at HMP Parkhurst has been shown to reduce subversiveness in normally highly disruptive inmates and observes that inmates receiving treatment are more likely to seek treatment in the community. He states that 60 per cent of the patients treated had eventually come off methadone of their own volition. An evaluation (no methodological details are provided) of a methadone maintenance programme in a Barcelona prison found the initiative resulted in less needle sharing and a reduction in overdoses (Boguna, 1995). Keppler (1997) reports that there is sporadic use of methadone substitution in German prisons and highlights the need for this form of treatment to be accompanied by psychosocial support tailored to patients' needs. This point is also recognised by Plant (1994), who observes:

> "…[M]ethadone maintenance yields significant and worthwhile results… [however] counselling and 'ancillary' aspects of methadone programmes may be very important influences on treatment outcomes"
>
> (ibid. p.49)

Despite the confidence of British, American and European advocates, there is little empirical evidence to suggest that methadone prescription programmes in prison are effective in reducing relapse and recidivism (although community-based evidence suggests some benefits in terms of harm minimisation and crime reduction (Coid, J. et al., 2000)). Given that addiction is a complex phenomenon, it is logical to expect that pharmaceutical prescription needs to be complemented by more therapeutic interventions.

12-step

The '12-step' approach to substance abuse treatment receives comparatively little attention in the literature concerning the treatment of prisoners (see Alcoholics Anonymous, 1993, for an outline of the philosophy and practice of this approach to treatment). However, it is included in this paper because of its use in a number of Prison Service establishments through the rehabilitation programmes run by the Rehabilitation of Addicted Prisoners Trust (RAPt).

Substance Abuse Treatment Programme (SATP) at HMP Downview

The Substance Abuse Treatment Programme at HMP Downview, and those used by the RAPt organisation in other British prisons, is based on four fundamental assumptions:

(i) addiction is an illness;
(ii) addiction is incurable but manageable;
(iii) addicts are at risk of cross-addictions; and
(iv) addiction is chronic and cumulative in nature, therefore recovery is progressive and staged.

The programme, as reported by Player and Martin in 1996[4], employs two treatment elements: the '12-step' model and the therapeutic community, and the programme runs for between ten and twelve weeks. Player and Martin (1996b) conducted a preliminary, essentially descriptive, evaluation in 1996 which found encouraging treatment outcomes in terms of drug use, behaviour generally, improved understanding of personal problems, offending behaviour and attitudes towards family. A further evaluation by the same authors (Martin and Player, 2000a) was conducted at Downview and three other adult male prisons (Coldingly, Pentonville and Wandsworth) using RAPt's treatment services.

The study found that fewer programme graduates had returned to their drug of choice and to drugs generally, while other, less tangible, benefits were expressed by respondents:

> "[A]lmost everyone who embarked on the treatment programme, both graduates and drop-outs, felt that they had gained from the experience.... more than anything else, they felt that they had achieved a sense of personal development that went beyond the limit of their dependence on drugs."
>
> (ibid. p.11)

However, while some respondents felt that the treatment deterred them from relapsing, "just as frequently the men put their success down to the strength of their own personal commitment to change" (ibid. p.20). Graduates were less likely to be convicted of a criminal offence following release: 20 per cent of graduates compared with 39 per cent of non-graduates had at least one post-release conviction – the average post-release period was 14 months (Martin and Player, 2000b, p.60).

The 12-step approach was widely used under the U.S. Bureau of Justice's Project REFORM in the mid 1980s (Lipton, 1998). However, other than a large amount of positive anecdote there is very little evidence concerning the effectiveness of this approach either in prison or in the community (ibid.; Correctional Service of Canada, 1996; Gendreau and Goggin, 1991; Plant, 1994).

4 For a more contemporary description of RAPt's services see Martin and Player, 2000a, 2000b and Chapter 6.

The RAPt reports appear to be encouraging. However, while the two evaluations discussed here support the 12-step approach, the limited nature of the methodology (small sample, background characteristics are insufficiently accounted for and possible selection bias) suggests the need for caution when interpreting the data.

TRIAD

TRIAD (Treating Inmates' Addiction to Drugs) was the evaluation of the U.S. Federal Bureau of Prisons' (BOP) drug abuse treatment programmes (DAPs). The project involved a three-year follow-up study conducted in the late 1990s and reported in September 2000 (Federal Bureau of Prisons, 2000).

The TRIAD evaluation is treated separately by this review as DAPs do not fall into any of the four treatment classifications otherwise addressed – they do, however, share a number of similarities with TCs and cognitive-behavioural approaches. Programmes are designed for both male and female prisoners with moderate to severe substance abuse problems, and include three stages of treatment: none to twelve months of unit-based treatment in prison; up to twelve months of transitional treatment in the general prison population and halfway house treatment following release.

The TRIAD evaluation used a rigorous methodology that differentiates it from previous studies. And while the results appear to be less impressive they do indicate positive outcome measures in terms of both relapse and recidivism that are likely to be more reliable than those provided by other studies summarised in this paper. The study tracked a large sample (over 2,000 in total) of DAP graduates and a control sample of untreated ex-prisoners with similar drug abuse backgrounds for three years following their release from prison. The results of the study are summarised in Table 5.3 below.

Recidivism was measured in two ways: either by arrest for a new offence during the three-year post-release period or by the revocation of post-release supervision. The results of the study found treatment effects in terms of recidivism: the probability of arrest or revocation for treated men was 44.3 per cent compared with a probability of 52.5 per cent for untreated men – a statistically significant difference. Although not statistically significant, the female recidivism rates were also lower for treated women: 24.5 per cent of this group were likely to be arrested or revoked with 36 months compared with 29.7 per cent of untreated women.

Table 5.3 Estimated three-year outcome measures for treated and untreated prisoners with a drug abuse problem in the TRIAD evaluation

Outcome	Males		Females	
	Without treatment (n=948)	With treatment (n=894)	Without treatment (n=245)	With treatment (n=228)
Arrest or supervision revocation	52.5%	44.3%	29.7%	24.5%
Relapse to drug use	58.5%	49.9%	42.6%	35.0%

Relapse into drug use was measured in terms of any drug or alcohol use during the follow-up period. Again, treatment effects can be observed in the results of the study: 49.9 per cent of treated males were likely to relapse compared with 58.5 per cent of untreated men; while 35.0 per cent of treated women were likely to relapse compared with 42.6 per cent of untreated women.

In addition to these encouraging results, the TRIAD report offers a critique of other studies and provides a methodological template that might be replicated in future evaluations of substance abuse treatment progammes.

The differential treatment needs of women and juveniles

The remainder of this chapter assesses a number of key themes in the literature. Firstly, the differential substance abuse treatment needs of female and juvenile prisoners are addressed, as this is a priority for the Prison Service. And secondly, several key themes that recur throughout the literature are summarised. These issues are followed by a brief conclusion.

Women prisoners

Peugh and Belenko (1999) review the literature concerning the treatment needs of female prisoners and suggest that while male and female substance users share many of the same characteristics – such as dependence, poor health, mental illness, employment problems and poor support networks – the manifestations and severity of these are often distinctly different for women. The authors highlight a number of areas where female prisoners' treatment needs differ from those of male prisoners.

The need for gender specific and comprehensive treatment

Confrontation techniques, anger management, group settings and other treatment interventions developed for substance-abusing men may be inappropriate for women. The increased prevalence of sexual abuse, low self-esteem and other emotional problems among female substance-users can result in such approaches being ineffective or even detrimental with women (ibid. p.31). Covington (1997) suggests that drug use among women is often associated with drug use by boyfriends or other significant men and that this might also be an area to be addressed through treatment.

Mental health

Peugh and Belenko argue that mental health issues are likely to be more pervasive for drug-using women inmates and that this is compounded by histories of sexual abuse that are connected to the development of drug problems:

> "Women who abuse substances often suffer more intense emotional distress, psychosomatic symptoms, depression, and self-esteem problems than male addicts."
>
> (1999, p.25)

Moreover, women are more likely to use drugs and alcohol as self-medication to cope with depression, psychological stress and traumatic events, whereas men more frequently report hedonistic factors (ibid. p.26).

Physical health

Female drug-users are at a greater risk of contracting sexually transmitted diseases and the consequences of STDs are often more severe for women, as they are at an increased risk of infection and complications such as pelvic inflammatory disease, cervical cancer and infertility (ibid. p.27).

Education, employment needs and family responsibilities

As with their male counterparts, substance-involved women are likely to have problems with employment and education; a situation that can result in women having feelings of helplessness and reduced motivation to change their lives. Furthermore, economic problems are compounded for women by the greater need to provide for dependent children, and many women will require childcare assistance if they are to regain custody of their children when released. Peugh and Belenko argue for educational and employment skills to be included as part of the treatment of female prisoners:

> "Treatment for women will be most effective if it seeks to address the financial and practical needs of these incarcerated mothers by offering family services as well as transition and aftercare programs."
>
> (ibid. p.33)

Treatment models

Welle, Falkin and Janchill (1998) state that the substance-abuse treatment of female offenders in the U.S. is increasingly employing a gender-specific approach that addresses victimization experiences, relationships problems and parenting skills. Findings from their research also suggests that prison-based treatment programmes specifically designed for the needs of female inmates can be effective in reducing relapse and recidivism.

An evaluation (Wexler, Falkin and Lipton, 1990) of the Stay'N Out programme for female prisoners in New York found that women who received treatment were less prone to recidivism that those in the comparison groups. And an evaluation of the Forever Free TC programme in California, which followed-up 246 female ex-prisoners, found improved recidivism rates for graduates, especially those who had completed the aftercare treatment component (Peugh and Belenko, op. cit. p.39).

Juvenile prisoners

Dembo et al. (1993) argue that younger substance-abusers differ from adults in a variety of ways:

> "Compared to adults, adolescents (1) use drugs at an earlier age, (2) have less involvement with opiates, shorter abuse histories, and more involvement with alcohol, marijuana and multiple drug use…. (3) have a greater incidence of family deviance and experience of past psychological treatment, (4) tend to be more fascinated with the drug-related life-style and less fatigued with the failure and the negative social consequences of their drug use, (5) have an unrealistic sense of their invulnerability, and (6) require a greater emphasis on addressing educational needs and parental/ family support in the treatment process."
>
> (ibid. p.115)

The authors also observe that substance abuse among juveniles is often related to a range of factors not always associated with adult abuse, including: physical abuse, sexual

victimization, emotional/psychological problems and educational difficulties. This recognition leads the authors to argue for the treatment of juveniles to encompass a range of interventions that address the problems in a holistic manner rather than focusing on a narrow interpretation of treatment needs.

Hoffmann et al. (2001) stress the issue of co-occurring mental health conditions among juvenile substance-users. While this is also an issue for adults, clinical findings tend to show extremely high rates of co-occurring conditions among juveniles who manifest dependency syndromes.

Citing a longitudinal study of over 400 juveniles in Florida, Dembo et al. highlight a number of issues associated with substance-involved youths:

- Drug-using youths are at an increased risk of contracting blood-borne diseases such as HIV due to their injecting behaviour and high-risk sexual activity.
- Youths with substance abuse problems display high rates of emotional and psychological difficulties that can be traced to histories of physical and sexual abuse.
- Young people with histories of poor educational attainment and disciplinary records are disproportionately represented in offending and drug-taking populations.
- At-risk youths are frequently raised in troublesome environments where family members have substance-use and mental health problems or are involved in violent and criminal behaviour.
- Peer group influences appear to be a significant factor impacting upon drug-using youths; many young people coming into contact with the justice system also have friends with criminal and drug-use histories.
- Physical and sexual abuse, drug-use and mental health difficulties within the family are more closely associated with juvenile delinquency and the use of soft drugs than socioeconomic status.

The literature seems quite clear that substance-involved women and juvenile prisoners do have distinct needs. The two main treatment modalities presented in this paper – Therapeutic Communities and Cognitive-Behavioural – view addiction as affecting the whole person in a

multitude of psychological, emotional, physical and sociological ways. The 'differential needs' literature serves to emphasize that these factors impact differentially on women and juveniles and thereby underscores the need to provide detailed assessment and referral procedures that lead to holistic treatment.

Cross-cutting themes

A number of themes and issues appear to transcend the different ideological and practical approaches to substance abuse treatment services – the effectiveness of ex-addicts as counsellors being an example (Inciardi, 1997). However, three issues – 'client matching', 'throughcare', and 'time spent in treatment' – recur particularly frequently throughout the literature.

Client matching

The recognition of the heterogeneity of drug use and drug-users leads a variety of commentators to argue for treatment services to be tailored, as far as possible, to the needs of individual prisoners. The severity of imprisoned drug-users' problems will vary (Player and Martin, 1996), as will the relationship between drug use and offending (Stoever and von Ossietzky, 1998). Gendreau and Goggin (1991) also argue for therapists' characteristics to be matched with client factors. The recognition that drug abuse often stems from a combination of factors reinforces the argument that services need to be responsive to needs of individual prisoners:

> "No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, the workplace and society…Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems."
>
> (NIDA, 1999, p.1)

Time in treatment

Numerous evaluations have found a relationship between the length of treatment and outcome measures: the longer a prisoner spends in treatment, the less chance he or she has

of relapsing or recidivating (Inciardi, 1997; Sherman, 1997; NIDA, 1999; Office of National Drug Control Policy, 1996; Sherman, 1997):

> "The effectiveness of drug abuse treatment is specifically related to the length of time an individual remains in drug abuse treatment, regardless of the type of treatment."
>
> (Lipton, 1998, p.11)

Throughcare

Possibly the most consistent observation to be found in the literature covered is the need for adequate throughcare – both within prison and following release. Field (1998) reviews the literature concerning the continuity of treatment from the prison to the community. He notes that some of the most effective TCs have active throughcare components in prison and that various studies have found that institutional programmes are more effective if prisoners receive treatment following release in addition to in-prison services (see the Kyle and Key-Crest sections earlier).

Field suggests that the transition from prison to the community can be a daunting experience and that inmates conditioned to a structured institutional environment – particularly those with psychological disorders – often find it difficult to transfer what is learned in the institution to the community, thereby nullifying any treatment progress.

The U.S. Centre for Substance Abuse Treatment (CSAT, 1998) recommends a model of throughcare that would ideally involve full-time case managers liaising with prison staff and relevant community workers and administering risk and needs assessments in prison in anticipation of release. 'Transition Plans' would be drawn up on the basis of these assessments and would involve the collaboration of service providers from both inside and outside the prison, with particular roles for each of the agencies concerned. The authors continue by arguing for a greater emphasis on the importance of community treatment to the extent that institutional treatment should essentially be a 'stepping stone', or preparation for, treatment on the outside. In-prison treatment should be seen as the beginning of the 'treatment commitment', where motivation is encouraged and relapse prevention is taught.

The literature consistently stresses the need for throughcare in prison and aftercare in the community (Inciardi, 1997; Leukefeld and Tims, 1993; Office of National Drug Control Policy, 1996; NIDA, 1999; Stoever and von Ossietzky, 1998). And the evaluations of programmes with aftercare components (Kyle and Key-Crest) show distinctly better results for prisoners completing aftercare treatment.

Conclusion

> "[T]he search for a universally effective treatment approach is misguided."
>
> (Annis, 1990, p.4)

Annis' statement reaffirms a number of points presented in this paper. The literature is replete with examples of the heterogeneity of both prisoners with drug abuse problems and the nature of these problems. And, while advocates of the various approaches to treatment assert, to varying degrees, the effectiveness of their chosen modality, none claim theirs to be universally superior.

However, as the Themes section of this paper argues, there does appear to be broad agreement on a number of key points: the need for 'client matching', for adequate time in treatment and, particularly, for effective throughcare and aftercare. The recognition that substance abuse often stems from, and is symptomatic of, the interplay of numerous social, genetic, biological, psychological, psychiatric, pharmaceutical, financial and legal factors adds weight to Annis' claim; the treatment needs of drug-abusing prisoners are clearly diverse and so a single approach is unlikely to be universally effective.

The following recommendations from the U.S. Office of National Drug Control Policy[5] encapsulate many of the arguments and observations made concerning the treatment of prisoners:

> "Regardless of the setting (e.g., inpatient, outpatient, or residential), a successful course of treatment will combine therapies, services, and methods that produce favourable outcomes. Since drug-users, especially hardcore drug-users, face many related problems (e.g., high-risk environment, unemployment, lack of education, and physical and sexual abuse), effective treatment requires several critical elements, including the following:
>
> - complete and ongoing assessment of the client;
> - a comprehensive range of services, including pharmacological treatment, if necessary; counselling, either individual or group; in either structured or unstructured settings; and HIV-risk reduction education;
> - a continuum of treatment interventions;
> - case management and monitoring to engage clients in an appropriate intensity of services; and
> - provision and integration of continuing social supports.

5 With reference to treatment in the wider criminal justice system, not just with prisoners.

> These elements, rather than the specific treatment models, determine whether a program will be successful in treating the individual clients and affecting the broader social or community problems that exist because of drug abuse."
>
> (1996, p.19)

Although Therapeutic Communities, cognitive-behavioural, 12-step and methadone services are addressed separately by this paper and have theoretical and practical differences, they also share similarities. TCs often employ cognitive-behavioural elements; the 12-step programme at Downview was delivered in a quasi-TC environment and advocates of methadone prescription recognise the need for these interventions to be accompanied by other more therapeutic services. It would, therefore, be misleading to view these modalities as autonomous approaches to treatment.

Each of the evaluations outlined in this paper has shown treatment to be effective. While the use of different methodologies and the questionable validity of the findings precludes meaningful comparisons between the individual results, even the TRIAD evaluation – which employed a rigorously strict methodology – found positive results. And, as highlighted by Lipton with reference to TCs, this consistency is unusual and suggests that treating drug-abusing prisoners can be effective in reducing relapse and recidivism – particularly when effective throughcare is employed (as illustrated by the Kyle and Key-Crest evaluations). Furthermore, while this paper has concentrated on relapse and recidivism as measures of effectiveness, treatment is also likely to benefit drug-users' physical health and numerous social factors.

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6. Results of evaluations of the RAPt drug treatment programme

Carol Martin, Elaine Player and Sarah Liriano

The Rehabilitation of Addicted Prisoners Trust (RAPt), previously known as the Addictive Diseases Trust (ADT), set up the first specialised programme exclusively for drug and alcohol misusers to operate in a prison in England or Wales. The programme is based on the '12-step Minnesota Model' that requires total abstinence from drugs and alcohol for its participants. The first group of prisoners received treatment at HMP Downview in 1992. The programme has since extended to operate in seven prisons in the south of England and the first independent review into the treatment began in 1994 (Player and Martin, 1996). In order to ascertain the effectiveness of the RAPt programme the following research projects have been conducted:

- An initial evaluation by Player and Martin – largely a process evaluation of the RAPt programme (Player and Martin, 1996).
- An outcomes evaluation by Martin and Player, following up RAPt graduates and non-graduates after release (Martin and Player, 2000).
- A reconviction analysis conducted by the Research, Development and Statistics Directorate of the Home Office (carried out by Sarah Liriano in 2002).

This paper begins by summarising the initial research by Player and Martin, reporting levels of drug use prior to incarceration, during incarceration and post-release. The results of the early study by Martin and Player into offending post-release are then reported along with a more recent reconviction study conducted by the Home Office, involving a larger sample of programme graduates released for a longer length of time.

The original research by Player and Martin (1996)

RAPt is a well established drug treatment organisation in the criminal justice field, operating substance abuse treatment units and CARAT (Counselling, Assessment, Referral, Advice and Throughcare) facilities throughout England and Wales. This paper focuses on RAPt's substance abuse treatment programmes operating in male prisons. RAPt's vision is that

addicts involved in the criminal justice system should have access to the same quality of treatment as is available in the community, so that they can be enabled to lead constructive lives free from addiction. By tackling addiction RAPt believes it can make a major contribution to reducing crime. To achieve this vision RAPt provides 12-step substance abuse treatment programmes, based on total abstinence, to those involved in the criminal justice system, together with support services to help addicts to achieve and maintain recovery and lead law-abiding lives. The focus of the programme is overcoming addiction, regardless of the substance involved.

Details of the '12-step' approach can be found in Martin and Player (2000) but it can be broadly summarised in terms of three main stages of therapeutic activity:

- a preparative stage – the inmate is forced to recognise the full extent of his own powerelessness over his addiction;
- an action phase – a detailed inventory of the inmate's personal defects is established, which is then shared and analysed with his group and peer counsellor; and
- a consolidation phase – this occurs after the inmate has completed the course and integrates the action component into a routine for daily living.

A preliminary evaluation of the effectiveness of the ADT drug treatment programme was conducted by Player and Martin and published in 1996 (Player and Martin 1996). These researchers reported that most men who applied to the ADT programme had long histories of substance abuse (almost three-quarters had been dependent on drugs and/or alcohol for over ten years) and were serious and persistent offenders serving medium-term sentences. An analysis of the types of crimes committed by those applying for places on the programme revealed that a high proportion were serving their current sentence for robbery, burglary or drug offences and relatively few were sentenced for theft and dishonesty, violence against the person and sex offences. Over half had served four or more custodial sentences. At the time the research was conducted, entry onto the programme was entirely contingent upon the prisoner volunteering for a place. There were no selection criteria in place at this time.

Individuals progress through the programme at their own pace. There is no minimum or maximum length of time an individual can remain on the programme. Heroin users or alcoholics in their late 20s to early 30s, who had experienced a physiological state of dependence and acknowledged their addiction, were most likely to persevere with the treatment. The majority of those who completed the programme said that they had not used

any drugs or alcohol since, and this was supported by a review of the results of random testing. Those who dropped out of the treatment programme tended to be younger, less serious drug users who saw themselves as 'recreational' users rather than 'addicts'. In addition to a reduction in drug use there was self-report evidence that the ADT programme influenced inmate attitudes and behaviour in more general ways, e.g. by improving relationships with staff, other inmates and families, and attitudes towards crime and offending behaviour.

The outcome study by Martin and Player: introduction

The key feature of this second study, by Martin and Player (2000), comprised interviews both in prison and where possible after release with a sample of 200 males, all of whom originally considered their substance abuse to be problematic[1]. The selection included programme graduates, drop-outs and non-starters from HMPs Coldingley, Downview, Pentonville and Wandsworth. Table 6.1 shows the proportions in each group.

Table 6.1 Sample by treatment status

Status	Number	Per cent
Graduates	95	48
Drop-outs	35	18
Non-starters	70	35
Total	200	100

Graduates are men who are deemed to have completed the RAPt programme according to the criteria outlined within their establishment. Drop-outs are those who started the programme but, for whatever reason, left early. Non-starters are men who had applied to join RAPt, some of whom had spent lengthy periods on the 'pre-admission groups', but, for whatever reason, had not started the actual programme. These reasons varied between different prisons. At Pentonville and Wandsworth most of those on the pre-admission lists who did not start the programme were serving sentences too-short to accommodate the length of the course, whereas at Downview and Coldingley non-starters tended to be inmates who had

1 One inmate identified gambling as his 'problem substance'; for the purpose of this study he regarded himself and was regarded by the researchers as any other 'substance misuser'.

changed their minds about embarking on the programme after they had experienced the pre-admission group. Most of the non-starters included in this study were from Pentonville and Wandsworth. All respondents had therefore experienced some form of treatment.

The fieldwork was conducted between August 1997 and August 1999 and involvement in the research was entirely voluntary. Those invited to take part in the research were interviewed both in prison and where possible at least six months after release. Graduates and drop-outs were approached for interview as soon as their participation in the programme had ended. Non-starters were identified from the pre-admission lists in each prison and were interviewed as soon as it was known that they would not be starting the course. The distribution of interviewees from the different prisons is shown in Table 6.2.

Table 6.2 Prison location for the original sample

Prison	Number	Per cent
Coldingley	30	15
Downview	46	23
Pentonville	91	46
Wandsworth	33	17
Total	200	100

The research instruments were three structured questionnaires, all of which were completed manually by the researchers. The first two were for use in prison and the third, post-release, in the community. Questionnaire one was used when the interviewee had completed their contact with RAPt, questionnaire two was used just before release and questionnaire three was used after release. All questionnaires asked about drug and alcohol use; further details can be found in Martin and Player (2000).

A total of 200 sentenced male prisoners were interviewed in four prisons. Their ages ranged from 21 to 62, although most were in their twenties. Ethnic minorities made up just over a quarter (26%) of the sample, most of whom were of African or Afro-Caribbean origins. These proportions closely reflect those of the national prison population.

Drug use before and during prison

Substance misuse for the vast majority of the original sample was long-standing. The average length of addiction for graduates was 13 years, dropping to ten years for non-graduates, but in both cases ranging from less than one year to 20 or more years. Although most of the sample could be classed as poly-drug users, the majority had a single drug of choice. Most commonly this was heroin (29%) followed by alcohol (20%) and cocaine (19%). A combination of drug and alcohol use was cited as the drug of choice by 9.5 per cent and a further seven per cent stated poly-drug use. Ecstasy, cannabis, other drugs and amphetamines were cited as the drug of choice by 6.5 per cent, 5.5 per cent, two per cent and one per cent respectively. Graduates or drop-outs were more likely to be heroin or cocaine users (53%) in comparison with non-starters (39%). Half the sample had previously succeeded in giving up their use of drugs or alcohol. Over half of the men (60%) had no prior experience of a drug treatment programme. Of those that had received treatment, 24 had participated in a 12-step programme, 18 had received methadone treatment and ten had received individual counselling. Although these interventions had usually led to a period of recovery the effect was generally short-lived, lasting in the vast majority (82% of cases) less than six months.

Drug use in prison was also common, with seven out of ten interviewees using drugs during their current prison sentence. Three-quarters of those who had used drugs in prison said that they did so on a very regular basis: either every day or at least two or three times a week. Cannabis was the single most widely used substance but fewer than one in three of the men had restricted their use to cannabis. Heroin had been used in prison by about half the men interviewed and a third (34%) of the sample said they had drunk alcohol in prison.

A dramatic change in drug use was observed following contact with RAPt. The vast majority (81%) said they had abstained from all drug use since leaving the programme or pre-admission group, with more than eight out of ten claiming to be clean for longer than one month. Amongst those who had moved on from the pre-admission group and had embarked upon the therapeutic programme, about one in five had failed to maintain total abstinence and had used drugs, usually heroin, whilst participating in the programme. In almost all of these cases their drug use had become known and they were required to accept a 'lie down' before rejoining the programme. In terms of sustaining a drug-free lifestyle in prison, graduates of the programme were most successful. Interestingly, the non-starters appeared to be more successful than the drop-outs, half of whom returned to drug use before being released, as shown in Table 6.3 below. Amongst the minority of persistent users almost half were solely using cannabis, but a similar proportion were using heroin, either with or without cannabis.

Table 6.3 Drug use in prison following involvement with RAPt

Status	Used	Abstained	Total
Graduates	5 (5%)	88 (95%)	93
Drop-outs	17 (49%)	18 (51%)	35
Non-starters	16 (24%)	51 (76%)	67
Total	38 (19%)	157 (81%)	195

Most inmates had applied for a place on a RAPt programme in order to get help to overcome their drug or alcohol problem. A small, but significant minority may have had a different agenda, which included making a good impression on the Parole Board and facilitating a prison allocation closer to home. There were also a few others motivated by curiosity who had no commitment to drug therapy.

Irrespective of their motivation, almost everyone who embarked on the treatment, both graduates and drop-outs, felt that they had gained from the experience. Although two-thirds said they thought they had gained the ability to control their drug or alcohol problem, the men felt that, more than anything, they had achieved a sense of personal development that went beyond the limits of their dependence on drugs. This had consequences for their behaviour and attitudes inside prison which, they argued, were less stereotypically hostile to prison staff and more tolerant towards other prisoners. Graduates and dropouts also felt more positive about their relationships with their families and claimed that their attitudes towards offending, which had largely been driven by their drug dependence, had also changed.

A commitment to abstinence from illicit drugs was expressed by about half the sample, although slightly fewer thought they would refrain from alcohol. There were 100 men who were confident of their ability to avoid future drug or alcohol dependence and most of these men thought this was due to their own commitment to change rather than the single impact of the RAPt programme. Graduates were almost twice as likely as non-graduates to say that they would not use illicit drugs post-release. Amongst those who anticipated using illicit drugs, or who thought they might do so, about half were referring to the use of cannabis, which was widely regarded as being non-harmful. However, the major test was still to come, after their release, when the controls and supports from within the prison environment would no longer be present, and this was recognised by most prisoners. The sub-sample that was followed-up after release confirmed the validity of this expectation.

Post-release follow-up: levels of drug use

It was anticipated that contacting many of these men in the community would be difficult and that the attrition rate would be high. The aim was to follow-up a sub-sample of 100 men, roughly half of which would be graduates. Participants were contacted by letter and telephone to arrange a final interview and a small fee for participation was offered plus the reimbursement of travel costs. A total of 75 participants were re-interviewed post-release, including graduates, drop-outs and non-starters as shown in Table 6.4 below.

Table 6.4 Treatment status of those re-interviewed following release

Status	Number	Per cent
Graduates	42	56
Drop-outs	13	17
Non-starters	20	27
Total	75	100

The composition of the sub-sample varied only slightly from the original prison sample in that it contained a marginally higher proportion of graduates and a lower proportion of non-starters. There were no significant differences between the two groups in their criminal histories, whether in relation to their original offence and sentence length, or the number of previous convictions or the number of previous custodial sentences. The sub-sample was also virtually identical to the original sample in terms of their drugs of choice and length of addiction.

The sub-sample of inmates who were contacted after their release from prison were men who typically had a network of interpersonal supports, provided primarily by their family of origin but also by their wives or partners. Almost all of them had a circle of friends or social contacts, mainly people they had known before their last sentence. Most strikingly the social world in which these men existed exposed them to regular contact with people who misused drugs and/or alcohol. The over-representation of men with family supports is likely to be due to the method of contacting men after their release from prison. Inevitably, it was easier to find men with established ties in the community than those who had a more rootless lifestyle.

Two-thirds of the 75 men followed-up in the community said that they had successfully avoided all drug use for the remainder of their sentence. However, after release, 58 respondents (77% of the sub-sample) admitted that they had relapsed. Graduates were the least likely to relapse. Over a third of graduates (38%) had abstained from all drug use post-release as opposed to

one drop-out (8% of all drop-outs) and none of the non-starters. Test results showed that two of those claiming to have abstained from all drug and alcohol use had used one of these substances. The programme drop-out who had abstained from drug use had spent two months on the programme and attributed his recovery to the RAPt programme.

In addition to complete abstention, eight graduates and nine non-graduates reported that although they had used other drugs (including alcohol) since release, they had managed to abstain from their drug of choice. Most of the men who had abstained from their drug of choice, but had used other drugs since their release from prison, had restricted their use to alcohol or cannabis or both. There was no significant difference between graduates and non-graduates using drugs other than their drug of choice.

Urine tests confirmed that 17 graduates (40% of all graduates followed up after their release) and three per cent of non-graduates had abstained from their drug of choice post-release. Drug of choice was an important factor in affecting whether or not the men returned to its use. Those who identified alcohol as their drug of choice were significantly more likely than other users to have returned to its use. Eight out of ten alcoholics in the sub-sample had relapsed since their release, in comparison with less than half of other users.

Post-release follow-up: levels of offending

Effectiveness of any prison-based drug treatment is measured not only by its primary focus, i.e. reducing drug use, but also by its ability to reduce subsequent offending. Reconviction rates are traditionally viewed as an important indicator as to whether an intervention has been effective. However, they have various limitations:

- Reconviction rates are not necessarily a true measure of offending.
- They are a product of factors including police and prosecution practice which vary over place and time.
- Numerous factors are likely to impact on rates of reconvictions including: age; gender; number and rate of previous convictions; type of sentence; and social factors such as drug addiction.

Two sets of reconviction data are reviewed here. First, the results of the work by Martin and Player (2000) are presented, followed by additional results from a recent analysis conducted by the Research, Development and Statistics Directorate (RDS) in the Home Office (Liriano, 2002). While Martin and Player (2000) used both official reconviction records and self-report findings, the RDS study was restricted to reconviction records.

The original 200 men who took part in the Martin and Player research were relatively serious recidivist offenders with substantial prison experience. Their current sentences had been imposed for a wide range of offences, most typically burglary and drug offences. Although fewer than one in three had received their present sentence for a violent offence, more than half the sample (59%) had a previous conviction for an offence involving violence. Eight out of ten had served a previous prison sentence. They had accumulated an average of 15 previous convictions and only seven of the 200 men interviewed had no prior criminal record.

Martin and Player (2000) found that 20 per cent of graduates and 39 per cent of non-graduates (non-starters and drop-outs) were reconvicted post-release. The length of time the sample had been out of prison varied from less than six months to over 18 months and any reconvictions within this period were included. Clearly, the longer the post-release period the greater the risk of reconviction. When only those men with post-release periods of twelve months or longer are considered, graduates were still less likely than non-graduates to have acquired a subsequent conviction. Over one-quarter (28%) of graduates and 52 per cent of non-graduates had been reconvicted after being released for at least twelve months.

Of those interviewed post-release, 24 per cent of graduates and 47 per cent of non-graduates were reconvicted post-release. Again the length of time the sample had been released varied from less than six months to more than 18 months. Those who had achieved first or second tier recovery (complete abstinence or abstinence from their drug of choice) were less likely to be reconvicted than those who had used their drug of choice. Just over one-fifth (21%) of all those who had achieved at least second tier recovery (graduates and non-graduates) had been reconvicted, as opposed to 44 per cent of those who had used their drug of choice (data includes both graduates and non-graduates). Those who had used their drug of choice acquired their subsequent convictions more quickly than those who had not.

Those interviewed post-release were also asked about their re-offending, since not all re-offending leads to a conviction. The re-offending levels are shown in Table 6.5 below.

Table 6.5 Self-reported reoffending by drug use

Drug use since release	Reoffended	Not re-offended	Total
First tier recovery	3 (18%)	14 (82%)	17
Second tier recovery	9 (53%)	8 (47%)	17
Used drug of choice	24 (58%)	17 (42%)	41
Total	36 (48%)	39 (52%)	75

Of those who had achieved first tier or full recovery, only three men said they had re-offended. The nature of the offences they reported is, however, worthy of note. Two reported paying 'on the spot' fines for fare dodging and the other admitted driving without a licence. This is a huge de-escalation in their offending, which had included at least two previous custodial sentences for each individual and an average of 31 previous convictions each.

The RDS reconviction study

Further reconviction analysis of a larger number of graduates from the RAPt programme has been conducted at RDS as part of the on-going monitoring of all Offender Behaviour programmes.

The RDS reconviction study: one-year results

A total of 274 RAPt graduates had been discharged from prison for at least one year by 31 March 2001 (which was the cut-off date for offences appearing on the Offenders Index at the time the study was conducted). These graduates had an average age at court appearance of 30 years, ranging from 18 years to 58 years. Three-quarters of the graduates released for at least one year were white, almost a fifth (18%) were black and the remaining seven per cent were of other ethnic groups. The average sentence length was 4.3 years ranging from less than six months to life. As is typical of drug-misusing offenders, graduates had a large number of previous convictions, the average being 25, ranging from none (eight graduates had no previous convictions) to 241.

Opiates were the most popular drug of choice, used by almost a third (31%) of graduates, while 28 per cent stated crack/cocaine as their drug of choice, and almost a fifth (19%) cited poly-drug use. Alcohol was the drug of choice for 14 per cent of graduates, while 1.5 per cent stated gambling as their problem addiction and the remaining 6.5 per cent stated other drugs including amphetamines, tranquillisers, LSD and cannabis.

In terms of previous offences, just over one-quarter (26%) were serving sentences for drug offences whilst they received RAPt treatment and a similar proportion (24%) were convicted of burglary. Approximately one-sixth (16%) were convicted of robbery and one-tenth (10%) were convicted of assault or violence against the person.

One-quarter (25%) of RAPt graduates had been reconvicted of a standard list offence within one year of release from prison. This result cannot be compared with expected reconviction rates because expected reconviction rates cannot be calculated for a one year time period. However, in a comparison group of 931 offenders released from Coldingley, Downview, Norwich, Pentonville and Wandsworth in 1997, with similar ages, numbers of previous convictions and OGRS scores, a higher proportion, 38 per cent, had been reconvicted within one year of release. This is a 13 percentage point difference and is highly significant, at the 0.1 per cent level. Table 6.6 below compares one year reconviction rates for offenders in the comparison group with those for graduates of the RAPt programme.

Table 6.6 Reconviction profiles of RAPt graduates and the comparison group

	RAPt	Comparison group
Number	274	931
Average age	30	27
No. of previous convictions	25	22
Average OGRS scores	54%	55%
Percentage reconvicted within 1 year	25%	38%

Taking drug of choice into account when comparing reconviction rates reveals some variations for the different drugs of choice. Almost a third (32%) of those stating poly-drug use as their drug of choice were reconvicted within one year of release as were 30 per cent of those stating opiates as their drug of choice. Only a fifth (20%) of those stating crack/cocaine as their drug of choice and 18 per cent of alcohol users were reconvicted within one year of release.

Whilst a quarter of programme graduates were reconvicted post-release, the nature of the reconviction may indicate whether there has been a change in behaviour. In particular, it is interesting to observe whether or not graduates were reconvicted of drug offences. Of those reconvicted, just over one-fifth were convicted of shoplifting offences and 19 per cent were convicted of burglary offences. A smaller proportion, 16 per cent, were convicted of drugs offences. This last group only accounts for 4 per cent of all graduates released for at least one year. Almost half of those reconvicted within one year of release (48%) were returned to prison; this represents 12 per cent of all graduates released for at least one year.

The RDS reconviction study: two-year results

Reconviction rates for periods of less than two years are subject to errors resulting from 'pseudo-reconvictions', therefore the usual follow-up period for reconviction studies is two years. (Pseudo-reconviction is the term used to describe convictions that occurred after the current conviction for offences which occurred before the current conviction.) The standard reconviction model also predicts reconvictions for a 2-year time period.

Expected or predicted reconviction rates are calculated using the Offender Group Reconviction Scale (OGRS). OGRS predicts, from a limited number of criminal history and demographic factors, the probability that an offender will be reconvicted within two years of release from prison or from the start of a community penalty for any standard list offence. Dynamic variables, such as drug use, are not included in the OGRS calculation. OGRS uses the following static variables to calculate the risk of reconviction:

- offender's age at time of sentence
- gender
- number of youth custodial sentences
- current offence group
- age at current conviction
- age at first conviction
- rate at which the offender has convicted
- history of burglary
- history of breach.

A smaller group of 137 RAPt graduates had been released for at least two years. This included graduates from the programmes at Coldingley, Downview, Norwich, Pentonville and Wandsworth. There were no data available for individuals who had dropped out of the programme before graduation. The graduates' average age at conviction was 30 years and approximately three-quarters (74%) were white, one-fifth (20%) were black and four per cent were South Asian (of Indian, Pakistani or Bangladeshi origin). The average number of previous convictions was 22, ranging from none (six graduates had not previously been convicted of a standard list offence) to 241. The most common offence resulting in the graduates' current prison sentence involved drugs; one-quarter (26%) had been convicted of a drug offence. Almost one-fifth (19%) had been convicted of burglary offences and 17 per cent had been convicted of robbery offences.

Two-year reconviction results show that 40 per cent of graduates have been reconvicted compared to an expected rate (average OGRS score) of 51 per cent. This is a reduction of 11 percentage points from the expected reconviction rate. This result is significant at the five per cent level (two-tailed binomial test). Of those reconvicted, 60 per cent had been reconvicted within twelve months of leaving prison.

Analysis of the criminal records of a comparison group of 931 offenders released from Coldingley, Downview, Norwich, Pentonville and Wandsworth in 1997, with similar ages, number of previous convictions and OGRS scores, found that 50 per cent had been reconvicted within two years of release. It is not known whether these offenders had a drugs problem. Table 6.7 below shows reconviction rates in the comparison group alongside those for graduates from the RAPt programme.

Table 6.7 Reconviction profiles of RAPt graduates and the comparison group

	RAPt	Comparison group
Average age	30	27
Number of previous convictions	22	22
Average OGRS scores	51%	55%
% reconvicted within 2 years	40%	50%

A ten percentage point difference in the reconviction rates is observed between the comparison group and the RAPt graduates; this result is significant at the five per cent level (95% probability of the result not occurring by chance).

Table 6.8 below compares the actual and expected reconviction rates by drug of choice. It shows the actual level of reconviction to be less than the expected rate for all drugs of choice except alcohol. These differences are significant at the five per cent level for those reporting opiate and poly-drug use before treatment.

The types of reconviction are also of interest. Burglary and shoplifting were the most common offences for which graduates were convicted after release; 44 per cent of those reconvicted committed shoplifting or burglary offences. One-fifth of graduates reconvicted within two years had been convicted of drug offences. This represents only eight per cent of all graduates released for at least two years.

Table 6.8 Reconvictions of graduates released for two-years by drug of choice (n=137)

	% reconvicted	Expected rate of reconviction
Opiates	33	50
Cocaine/crack	44	53
Poly-drug users	48	62
Alcohol	37	36
All drugs	40	51

It can be seen that the reconviction rates decrease with the amount of time spent with RAPt. Taking the amount of time spent with RAPt to be the difference between the date of interview and when the case closed, the reconviction rates are compared. Whereas 70 per cent of those with less than six months contact with RAPt were reconvicted within two years of release, this fell to 46 per cent of those with six to twelve months contact, 36 per cent of those with 12 to 18 months contact, 20 per cent for those with 18 months to 24 months contact and 14 per cent of those with more than two years contact with RAPt.

Aftercare is a key element of the RAPt programme and significant effort is made to link graduates to the most appropriate community treatment available to them on release. Of the 137 graduates considered here, 41 per cent received secondary care on release and less than one third of these (30%) were reconvicted within two years compared with an expected rate of 54 per cent; this result is statistically significant at the five per cent level.

Summary

Successive examinations of the impact of the RAPt drug treatment programme continue to show the effectiveness of this intervention from within prison establishments. Early research highlighted changes in behaviour whilst inside prison (Player and Martin, 1996) and subsequent studies have found the programme to have an impact on both drug use and offending once released (Martin and Player, 2000; Liriano, 2002). The one-year and two-year reconviction results show RAPt graduates to have a significantly lower rate of reconviction than a comparison group and the two-year reconviction rates are significantly lower than the expected rates for these individuals. Whilst the RAPt programme may not be suitable for all offenders with drug-misuse problems, the current policy of providing a 'mixed-

bag' of treatment styles and intensities should in theory enable those interested in addressing their substance misuse whilst in prison to receive appropriate treatment. Although the RAPt programme has growing evidence to highlight its effectiveness, work is still required for other treatment programmes currently running in prisons in England and Wales.

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7. A process evaluation of drug treatment in English and Welsh prisons

Peter Mason, Diana Mason and Nadia Brookes

The aims and methods of the research

In April 1995 the Prison Service for England and Wales published the policy and strategy document 'Drug Misuse in Prison' as part of the government's 'Tackling Drugs Together' strategy. 'Drug Misuse in Prison' identified measures to reduce the demand for drugs in prison and to rehabilitate drug misusers. The key elements were: supply reduction; mandatory drug testing (MDT) and increased treatment provision.

This evaluation, carried out by PDM Consulting between 1996 and 1998, was a non-experimental study, which looked at the effectiveness of the treatment projects in delivering a service and meeting their own aims and objectives. The study covered the process of setting up the services, the content and delivery of those services and the impact of the programmes on the prison and the prisoner. Most services were within the first year of implementation.

The study objectives were, as far as possible:

- to analyse and evaluate drug programme processes;
- to analyse and evaluate the critical success factors of the programmes;
- to measure the impact of the programmes on prisoners, prisons and staff;
- to compare different types of programmes;
- to analyse and offer guidance on service development and contracting; and
- to make recommendations to inform the Prison Service drugs strategy.

The requirements included: evaluation of programme content, structure and intermediate outcomes; independent performance and contract management audit; and a report on the costs and benefits of the drug treatment programmes. The project did not include a longer-term outcome study.

The study also involved a large-scale survey, successfully completed by 1,110 prisoners, in nineteen locations. The sample was predominantly male (90%) and white (86%).

Questionnaires were given to prisoners on entering treatment and on leaving. Participation was voluntary. The self-completion questionnaires included variables on demographics, drug history, criminal history, dependency, readiness to change and a number of items known to be significant for drug-using offenders. Given the lack of any physical testing for drug use, self-report results need to be treated with appropriate caution.

Prisoners' concerns over the questionnaires mostly related to the use of the prison number. The information sheet assured them of confidentiality, and that personal information would not be given to either the Home Office, or the prison or the programme staff (the staff of one programme interpreted the latter negatively). In some cases the prisoners who were not reassured refused to complete the questionnaires; others did complete them but left blank the space for their prison number. In any event, the returned questionnaires were completed with a seemingly high degree of compliance, although some misunderstood one key question. There were very few spoilt papers.

The programmes and the prisons

After some initial piloting, 21 treatment programmes were evaluated in 19 locations. In one of these prisons, there was a voluntary testing unit (VTU), without any treatment programme, which was also assessed. The main types of treatment programme were:

- counselling, advice, education and throughcare (CAET)
- enhanced drug detoxification units (detox)
- 12-step programmes
- residential rehabilitation drug treatment units (rehabs)
- cognitive behavioural
- harm reduction/education
- modified therapeutic community (modified TC)
- therapeutic community (TC)

The programme delivering counselling, advice, education and throughcare (CAET) is a screening and support service, which has since become known as CARAT (Counselling, Assessment, Referral, Advice and Throughcare).

Two models of contracting were used by the Prison Service, for delivering drug treatment services. First, there were directly managed services: prisons redeployed existing resources and/or directly employed additional specialist staff (i.e. nurses and drug workers) to

develop the enhanced services. Detoxification services in Prison One and Prison Two were directly managed by the prison concerned (see Table 7.1).

Secondly, there were externally contracted independent providers. Most of these were with established community drug treatment providers. One was a statutory drug service provider, the remainder were from the voluntary sector. In Prison Three a National Health Service (NHS) specialist clinical drug treatment service was contracted to provide services to support the directly managed health care services. In Prison Eight an external agency provided programme development and staff training.

The 19 prisons (or, in three instances, clusters of prisons) involved in the research were those formally designated as pilots under the drugs strategy, and covered the range of security types for men, women and young offenders, both sentenced and remand. The largest group of prisons was category C trainers.

Over the one-year monitoring periods which occurred at different times in different prisons (between January 1996 and December 1997), a total of 6,623 prisoners made contact with a drug treatment service (n=3,820) or simply with CAET (2,803). They constituted the full group in the contract monitoring data. As shown in Table 7.2, of the 3,820 prisoners who were assessed by a drug treatment service, 2,500 (65%) entered a treatment programme, including detoxification. Of those who started a programme, 1,754 (70%) were reported to have completed it or graduated. Of the other 30 per cent (n=746), most (n=621) did not graduate, though some (n=125) some were still in treatment at the end of the monitoring period.

A separate study was made of a group of 1,118 prisoners who entered a planned programme of treatment (this group included some but not all of those mentioned in the previous paragraph as entering a treatment programme). At this very early stage in the development of drug treatment facilities in prisons, some of these programmes experienced high rates of attrition during the year-long monitoring period. Altogether, 55 per cent of those starting a programme did not complete it. In particular, at this point in the early development of drug treatment in prisons, TCs (therapeutic communities) had high attrition rates. The reasons for this are discussed in more detail below (see Table 7.5), and include the fact that such programmes are relatively lengthy, so that some people were still taking part at the end of the monitoring period.

Table 7.1 Nineteen prison locations and their treatment programmes, involved in the evaluation

Prison	Category	Programme / Service
Prison One	Local and remand	10-bed detoxification unit 8-place 12-step relapse prevention unit
Prison Two	Local and remand	7-bed detoxification unit
Prison Three	Women's remand closed	33-bed detoxification unit 33-bed 12-week residential programme
Prison Four	Local and remand	20-place 12-step programme
Prison Five	C trainer	24-place 12-step group programme
Prison Six	B trainer	28-bed 12-week residential programme
Prison Seven	C trainer	32-bed 3-month residential programme
Prison Eight	B trainer	65-bed therapeutic community
Prison Nine	C trainer	84-bed therapeutic community
Prison Ten	Young Offenders Institute (YOI) closed	72-bed therapeutic community
Prison Eleven*	A	Sessional drug worker – CAET service
Prison Twelve*	C trainer	Sessional drug worker – CAET service
Prison Thirteen*	C-D	Sessional drug worker – CAET service
Prison Fourteen*	B, C and YOI	Sessional drug worker – CAET service
Prison Fifteen*	Women's open	Sessional drug worker – CAET service
Prison Sixteen*	YOI closed	Sessional drug worker – CAET service
Prison Seventeen	YOI remand & sentenced	Full-time drug worker – CAET service
Prison Eighteen*	Contracted	Sessional drug worker – CAET service
Prison Nineteen*	Contracted	Sessional drug worker – CAET service

Note: *=A 'cluster' of prisons where sessional drug workers were provided by one agency.

Table 7.2 Involvement of prisoners in different types of treatment

	Detox, Planned	Detox, acute	12-Step	Rehabs	TCs	Totals
No. applied			758	878	644	2,668
No. assessed (percentage)	529	1,770	449 (59%)	491 (56%)	581 (90%)	3,820
No. started (percentage)	213 (40%)	1,382 (78%)	200 (45%)	337 (69%)	368 (63%)	2,500
No. completed (percentage)	147 (69%)	1,382	91 (46%)	91 (27%)	43 (12%)	1,754
Non-completed	64 (30 %)	-	96 (48%)	176 (52%)	285 (77%)	621

Notes: Source was contract monitoring data. Numbers applying for detox were not available. Numbers completing/not completing were affected by a range of factors including length of programmes. At the end of the contract monitoring period, 125 prisoners were still participating in programmes. The acute detox data were incomplete; the figure given for completion was the same as that for starting.

Key factors that influenced programme participation and completion rates were:

- whether participants had enough time left to serve in which to complete the programme;
- 'threshold' or ease of access to the service;
- level of treatment intensity and whether the programme was modular or phased;
- level of supervision: the extent of urine testing and segregation; and
- action on drug use: whether it involved instant dismissal, suspension or a series of warnings.

Treatment was not always trouble-free (as shown by data from security sources and treatment provider reports). Over the twelve month monitoring period, 300 adjudications were carried out on the treatment programme population and there were 56 untoward incidents. In addition, 346 misconduct reports were filed on prisoners in the TCs.

Characteristics of prisoners entering treatment

Altogether, 1,110 prisoners took part in a confidential questionnaire survey, completing at least one questionnaire. They reported high levels of drug use.

- The two drugs most often reported as being used in the four weeks before imprisonment were cannabis and heroin. Respective prevalence rates were 64 per cent and 60 per cent.
- The same two drugs were also most often reported as being used in the last four weeks while in prisons. Equivalent rates were appreciably lower in prison, at 50 per cent (cannabis) and 34 per cent (heroin).
- In the four weeks before entering prison, 33 per cent reported having injected a drug.
- Injecting behaviour within prisons was far less commonly reported. Just two per cent reported that they had injected in prison, during the last four weeks.

Given these relatively high levels of drug use, it is unsurprising that a majority (51%) of those seeking treatment while in prison had also received treatment at some point before entering prison. However, only a third (34%) had reported any contact in the month before coming into prison. Methadone maintenance or other prescribing were the most frequently reported forms of previous treatment.

It is also unsurprising, given the well-documented links between problematic use of drugs and alcohol, that many of those prisoners seeking treatment for drug use had, in addition, difficulties with alcohol. Respondents were asked if they had 'a drink problem', to which 30 per cent answered 'yes'. A smaller proportion (16%) reported having used alcohol during their current sentence of imprisonment. Although primarily geared to drug users, the treatment programmes organised by the Prison Service appeared to be attracting some people who, either additionally or instead, had a drink problem.

Use of drugs impinged widely on the lives of the prisoners. At the point of entry into treatment, 81 per cent stated they were currently drug-free; while 30 per cent reported that they were in 'withdrawal' from drug use. Looking back over the previous four weeks in prison, 73 per cent stated they had been offered drugs, 60 per cent had refused drugs, 42 per cent had accepted an offer of drugs and 26 per cent had sold or exchanged things for drugs.

Perhaps the best indicator of the relatively serious and damaging patterns of drug use on the part of the prisoners lies in their injecting behaviour. As previously mentioned, a third reported injecting a drug in the four weeks prior to going to prison; two per cent reported injecting during the last four weeks while actually in prison. Over half the sample (55%) had injected at some point in their lives. This amply demonstrates that those entering treatment tended to be problematic drug users. In a contemporaneous sample of the prison population as a whole, as surveyed by the Office for National Statistics, only a quarter reported any experience of injecting drugs, at any time in their lives (Singleton et al., 1999). Moreover,

as shown by Table 7.3, levels of injecting were relatively high across the different types of treatment, although the detox group had, fairly consistently, comparatively high rates of injecting. Some contrast between those in detox and the other programmes is however to be expected; detox units cater primarily for prisoners, including recently arrived ones, whose drug use is likely to be chaotic.

Table 7.3 Injecting behaviour of those entering different types of treatment

	Detox		12-Step		Rehabs		TCs		Total	%
	No.	%	No.	%	No.	%	No.	%		
Ever injected	81	62	87	48	96	50	190	59	454	55
Ever injected with used equip.	41	32	38	21	44	23	69	22	192	25
Injected in 4 wks before prison	60	37	60	31	62	31	108	33	290	33
Injected with used equip in 4 wks before prison	31	23	5	9	23	16	24	9	83	14
Ever injected in prison	22	17	28	15	33	16	53	16	136	16
Ever injected with used equip. in prison	13	10	14	7	19	10	28	9	74	9
Injected in last four wks in prison	11	8	0	-	0	-	1	<1	12	1.5
Injected with used equip. in last four wks in prison	5	4	0	-	0	-	0	-	5	<1

Notes: The source was the survey of 1,110 prisoners involved in treatment. Baseline numbers varied for different questions, as not all respondents answered every question.

The sharp contrast between levels of injecting in 'four weeks before prison' and in 'last four weeks in prison' appears to suggest that respondents modified their injecting behaviour in prison. Also, that while some had injected in prison in the past, this was not a part of their current behaviour. It is possible that most prisoners who inject only do so very rarely. Shewan et al. (1994) found that prison was a modifier of drug behaviour and that current injecting in prison was confined to a small but significant minority of prisoners.

Drug testing was, for many of those in the sample, a familiar feature of prison life. At the point of entry into treatment, 76 per cent had been urine tested during their current sentence of imprisonment; the average number of tests was four. Just one per cent had refused a test. Almost a third (32%) of those tested had tested positive for their last test. Of these positive tests, 53 per cent were for cannabis, followed by heroin (24%) and other opiates (16%).

Finally, the sample comprised experienced offenders, in particular those convicted of offences against property. Over three quarters (78%) had been in prison before. They had been in prison on average five times previously, ranging from 0 to 40 times. The average time they had already spent in prison was twelve months, and the average time sentenced prisoners had left to serve was 17 months. The main current offence was burglary (23%), followed by robbery (19%), drug offences (15%), theft (13%) and violence (12%), with small numbers convicted of handling stolen goods (3%) and fraud (1%). Of the 849 who answered the question, 88 per cent stated that they had been on drugs at the time of offence.

Differences between those completing and not completing treatment

In this evaluation, some interesting differences were found between those completing and those not completing treatment. To summarise, while completers and non-completers did not vary greatly in their levels of offending, completers had more serious histories of drug use prior to going to prison. This is shown in the Table 7.4, which is based on subgroups of 272 completers and 136 non-completers.

Table 7.4 Background variables differentiating adult completers and non-completers

Variable	Completers (n=272)	Non-completers (n=136)
Average age	30	27
Ethnicity	90% white	89% white
Main conviction	26% robbery	27% burglary, 27% robbery
Housing - unstable or NFA	20%	12%
Main source of income	58% benefits, 29% crime	58% benefits, 35% crime
Criminal activity 1 month prior to prison*	57% theft, 31% property, 29% dealing	63% theft, 59% property, 42% dealing
In prison before	80%	77%
Average age first drug use	15	14
Drug use 1 month prior to prison**	80% cannabis, 62% heroin	46% cannabis, 35% heroin
Daily drug use 1 month prior to prison**	51% cannabis, 49% heroin	41% cannabis, 27% heroin
Drug use last 4 weeks (in prison before entering treatment)**	51% cannabis, 43% heroin	49% cannabis, 43% heroin
Daily drug use last 4 weeks (in prison)**	17% cannabis, 11% heroin	28% cannabis, 23% heroin
Injecting with used equipment in last 4 weeks***	3%	X

Notes: The 'non-completers' are those who were either dismissed from their programme or left of their own accord; those who left for other reasons (transfers or release) are excluded from the table. The baseline for all background variables is 272 for completers and 136 for non-completers. The information for all such variables was drawn from the survey of 1,110 prisoners entering treatment; hence 'last four weeks' refers to last four weeks in prison before preparing to enter treatment. X denotes missing data.

* prisoners may have been involved in more than one criminal activity.

** prisoners may have used more than one drug, the two main drugs only are shown.

*** refers to needles and syringes.

The broader and varied picture in terms of all non-completions is shown in Table 7.5. Of the full group of 621 who did not complete detox, 12-steps, rehabs and TCs, 289 (47%) left through choice, transfer and/or release by the courts; 201 (32%) were told to leave for drug use and 131 (21%) for discipline offences.

Still focusing on the contract monitoring data, 255 prisoners were reported as receiving follow-up, aftercare or as being discharged to community drug treatment or probation. The majority of these were receiving aftercare in prison, as they had not been released. The aftercare varied considerably from placement on a Voluntary Testing Unit (VTU) to visits from programme staff whilst in the normal location. In some cases there was little or no aftercare.

Table 7.5 Completion and non-completion rates for different types of treatment

	Planned detox (n=211)		12-Step (n=184)		Residential rehabs (n=267)		TCs (n=328)		Totals
Complete	147	70%	91	49%	91	34%	43	13%	372
Left – drug use	20	9%	31	17%	69	26%	81	25%	201
Left – discipline	11	5%	9	5%	35	13%	76	23%	131
Left – chose to leave	7	3%	24	13%	16	6%	35	11%	82
Left – transfer	9	4%	29	16%	4	1%	27	8%	69
Release and other	17	8%	3	2 %	52	19%	66	20%	138
All non-completers (as % of total ns)	64	30%	96	52%	176	66%	285	87%	621

Notes: Source is the contract monitoring data.

Delivery of treatment programmes: key findings

This section summarises the main findings concerning the initial delivery of new treatment systems. It starts by listing benefits for prisons (primarily for those parts of prisons directly involved in delivering treatment). This is followed by the benefits for prisoners (primarily for those prisoners receiving treatment). Difficulties or 'negative impacts' are then specified, followed by other issues that remain unresolved. Overall, benefits clearly outweigh any difficulties, although important issues remain to be clarified or addressed.

General treatment impacts on prison

- reduced numbers of violent incidents and bullying compared to similar sized locations
- reduced numbers of adjudications and rule infractions involving treatment group

- improved quality of prison life as recorded on satisfaction measures
- cleaner and tidier environments
- increased periods of association and time out of cell
- lower levels of MDT positivity in residential sample
- improved health care in enhanced detoxification units
- reduced staff sickness on VTU compared to comparative size unit

General impacts on the prisoners

- reduced drug taking
- reduced drug-seeking behaviour and reduced consequences of buying drugs
- improved readiness-to-change scores in detoxification units
- more positive attitudes in 12-step and residential programmes
- increased responsibility and day-to-day involvement in running of the wings in TCs
- increased positive regard for prison regime in most programmes
- improvements in health and control of withdrawal in detoxification
- improved access to hepatitis vaccine on one enhanced detoxification unit
- improved relationships with other prisoners and staff

Negative impacts

- population pressures impacting on programme autonomy
- reduced work opportunities for some prisoners
- isolation at weekends
- some institutional resistance from prison staff
- follow-up and aftercare and throughcare poor
- high staff turnover on the part of some external providers
- prison staffing and detailing problems for in-house staff
- lack of prison staff training
- poor fit between some units and length of time to serve

Other issues

Key factors that influenced programme completion rates included variations in

- time and length of treatment in a prisoner's sentence, and whether participants had enough time left to serve in which to complete the programme;
- variations in the 'threshold' or ease of access to the service, with residential rehabilitation programmes appearing to take more difficult prisoners;

- level of treatment intensity, and whether the programme was modular or phased;
- level of supervision; extent of urine testing and segregation; and
- level of action on drug use, whether instant dismissal, suspension or 'three strikes'.

Costs of treatment

An analysis of the cost of providing drug treatment in prisons was conducted using data from the tender documentation, information from the Prison Service Directorate of Health Care and contract monitoring.

Table 7.6 shows the cost to the Prison Service of the pilot counselling, advice, education and throughcare (CAET) services. The cost per prisoner and the cost per session were calculated. A session was defined as an occasion when a prisoner attended a meeting with a drug worker for individual counselling.

Table 7.6 Cost of CAET services at 1996 community and prison prices

Cost per prisoner	£83
Cost per session	£35

Table 7.7 shows the costs of providing services in the other types of programme. The cost per bed night, cost per available place and cost per completion were calculated. The cost per bed night assumes 100 per cent occupancy. The numbers for completion were supplied by the treatment service providers.

Table 7.7 Cost of in-patient and residential services at 1996 community and prison prices

Item	Rehabs	Detox –all	12-Step	TCs
Cost per bed night	£10	£55	£24	£16
Cost per place	£3,606	£20,109	£8,803	£5,669
Cost per completion	£4,992	£3,275	£4,945	£227,479

Note: Cost per place is on an annual basis. The very high costs per completion for TCs should be interpreted with great care, as they reflect, among other reasons, the fact that some participants were still taking part at the end of the one-year duration of the study, and the fact that this was very much the early development phase.

The cost per completion is higher than the cost per place for residential rehabilitation and for TCs, as not all participants completed a programme of treatment. In particular, as noted earlier, the cost per completion is artificially high for the TCs as few prisoners completed the full course of treatment in a TC in the year under study, due partly to the length of those programmes. The cost per place in the detoxification programmes is high due to the additional costs of medical and nursing staff combined with the low number of places in two locations (Prisons One and Two).

Table 7.8 presents the prison drug treatment costs compared with figures reported by the National Treatment Outcome Study (NTORS) and those supplied by a local health commissioning authority. It shows that the cost of providing drug treatment in prison is comparable to the other two sources of treatment costs. However, the prison treatment costs include the fixed overheads of keeping someone in prison, costs that do not apply in community settings. The full costs are shown as these are costs to the Prison Service for individuals in treatment.

Table 7.8 Comparison of prison drug treatment costs with community services

Service	NTORS	Local Health Authority	Prison (inc. prison costs)
Counselling	£33 per client visit	£30 per session	£35 per inmate visit
Residential rehabs/TCs/ 12-steps	£461 per resident week		£432 per inmate week (residential) £380 per inmate week (TC) £440 per inmate week (12-steps)
In-patient detoxification services	£327 - £560 per resident week	£153 per bed night	£562 per inmate week £132 per bed night

Note: For counselling, prison costs are not included in the treatment costs.

Conclusions

- An ambitious project of expanding drug treatment in prisons was making good progress at a time when population pressures were reaching unprecedented levels.

- Drug-using offenders were attracted into programmes and a large number completed treatment.

- Overcrowding pressures had a major negative impact on some programmes and de-stabilised continuity and intensity of treatment.

- Drug use continued to be a problem within the prison system, and cannabis use was particularly problematic in both ordinary and therapeutic locations. Cannabis remained the most frequently reported drug of use; a large number of prisoners who entered treatment were unable to complete due to continued drug use, principally cannabis.

- Completion rates for residential rehabilitation programmes appeared to be similar to those in the community, and the costs of service provision comparable. The most expensive services were clinical detoxification services provided through health care centres but these were still cheaper than NHS services.

- External contracted providers settled in prisons and many were working alongside prison staff in mixed teams. There was a high level of institutional resistance to outside providers, and drug treatment in particular, from some parts of the uniformed service. These tensions were slowly reducing and collaboration was improving as drug treatment providers became more experienced and trusted in the prison system.

- Many of the drug programmes, including the large scale Therapeutic Communities, remained unstable and required added support to help isolate them from external contamination within their prisons.

- Drug detoxification programmes can increase safety and effectiveness in the administration of methadone through the implementation of relevant guidelines (Health Care Standard 8). However, introducing these measures will require more resources for health care centres that are located in local and remand settings.

- Counselling, Advice, Education and Throughcare (CAET) services were found to be useful flexible services, able to provide a range of interventions for prisoners and prisons staff. Drug workers were able to increase throughcare links and act as a resource for the prison.

- We found that, in some services, prisoners had limited amounts of treatment and there were no standardised outcome monitoring systems.

- Aftercare and follow up in the prison system was particularly poor and few services had voluntary testing units in which to place treatment completers or those awaiting primary treatment.

- We assessed each programme performance by analysing the contract monitoring data for 905 prisoners who entered the residential rehabilitation, 12-step and Therapeutic Community programmes in a one-year period. As shown within Table 7.5, we found that of the prisoners who entered these three types of treatment, 225 completed to the defined graduation point (usually having remained for the length of the treatment programme). Over twice as many (n=557) were either dismissed for negative reasons following drugs or discipline problems (n=301), or left for other reasons (n=256).

- The residential rehabilitation programmes seemed to be picking up more applications as they became more settled. However, there was under-capacity in some of the large TCs, despite being national resources. This may have been due to the location of the prisons and/or prisoners' resistance to treatment.

- These programmes made some impact on roles and responsibilities within the units by establishing encounter groups which confronted the 'non-grassing' prisoner codes. However, prisoners commented on the need for safety and longer-term protection if they were to move back into the ordinary prison location.

- Prison officers and drug treatment staff reported a marked difference in the behaviour of prisoners and relationships between prisoners and staff in the new programmes. Impacts were found on a range of indicators including: improved health; reduced drug taking and seeking; increased knowledge; changed attitudes; and positive regard for the prison regime.

- Regimes were enhanced, and adjudications and violent attacks on prisoners and staff within units were reduced compared to other areas. Levels of adjudications and untoward incidents were very low in the treatment units compared with similar size wings.

- The urine testing regimes varied considerably across the treatment programmes as did the reasons for ejection from a unit. It was most common for inmates to be tested less than once per month.

- It was noted during the study period that most programmes changed requirements for drug testing and that the criteria for dismissal following positive in-treatment drug tests varied from 'one strike and out' to 'three strikes and out', with additional individual case-by-case flexibility, due to the difficulty in controlling drug use on the units.

- We were unable to identify the true and real costs of providing drug treatment services within prisons, as it was difficult to separate treatment costs from other prison costs.

- Prison officers, in many cases, showed marked enthusiasm to embrace drug treatment and rehabilitation principles and to actively learn drug treatment and counselling skills. However, discipline staff and nurses were often unable to attend training as planned and were frequently detailed from therapeutic duties to support other prison requirements.

- The characteristics of prisoners entering programmes varied across modalities. Many reported problem drug use (high rate of heroin use); 50 per cent had little or no history of treatment; and long criminal histories were reported.

- Prisoners rated programmes to be of use and offered constructive comments for realistic enhancement of the programmes (overcrowding issues aside).

- The prison drug treatment and rehabilitation programmes made a significant impact on improving regimes and opportunities for prisoners in many prison establishments. The emphasis on community-based and self-directed change through peer involvement and confrontation changed the prison culture and prisoner codes. Peer counsellors and supporters were beginning to be established in many programmes.

- Many prisoners were taken into programmes with an insufficient length of time to serve to complete the core programme.

- The information from this evaluation of prison drug treatment is now available to make recommendations and to develop guidelines for drug treatment in prisons and to support the prison service strategy review.

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8. Management of drug-using prisoners in Leicestershire

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Introduction

The research reported on here was conducted in the late 1990s during a time of wide-ranging change as the Prison Service and individual prison establishments sought to develop their drugs strategy in line with the Government's national strategy (Home Office, 1995; HM Prison Service, 1995). Our research formed part of the approach of senior managers, in three Leicestershire prisons, to developing their local strategy. Very early during the course of the research Mandatory Drug Testing was introduced into all prison establishments, including the three male prisons in this case study. These were Stocken, Ashwell and Leicester, two relatively low-security ('Category C') and one general-purpose ('local') prison.

In this chapter, we start by considering the extent of drug use before imprisonment, together with drug use in prison and its links with prior use. We then consider actual and potential management responses in prison for reducing demand and for working in partnership with community agencies and with families. Our analysis is based on a wide range of data collected in 1996-7 from interviews, surveys and other sources, of 240 adult male prisoners, over 200 prison staff, a small group of ex-prisoners, visitors to prisons, probation officers and staff working in community drug agencies.

Drug use prior to imprisonment

We looked first at drug use before imprisonment. In so doing, we chose to focus on prisoners' lifetime use of drugs and also their use one month prior to this period of custody. We found that 85 per cent of prisoners reported using drugs at some point in their lives and 66 per cent reported using drugs one month prior to custody.

Prevalence rates give only a limited indication of the nature of the problem, however. For this, a more in-depth analysis about the type of drugs used, the frequency and pattern of use, and the method of use is required. Such an analysis produced a complex picture. On the basis of this picture, we found that a fairly accurate assessment of prior drug use could be provided by focusing simply on month prior use. The prevalence rate dropped but primarily because a considerable degree of experimentation was excluded; and, whilst drug use was focused around a smaller number of drugs, cannabis, amphetamine and ecstasy remained the most popular. Since prison populations are subject to constant change, particularly those in busy local prisons, this is not an insignificant point. In order to focus and monitor their drug strategy, prisons will need to conduct regular needs analyses and these require resources. Focusing on only one aspect of drug use - month prior use - limits the amount of analysis needed.

Our more detailed picture of month prior use revealed that less than a fifth (16%, n=39) of the total sample had used cannabis only, whilst half (50%, n=120) had used drugs other than cannabis. Overall, the most popular drug was cannabis which was used by 90 per cent (n=143) of drug users. But more than half (54%) of those using drugs other than cannabis reported using amphetamine, a third (33%) had used ecstasy, more than a quarter (28%) had used heroin and crack, whilst around a fifth had used cocaine (23%) and tranquillisers (21%).

When we focused on the extent of use, we found that nearly three-quarters (71%, n=113) of month prior users reported dependent use of drugs: 31 per cent of cannabis (half of this group used cannabis only) and 40 per cent of other drugs. In addition, nearly a quarter (23%) of month prior users, who had not reported any dependent use, reported regular use of drugs: seven per cent used cannabis only and 16 per cent used other drugs (in three of these cases cannabis was the only regular drug used).

In terms of method of use, we found that 16 per cent (n=38) of the total sample but nearly a third (32%) of those using drugs other than cannabis reported injecting drugs in that month. The majority (92%) were dependent users.

We considered the additional issue of first use of drugs in prison. There has been some debate about the effects of prison sentences on drug-using careers (Advisory Council on the Misuse of Drugs/ACMD, 1996) particularly the issue of whether drug-using careers begin or escalate during periods of incarceration. We found that only a handful (6) of men reported starting their drug-using careers during a prior period of imprisonment. On the other hand, 16 per cent (n=32) of prior lifetime users reported first using a particular type of drug during an earlier period of imprisonment and nearly half (47%, n=15) of this group

reported first using heroin in prison. This is an important issue, and one to which we return below, since it indicates some switching and experimentation with various substances prior to the implementation of MDT.

In order to 'track' the prisoners and their drug use through the prison system, we categorised them into four potential 'needs' groups: high, medium, low and no immediate need. In so doing, we gave priority to a number of factors either singly or in combination: month prior use, dependent use, injecting, and use of drugs other than cannabis.

On this basis, we categorised approximately a third (33% n=80) of the men as high need, approximately a quarter as medium (29% n=69) and low need (23% n=54), and only 15 per cent (n=37) as having no immediate needs.

When we examined the men's personal characteristics, their offending behaviour, and their social situation and health before custody, we found that those who were most drug-involved prior to imprisonment (the men in the medium and high need groups) appeared to form a distinct cadre. In many respects, these men were the failures of the system: they typically had had extensive contacts with various criminal justice agencies over a number of years and, often, their offending behaviour was inextricably linked with drug use.

Three further issues, which may have implications for tackling the problem of drug misuse in prison, became apparent from our analysis of the differences between 'needs' groups. First, few prior users had tried to obtain help with their drug use and so, contrary to the recommendations of the ACMD (1996), little information would be available in the community in order to help with identification of drug users in prison. Second, drug misuse varied little according to sentence length. Thus, in some cases, the most that might be achievable in a prison setting would be to encourage drug-users to recognise their problems and to seek help on release. Remand prisoners would also pose particular problems. Third, the men demonstrated a lack of knowledge about Hepatitis B and C, particularly the latter condition, and its method of transmission. A significant minority of these men had engaged in intravenous drug use, a sizeable proportion of this group reported 'risky' injecting practices, and a handful of men had done this despite the knowledge that they had already tested sero positive to this condition.

Drug use in prison

More than two-thirds (70%) of the 240 prisoners interviewed reported using drugs during this current sentence/remand: 34 per cent had used cannabis only; 36 per cent had used

other drugs; which left 30 per cent reporting no use of drugs. This prevalence rate was very similar to the 75 per cent reported by Edgar and O'Donnell (1998) in their evaluation of Mandatory Drug Testing in prisons.

On the basis of a closer examination of drug use in prison, we want to stress five points. First, drug use in prison was closely related to prior drug use: men in the high need group reported the highest level of drug use and the highest level of use of drugs other than cannabis. Thus, the problem of dealing with drug use in prison requires both the identification of and then engagement with the most drug-involved men prior to prison. This may pose particular difficulties. We return to this issue below.

Second, cannabis was the most commonly reported drug and was used by 96 per cent of men using drugs in prison. But around half (51%) of these men also reported using drugs other than cannabis. Heroin was the second most popular drug and was used by around a quarter (23%) of the total sample, a third (33%) of the total prison drug-users and a sizeable majority (64%) of those using drugs other than cannabis. Overall, the most popular substances in prison were those which offered a relaxing or soporific effect (40% of men using drugs other than cannabis reported using tranquillisers) but, even so, a sizeable proportion had used stimulants (34% of men using drugs other than cannabis reported using ecstasy, 26% amphetamines, 15% cocaine and 21% crack).

There was a considerable degree of similarity between our prevalence rates, for individual drugs, and those reported by the ACMD (1996) although they omitted to ask about tranquillisers. Our view was, therefore, that anonymous surveys, of the type deployed by the ACMD, could be a valuable tool for eliciting basic information about levels of drug misuse in prison.

Our third point is that, in order to ascertain the exact nature of drug misuse in prison, the key question concerns patterns of use rather than prevalence rates. In order to assess these, we distinguished between daily, weekly, monthly and less than monthly use of different drugs. In relation to the men using cannabis only, we found that around half (49%) reported that, at its maximum, their use had been daily; more than a quarter (29%) had used only weekly; and a quarter (22%) had never reached, at maximum, weekly use. A greater proportion (70%) of men using drugs other than cannabis reported, at most, daily use; around a quarter (22%) reported weekly use; and only seven per cent reported that, at most, their use had never reached a weekly level. But two-thirds of the men reporting daily use associated this with cannabis only. A very similar picture emerged when we examined weekly use in more detail. When we looked

at individual substances, for the majority of heroin users, the frequency of use never reached a weekly level. Only a handful of men reported daily or weekly use of tranquillisers, which was the third most popular substance. Except for two responses, all use of any other drug never reached weekly levels.

Our fourth point demonstrates our agreement with the ACMD (1996), although we came to our conclusions by a somewhat different route. In the three Leicestershire prisons from which our samples were drawn, drug use was dominated by the use of cannabis. Heroin was the second most popular substance in prison but the data, however presented, did not indicate an extensive heroin problem in these three prisons. Nine per cent of total drug-users claimed daily use of heroin and three per cent weekly use. These figures rose to 29 per cent and nine per cent respectively when we focused on heroin users.

Our final point is that, in terms of size, intravenous drug use was not a problem in any of the three prisons: only five men had injected in prison and only two had injected in the establishments under study. But the size of the problem was not the only issue. Three of these five men had been included in our group of 'risky' injectors in the community, one of whom had tested sero positive to hepatitis C. All three men had, at some point in prison, cleaned their equipment less than efficiently and two had shared equipment.

At this point, we turned our attention to two contentious issues concerning drug use in prison: the extent to which prisoners leave prison with a greater or lesser drug problem than when they entered; and the problem of switching from cannabis to 'harder' drugs following the implementation of mandatory drug testing.

In terms of the first issue, we examined three factors: first use of drugs in prison; first use of specific substances in prison; and changes in type and patterns of use during imprisonment.

Ten men had used drugs for the first time during the course of this sentence/remand (in eight cases this was cannabis only). This resulted from a degree of experimentation, which in some cases was related to the absence of alcohol, and only one of these men continued to use any drugs at the time of our research.

A much larger number (n=31) of prior drug users had used a specific type of substance for the first time during this sentence/remand. The majority (n=22) first used only one substance and here heroin featured largely (n=18) although nine men reported first use of tranquillisers in prison. The men most drug-involved prior to prison were more likely to report a broadening of their drug use.

In terms of increases or decreases in levels of use during imprisonment, we found that 96 men reported a decrease in drug use and 45 men claimed to have increased their use. The decreased use arose because: 19 men (12% of month prior users) had ceased use in prison; 36 men (30% of month prior users of drugs other than cannabis) had limited their use to cannabis only; and 41 men (26% of month prior users) reduced their frequency of use - six had previously used cannabis only and 35 had used other drugs.

The increases in use were made up of: the ten men (discussed above) who had first used drugs during this period of custody/remand; 19 men who had resumed using drugs in prison whilst not using one month prior (13 used cannabis only and six used other drugs); nine men who had begun using drugs other than cannabis in prison whilst using cannabis only one month prior; and seven men who reported using drugs more frequently - three men were users of cannabis only and four men users of drugs other than cannabis.

Of most concern was the fact that 47 men (30% of our month prior drug users) reported no change in drug use whilst in prison. Approximately two-thirds (n=31) of these men were using drugs other than cannabis one month prior to custody and more than half (25) of these 47 men continued to use drugs daily in prison.

The second contentious issue concerns the problem of 'switching' which is said to occur because cannabis is detectable in the system for a longer period. We found little evidence of switching from cannabis only use to use of drugs other than cannabis: eleven men using drugs other than cannabis prior to MDT reported using cannabis only after its implementation, and five men reported using cannabis only prior to MDT but used drugs other than cannabis after its implementation. All five, however, continued to use cannabis although three had decreased their frequency. However, their use of other drugs was far from extensive – only one used heroin daily, one used heroin a few times, two had tried crack once or twice, and one had used ecstasy once or twice.

This lack of 'switching' may result from four factors, either singly or in combination. The majority of men thought that a positive test could be avoided. The impact of MDT may not have been felt at the time of our research - more than three-quarters of those testing positive had thought that a positive test could be avoided. The frequency of cannabis use was such that the men may have thought that their drug use would not be detected - around half of the men used cannabis weekly or less than weekly. Finally, heroin was not the preferred drug of the majority of men using drugs in prison: 72 per cent preferred cannabis and only six per cent preferred heroin.

Whatever the reason or reasons, our findings are not dissimilar to those reported by Edgar and O'Donnell (1998) from their research evaluating the impact of MDT: only four of the 111 prisoners using drugs in prison had tried heroin for the first time, none persisted in this use, and their use of cannabis was reduced rather than stopped completely.

The point we would stress at this stage, however, is that great care needs to be taken in interpreting aggregate changes in the use of heroin and other substances pre- and post- MDT. We have already shown that some prisoners may begin or return to the use of heroin and other substances in prison but it takes a conceptual leap to attribute these changes, solely, to MDT.

Responses in prison: reducing demand

The Prison Service has acknowledged the need for prisons to tackle the demand for drugs as well as the supply of drugs (Prison Service, 1995). Tackling demand requires the identification of drug-users and the assessment and addressing of their drug-related needs at various stages in the prison system.

Identification of individual users requires: the encouragement of disclosure; a skilled interviewer to facilitate this; documentation sufficient to make an informed assessment of needs; and documentation which can be shared with staff in other functions in the prison. We found little evidence to suggest that this was happening through reception procedures, induction, sentence planning, prison probation, shared working, education, or support in the form of listener schemes and the chaplaincy. We also found problems of disclosure to uniformed staff, because of the conflict between their security/control and welfare functions, and problems of disclosure to peers. Finally, we identified problems with disclosure outside a medical setting in terms of how the information was then recorded, shared and acted upon.

Our recommendations were that any disclosure on drug misuse needed to be recorded on a standard pro-forma and that this information should remain confidential - if it did not, the number of disclosures would soon go down. But the fact that it was confidential should not preclude access to such information for staff with specific responsibilities. Indeed, the sharing of information was crucial to the subsequent assessment of needs and the targeting of specific responses to those men who most needed them.

More importantly, summary assessments of these forms at regular intervals could inform senior managers of the extent of disclosure, the extent and type of drug misuse presented, and the programmes to which these men were directed and such forms could be used for notifications to the Regional Drug Databases (now the National Drug Treatment Monitoring System).

But identification performs another key function in that it is the basis on which to plan the services which might be provided in a specific prison. This type of identification requires a systematic survey of prisoners. Such surveys need to be anonymous in order to remove concerns about the effects of disclosure and require to be repeated at regular intervals because the needs of prison populations will be dynamic, particularly in the local prisons.

Our view was that programmes and services could be systematically planned on the basis of such surveys. Furthermore, comparison of the summary assessments of individual disclosure, in terms of type and extent of drug misuse, with the results of these surveys would give senior managers a clear idea of the extent to which individual drug-users were successfully identified for treatment.

Assessment of needs is crucial to effective service delivery, particularly where resources are limited and require targeting to those most in need. It follows that, if the identification of needs should be of two different types (to ascertain individual needs, and to plan programmes and services), then so should needs assessments.

We suggested that assessment for the development of programmes and services needed to consider the results of the anonymous surveys and involve a wide range of staff in a variety of disciplines, especially medical staff, seconded probation staff, probation officers from the supervising area but, most importantly, staff from voluntary community drug agencies. The use of multi-disciplinary teams for the planning of programmes and services has a number of potential benefits. It brings to the planning stage a wide range of expertise and, hence, options in dealing with the problems of very different types of drug-user. It also creates an important link between the prison and the community which is vital for continuity of service provision after release. And it aids mutual understanding of the aims and problems of dealing with drug-users which could lead to greater input from community agencies during the early days of a prison sentence, in terms of identification of drug use.

We found little evidence, at the time of the research, of individual assessment in order to target resources to needs and recommended that specialist teams of trained assessors should operate in all prisons. These specialist assessors should be: involved, at the earliest possible moment, in the planning of services and programmes; involved in their delivery; responsible for ensuring that these are targeted to the appropriate groups; and should monitor such targeting for review by senior management. Most importantly, these specialist assessors should form part of induction programmes and sentence-planning boards.

Service provision was extremely limited in all three prisons in terms of maintenance prescribing, rehabilitative programmes, provision of drug awareness courses, and counselling/support. This was not surprising, given the aims and timing of the research and the picture will have changed considerably given the new drug strategy and subsequent funding provisions.

We considered the content of programmes/services to require the expertise of those far more skilled than ourselves in tackling drug use, but we raised four points which remain relevant about the mode of delivery of such programmes within a prison setting. These points concerned the who, the when, and the where of service provision, and the problem of evaluation.

In terms of who should be involved in the delivery of treatment courses and programmes within prison establishments, we suggested that the expertise and experience of workers within community drug agencies would take some considerable time to replicate from existing prison staff and would be extremely costly. There were sound arguments, also, for involving prisoners in helping to deliver some of the courses. Difficulties arise with such suggestions because of concerns that prisoners might be exposed to ex-drug-users working in community agencies and current drug-users in the prison. But we stressed that prison staff need not abdicate their responsibility for course/programme delivery; the issue was how to find joint ways of working so that programme/course content could be continually assessed.

In terms of when courses and programmes should be targeted to drug users, given the level of prior and prison drug use, it was clear that demand would not be reduced by attendance at one-off courses with waiting lists of some three to six months. Instead, a battery of courses should be constantly available and staff with responsibility for assessment of needs would have to ensure that these courses were targeted, continually, to those men who most needed them. Existing induction and pre-release courses might be adapted, but this would have to take account of variations in men's needs.

A crucial question was at what point in a sentence prisoners should be targeted for additional courses. This decision would depend on two types of criteria: the aims and objectives attributed to the courses and programmes at inception; and the initial individual assessment of needs as amended by any feedback from sentence planning, staff in other functions, and attendance at previous courses.

In terms of where courses/programmes might be delivered, we suggested that offering a full range of treatments only within a cluster of prisons might pose a number of difficulties. Identification might be avoided in cases which required a transfer to another prison when

men had reasons for wanting to remain in a particular prison. Also, in order to maintain motivations to become drug-free, consideration would need to be given to the support services available to men returning to normal location after undergoing intensive rehabilitation, either at another prison or on a drug-free wing at the same prison. These support services would require that staff familiarise themselves with the aims, objectives, and content of such courses, at the relevant prisons, and that these staff had access to professional advice in order to deal with specific problems.

The final point was, for us, the most important and concerned evaluation. Evaluation is crucial for maintaining the credibility of courses/programmes but no course or programme could be expected to lead to the instant cessation of drug use. Instead, courses and programmes would need to be evaluated on the basis of their more achievable aims. In order to do this, exit questionnaires might be used to assess the impact of the course on individuals and this information could be used by staff to monitor the targeting of the course and aid further course development. Dissemination of the results of evaluations would help maintain course/programme credibility by assisting staff and other prisoners to understand better the aims of different courses and programmes.

Working with community agencies

The ACMD (1996) stressed that drug agencies based outside the prison could bring a source of specialist expertise into the prison environment. At the same time, the problems of providing such services in a prison setting were recognised. We considered partnership working with community drug agencies and also with visitors to prisons, particularly family members.

Partnership working with community drug agencies

There are numerous practical problems to bringing the services of community drug agencies into prisons, but our view was that these could only be tackled if attention was given to three more fundamental issues.

The first concerned lack of understanding of the way in which drug misuse is tackled in the community. In order to contract and fund services, prison managers need to know what they want and this requires some general understanding of the way in which services are provided in the community and some specific understanding of what is available in the areas to which their inmate population is likely to be released, as well as in the area in which their establishment is located.

The second issue concerned lack of a coherent strategy. The conflicts between reducing supply and reducing demand, and between abstinence and harm minimisation, need to be addressed at policy level and integrated into a coherent drug strategy so that staff will be able to manage, at a practical level, some of the contradictions which arise.

The third issue concerned lack of confidence. Staff in community agencies were extremely critical of MDT, the standard of healthcare offered to prisoners generally, and the efficacy of attempting to deal with drug-related problems in a custodial setting. Many thought that their efforts should be concentrated on developing community responses which kept drug-users out of prison and providing services on release.

Only by addressing such issues could the more practical problems of actually attempting to bring drug-related services into a prison setting be properly tackled. Such problems include service delivery, contact on release, funding, and evaluation.

Problems of service delivery concerned the co-ordination of services from a variety of agencies, the way in which referrals might be made, and the problems of receiving referrals, whilst maintaining confidentiality. Linked to this was the problem of the extent to which inmates can be coerced into programmes. In order to tackle these issues, and to help deliver more effective interventions to prisoners, representatives from community agencies favoured the appointment of specialist independent drug co-ordinators.

Recognition of the limitations of service provision within a prison setting raised the question of how to ensure contact on release: not all agencies were keen to advertise their services in prison; some agencies would find it difficult to cope with any extra demand generated; providing posters and leaflets could have cost implications; the catchment area of some prisons would cover a vast number of agencies; and some prisoners would live in areas not covered by relevant agencies.

Whatever the difficulties, our view was that the responsibility for contact should not be left to prisoners. Instead a more pro-active approach to encouraging prisoners to seek help on release needed to be considered.

In terms of funding, the ACMD (1996) advocated that services from community agencies should be paid for from prison budgets and that money for such services should be ring-fenced. But the position was not so simple and left open the question of how less formal types of service were to be funded: for example, visits to individual prisoners during sentence and in preparation for release; advertising services; and support to families of

prisoners. Raising the profile of community agencies, in order to get services to prisoners and their families, at whatever stage of their sentence, would have resource implications for these agencies, some of which were better equipped to cope financially than others.

Finally, the ACMD (1996) recommended that drug programmes, provided by outside agencies, be evaluated. Again, however, the position was not so simple. Some items of service provision will pose problems for evaluators: for example, on what basis can individual counselling be evaluated; to what extent can the more ad hoc input of community agencies be evaluated; and how can evaluation be achieved whilst maintaining confidentiality? Furthermore, prison staff may have expectations of programmes which far exceed programme aims, for example, abstinence. And prison staff can have a profound effect on what can be achieved: some respondents referred to intentionally obstructive practices in relation to various initiatives.

Partnership working with families

Visitors to prisons have featured prominently in the problems of tackling supply but their potential as partners in reducing demand has not been recognised. Prisoners can, and do, stop using drugs on release when sufficiently motivated. Much of this motivation is to do with relationships with their families.

Our view was that benefits could be gained by working with family members in order to: educate them about the problems of drug misuse in prison, particularly the health risks involved inside and the risks of overdose on release; enable them to recognise the signs of drug use in the individual prisoner; explain where help can be obtained for themselves and for the prisoner on release; and encourage them to recognise their own possible role as providers of purchasing power in prison. Visitors told us over and over again of the problems of providing various items such as phone cards, electrical goods, and clothing to prisoners at visits. They told also of the pressures to visit. Prisoners told us how such items were used to pay for drugs.

In terms of the problem of developing such partnerships, there could be scope to offer advice, information and support services to visitors from Visitors' Centres although not all prisons have these. But attention would need to be given to the inter-related difficulties of what the service should actually involve, who should deliver it, and how to motivate family members to make use of it.

Overall, our view was that there were advantages to be gained from both types of partnership and, whilst there were difficulties, many of these could be overcome.

Conclusion

A final caveat is in order. Our views, as presented here, were developed on the basis of fieldwork carried out in three Leicestershire prisons in 1996-7. The Prison Service issued its updated drug strategy in 1998 (HM Prison Service, 1998) and this project informed the development of that strategy. Thus, there has been considerable change since our research took place. But the points we have raised here about the management of drug-using prisoners remain relevant. What is required now is fresh research in order to update our assessment, taking account of the changes.

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9. Conclusions: policy implications and lessons for practitioners

Malcolm Ramsay

Introduction

The drug strategy in prisons, in any ambitious form, is little more than four years old. Despite this, a reasonably promising picture is starting to emerge. At the same time, there are still plenty of challenges to be more fully addressed. This chapter starts with the key conclusion, before itemising complicating factors.

Prisons are well placed to deliver drug treatment that can reduce crime

It is clear that prisons are well placed to deliver effective drug treatment, and that this can help to reduce crime as well as provide health benefits. Perhaps partly because prisoners are literally a captive group, the prospects for getting them into treatment, and keeping them there, are quite good. Moreover, the prison environment significantly reduces the availability of drugs (as shown in Chapter 3), which also has a positive impact on treatment. Although it is difficult to keep drugs out of prisons altogether, they tend not to be present in such large quantities as outside the walls.

Importantly, while many prisoners have extensive histories of drug use, a substantial minority has a strong interest in treatment. Chapter 2 shows that almost three-quarters (73%) of a large sample of newly arrived male prisoners had used one or more prohibited drugs during their last year at liberty. Over a third (38%) of the recently arrived prisoners accepted that they had a drugs problem. Of this subgroup acknowledging that they had a problem, four in ten expressed an interest in treatment; while another one in ten was already in treatment in prison when interviewed. Women likewise had extensive experience of drug use. As Chapter 4 indicates, 72 per cent of a sample of female prisoners had used prohibited drugs in their last year at liberty. Within this large subgroup of drug-using women, levels of use of heroin and crack were even higher than for men. The women too had a strong interest in treatment.

The ability of prisons to deliver treatment is not just theoretical, but proven, even for this country. Chapter 6 shows that reasonably intensive programmes, specifically the 12-step ones delivered by RAPt (Rehabilitation of Addicted Prisoners Trust), can result in significantly lower reconviction rates for programme graduates than for equivalent prisoners who have not been treated. Lower reconviction rates imply, in turn, a reduction in the total amount of crime committed.

While only one treatment programme in this country's prisons has been authoritatively evaluated in terms of its outcomes, the international literature strongly suggests that treatment programmes in prison can be effective in reducing drug use and reoffending. This literature is reviewed in Chapter 5.

Drug treatment needs to be appropriate and accessible

As shown by Chapters 7 and 8, drug treatment in prisons was extremely limited in nature and availability in the mid to late 1990s. Starting from that low level, it is unsurprising that while the quality and accessibility of treatment is often rated quite highly by the consumers who matter, the prisoners themselves, there is still a need for further enhancements. For instance, detoxification is a vital starting point, particularly but not exclusively for newly arrived prisoners. Chapter 3, which focuses on samples of prisoners who had used drugs when last at liberty, shows that nearly a quarter, interviewed in 2000-2001, had been on a detox programme, and that nearly all of them had completed it. Most (85%) of those who had been in detox were treated primarily for heroin withdrawal, although many had problems with numerous substances. Altogether, roughly half (49%) of all prisoners using opiates, tranquillisers or alcohol on a daily or near-daily basis when last at liberty benefited from this service; by the same token, of course, the other half of these 'heavy-end' users did not. The views of those prisoners who had experienced detoxification were once again evenly balanced between, on the one hand, those who felt this had been beneficial, and on other, those with reservations. The main criticism concerned the short duration of detoxification.

Of course, detoxification is only one way of starting to involve people in treatment. The Prison Service has introduced a wide-ranging screening and assessment service for drug treatment. Known as CARAT (Counselling, Assessment, Referral, Advice, and Throughcare), its role is to engage as many drug-using prisoners as possible, and to offer basic support. Judging by the sample of prisoners discussed in Chapter 3, this relatively new service is having some success in accessing prisoners. Nearly a third of this set of prisoners who had used drugs when last at liberty had received an assessment. Importantly, of those assessed,

nearly all agreed with their care plan. All of that is promising. However, it was also true that less than half of regular drug users were being assessed. So it is reasonable to conclude that here, too, there is still scope for further improvement.

Finally, more full-blown therapeutic interventions are likely to be necessary for those prisoners with serious histories of drug use. This can involve one-to-one counselling, or group work, or longer-term, intensive programmes (including cognitive-behavioural rehabilitation programmes, 12-step programmes and therapeutic communities). Still drawing on Chapter 3 with its sample of prisoners who had used drugs when last at liberty, it is clear that some good progress is being made. The proportions engaging in one-to-one counselling, group work and more intensive programmes were respectively 16, 7 and 11 per cent. Levels ranging from more than half to over three-quarters of those involved in each type of programme rated the service as beneficial. While all of this is useful, it still suggests that there is scope both for drawing more prisoners into treatment and for improving levels of consumer satisfaction.

The drug treatment needs of prisoners are large but variable

The drug strategy for prisons is complicated by the fact that while there is in general a relatively high level of need for treatment, there are some important variations both between and within different groups of prisoners. Treatment should be matched to individuals, even where it is delivered to groups (Chapter 5). And there are important differences between groups. For instance, as shown respectively for men and women in Chapters 2 and 4, black prisoners were more likely to use crack than heroin, prior to custody. However, this was not the case for white prisoners, who tended to favour heroin. Such ethnic differences in drug use need to be taken into account in planning and delivering treatment programmes. It is important not to forget that whites tend to have higher rates of drug use both pre-prison and within prisons, not just for 'any drug' but even for crack (Chapters 2 and 4). Focusing simply on gender rather than race, female drug use tends to be broadly on a level with that of men. However, women who are sent to prison seem to have greater recourse than their male counterparts to the more damaging drugs, particularly heroin, whether pre-prison or within prison (Chapter 4). In many cases, their lives were complicated both by child-care responsibilities and/or mental health problems.

Another important contrast is between younger and older prisoners. Chapter 2 shows that pre-prison prevalence rates for heroin, perhaps the single most important drug used by offenders outside and inside prison, were much the same for those aged under 25 as for

older prisoners. However, younger prisoners were not necessarily as interested in treatment as older ones. Chapter 6, the evaluation of RAPt programmes, notes that treatment programmes were most successful for those in their late twenties and early thirties, and that there is a need for further efforts to motivate and involve younger prisoners in treatment, and to find out how best to do this.

Any discussion of variations in drug use or treatment needs on the part of particular categories of prisoner can usefully conclude by focusing on offence categories. Heavy drug users are particularly likely to be acquisitive offenders. Of the recently arrived prisoners discussed in Chapter 2, almost half of those using drugs on a daily basis prior to prison were sentenced for burglary or theft or handling of stolen property. To put that in the broader national context, little more than a third of all recently received prisoners have been sentenced for burglary, theft or handling (Home Office, 2003, T 4.5). A key constraint is that almost three quarters of male prisoners sentenced for burglary, theft and handling (and roughly nine out of ten female equivalents) are serving relatively short sentences, of less than a year (Home Office, 2003, Fig 4.9). Their actual time in custody is shorter still. This means that it is not straightforward to involve this group of often highly prolific offenders in treatment: it is in fact a considerable challenge. In practice, this constraint also affects many other prisoners. There are some relatively short programmes already in operation in local prisons (such as the ten-week ones run by Turning Point). It is also possible that the implementation by the Prison Service of its own 'central model' may help (P-ASRO, or Prisons – Addressing Substance Related Offending, which caters partly for short-term prisoners, and began in a number of prisons in mid 2002). But while P-ASRO aims to provide relatively intensive treatment of a shorter duration than major existing programmes, it is likely to be mainly for prisoners with sentence lengths of at least six months. Ultimately, unless or until there is a major shift in sentencing practice (involving a substantial reduction in numbers receiving relatively short sentences, as recommended by the Halliday Report), it may make better sense to think of prisons as places where people may well only start to receive treatment, which then continues back in the community. This reflects both the need for treatment to be of sufficient duration (a theme highlighted in Chapter 5) and the importance of continuing to provide support to prisoners after they have been released.

The importance of aftercare

This collection of studies consistently emphasises the importance of aftercare, for those receiving drug treatment. This can mean follow-up care within the prison system, as well as

after release. Indeed, to see the largest gains from prison treatment programmes, both should be readily available. Chapter 5, which reviews the international literature, argues that treatment programmes within prisons depend quite crucially on aftercare, particularly post-release. Chapter 6, evaluating the outcome of the RAPt programme in this country, also makes the point that good-quality aftercare, both during and after imprisonment, can significantly reduce reconviction rates. Lastly, it is clear from Chapter 3, which follows through a subgroup of drug-using prisoners, after their release, that levels of reoffending post-release are strongly associated with levels of drug use. This lends further emphasis to the seamless delivery, wherever appropriate, of drug treatment to ex-prisoners, in addition to general support.

Conclusion: better drug treatment implies better prisons

Most prisoners have previously been sent to prison, as Chapter 2 notes. It also suggests that such 'serial' or 'repeat' prisoners are particularly prolific drug users. In other words, it is likely that as a result, no doubt, of complex, inter-related factors bearing on the lives of offenders, sustained drug use and repeated imprisonment can be mutually reinforcing.

The main reason why prisoners, or some of them, take drugs when they are in custody is to combat boredom and alienation, and promote relaxation (Chapter 3). This in turn suggests the need for more purposeful activity within prisons. While MDT (Mandatory Drug Testing) is supposed to deter prisoners from drug use, Chapter 3 indicates that prisoners' responses to it are complex. Two out of three felt that MDT encourages the use of heroin, the classic 'time killer' drug that happens to be detectable only for relatively short periods of time after consumption.

The challenge for the criminal justice system is to find ways of intervening purposefully with drug-using offenders. If this can be done in prison, society can expect to gain, through significant reductions in crime. The prison system, inmates and staff also gain. For instance, as Chapter 7 shows, prisons or prison wings with treatment programmes are more decent and orderly places than other parts of the prison estate. Similarly, Chapter 3 suggests that voluntary testing units are viewed favourably by their inmates. Ultimately, there is perhaps a sense in which the recent expansion of drug treatment and other programmes designed to rehabilitate prisoners is helping to 'reinvent' the prison, or at least to give it a fresh sense of purpose.

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