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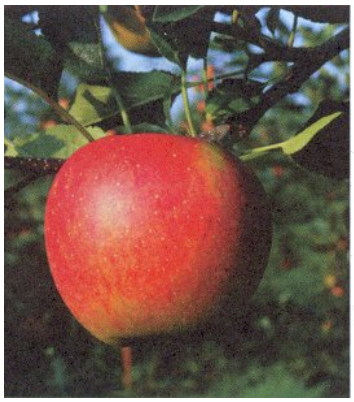
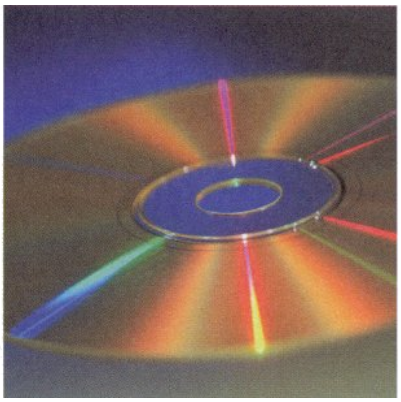
Identifying Health Needs and Risks of Prisoners:

A Survey of Health, Smoking, Drinking, Drug Use and Treatment amongst Prisoners in the South East

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Contents

1. Introduction

Prisons have until comparatively recently been closed institutions with a very limited interface with health services on the outside. A policy context for bringing together Prisons and Health and Social Services has developed over the last eight years. The first significant report was Her Majesty's Chief Inspector of Prisons report "Patient or Prisoner"[1] which drew attention to the disparity between NHS and Prison healthcare. It recommended that the NHS include prisons within its orbit of responsibility. "The Future Organisation of Prison Healthcare", 1999[2], recommended the setting up of a Taskforce to develop the Prison/NHS Partnership. "Improving Healthcare for Prisoners, 2000"[3] laid out the timetable for action; each prison is now expected to receive health services equivalent to those offered in the community. As a result of this from 2001 each prison was required to have its own Health Improvement Programme, which is part of the NHS local plan.

In order to address the issue of bringing health care and treatment in prison (in relation to drugs in particular) inline with that offered in the community, the Centre for Health Services Studies at the University of Kent was commissioned by the Drug Strategy Unit of the Prison Service in the Kent, Surrey and Sussex area and East and West Kent Health Authorities to carry out a research project. The objectives of the project were to identify drug needs and risks in prison, the type of treatment provided, it's effectiveness, and the ways in which such treatment can be aligned with and linked to treatment provided in the community. The project used a number of quantitative and qualitative complementary methods in three separate phases. The first was a review of the current evidence for drug misuse and effectiveness of different treatment regimes and a profile of all prisons in the area and identifying their needs and the services provided in each prison in relation to drug misuse. In the second phase a survey and focus groups were used to identify prisoners' drug use and treatment needs, risks and experiences. The third phase involved the screening of information to identify how far current provision meets the needs and risks of prisoners.

This report presents the findings of the survey in the second phase of the project. The main aims and objectives of the survey were :-

- To map the health and health related behaviour of prisoners
- To document prisoners current attitudes and behaviour in relation to drug use, awareness and experience of treatment services for addiction in prison
- To explore experiences and pressures within the prison environment which have affected their drug taking careers
- To place these current attitudes and behaviours within the context of prisoners previous experience especially alcohol and drug misuse, offending, use of services and access to various support services
- To find out what prisoners anticipate they will do about drug and alcohol use on return to the community

[1] Her Majesty's Inspectorate of Prisons for England and Wales. Patient or prisoner? A new strategy for health care in prisons. London: Home Office, 1996.
[2] Prison Health: The Future Organisation Of Prison Health Care - The Future Organisation of Prison Health Care: Report by the Joint Prison Service and National Health Service Executive Working Group, Prison Service/NHS Executive, March 1999. http://www.doh.gov.uk/prisonhealth/prisonhealthcare.htm
[3] Improving Health Care Services for Prisoners Guidance (8 March 2000). http://www.doh.gov.uk/prisonhealth/publications.htm

The report is broken down into five main sections. Firstly the methodology of the study; secondly a general profile of the prisoners in the study in relation to demographic data, relationships, prison experiences, and general health, including mental health and smoking. Thirdly it looks at the needs and risks of this population in relation to substance misuse - drugs and alcohol, and then followed by a section that identifies treatment services used and required by the prisoners in the light of needs and risks. Finally some conclusions and recommendations are drawn.

2. Survey Methodology

2.1 The Context

Adopting a quantitative approach to satisfy the aims of assessing prisoners' needs and risks allowed data to be collected from a large number of respondents in a number of prison establishments. Even though the quantity of data in order to generalise cannot be reached using qualitative research methods, they are important in giving a more in depth knowledge of the needs and risks of the prisoner population. Therefore focus groups amongst prisoners where also conducted in this phase of the research project further enhances the information provided from the survey.

In total the Kent, Surrey and Sussex (KSS) prison estate includes 11 male prisons[4] in the South / South East of England which are a range of both large and small prisons, housing adult and young prisoners[5], convicted and remand prisoners, all operating at different levels of security[6] in either an open or closed environment.[7] At the time of the survey there were four local prisons[8], five training prisons[9], one resettlement prison[10] and one Young Offenders Institute. Geographically within the KSS area there are 4 female prisons, which are administered as part of a separate Female Prison Estate, and therefore not able to be part of this study. The Home Office Prison Population Brief in January 2003, indicated that there were 5265 male prisoners in custody across the KSS area, which was approximately 8% of the total prison population in England and Wales[11]. At the time of the survey, a greater proportion of adult and male prisoners in the Kent, Surrey and Sussex estate reflected the overall prison population with roughly 1 in every 7 being classified as a young prisoners or a remand prisoner, and only 1 in 17 prisoners being female in England and Wales[12].

2.2 The Pilot Survey

A pilot study of the survey was first conducted in three Hampshire prisons in October 2002 as these were considered to be housing a similar prison population to that of Kent, Surrey and Sussex. The pilot was a methodological exercise to assess the questionnaire and the best method for administering the definitive survey within a prison environment, it was not intended to produce representative results. A short and a long version of the questionnaire was tested as well as comparing different methods of delivery. Either prison staff or 'responsible' prisoners distributed questionnaires to prisoners on their wing, and some questionnaires were given to prisoners in their education class to complete under supervision. The supervised education classes proved to be a useful way of gaining direct feedback from prisoners about their thoughts on the survey. However such a method didn't give the researchers access to those prisoners who didn't attend education classes and there wasn't a similar way of accessing these prisoners in one location at one time where they could complete the questionnaire. Distribution to prisoners on the wings was therefore chosen as the method to use in the actual survey in order to maximise the number of prisoners who could complete the questionnaire in the

[4] Excluding HMP Dover which has re-roled as an immigrant removal centre.
[5] Young prisoners include all those aged 15 to 20
[6] Category A is the highest level of security and category D is the lowest level.
[7] Closed prisons have a physically secure perimeter of a fence or wall, open prisons do not have a physical perimeter.
[8] A local prison receives prisoners directly from court on remand or that are newly sentenced.
[9] Training prisons accept adult sentenced prisoners where they are sent on initial or later allocation.
[10] A prison to prepare adult long-term prisoners for their eventual release.
[11] Simes, J and Chada, K. Prison Population Brief: England and Wales: May 2002. Home Office Research and Development Statistics www.homeoffice.gov.uk/rds/pdf2/prismay02.pdf
[12] Hollis,V. Goodman, M. and Cross, I. Prison Population Brief: England and Wales: January 2003. Home Office Research and Development Statistics www.homeoffice.gov.uk/rds/pdf2/prisjan03/pdf

most efficient way. However a 'sit down' methodology has been used in other prison studies.[13] When testing the delivery of questionnaires on the wings, the pilot study indicated that questionnaires being distributed by prison staff may have a negative effect on the response rate, and that a better response would be obtained by using 'responsible' prisoners who, for a small monetary incentive, would distribute the questionnaire and try and encourage completion of the survey[14]. The length of the questionnaire didn't appear to affect the response rate in the pilot study and most of the respondents reported that both versions were easy to fill in.

2.3 The definitive survey

Between January and September 2003 the whole population of eight prison establishments (3141 prisoners) were given a self-completion survey. The eight prisons were sampled to reflect the population of prisons and prisoners in the KSS area and in England and Wales. They were a cross-section of local or training prisons, open or closed prisons and with varying levels of security, holding both adults and young offenders and both prisoners who were convicted or on remand.

A meeting between the researchers, relevant staff and 'responsible' prisoners (selected prisoners, asked to help deliver the survey) was arranged a week before distribution in each prison to discuss the survey and its delivery. In this meeting the 'responsible' prisoners were given time to look at the questionnaire and to discuss any anxieties or problems they envisaged so they were in a position to explain the purpose and the confidentiality measures taken to protect their data, to fellow prisoners. They were asked to encourage fellow prisoners to complete the survey and offer help to those who found it difficult to complete it. The majority of the 'responsible' prisoners selected were 'listeners' in the prison who were people who fellow prisoners could trust to speak to about any problems in confidence.

Posters were put around the prison to inform the prisoners of the survey a week in advance of distribution in their prison. A new poster was put up when the survey was in progress. Each prisoner was given the questionnaire and an information sheet under their cell door or in their dormitory. Prisoners were given 3-4 days for completion (usually over a weekend). Prisoners were instructed to return their completed questionnaire in a sealed envelope, into a red post box situated on their wing[15], by a specified date. Only information about the number of prisoners on each wing was known by the researchers and prison staff to ensure anonymity and confidentiality, so the names of the prisoners or a identification number was not required during data collection. The survey was a self reported survey so results are subject to the degree of honesty with which the prisoners approached the exercise.

2.4 The Response

After data collection the survey included 821 respondents from the eight prisons in the Kent, Surrey and Sussex male prison estate. The survey reached a 26% response rate (table 2.1). The response was higher for the closed prisons (28% in local prisons and 29% in training prisons) and lower for open training prisons (20%) and the open resettlement prison (24%). Response was possibly lower in open prisons as many prisoners have jobs and other activities to occupy

[13] Dr. Ann John (IMH). Nic Bowler, (Univ of Wales, Swansea).Out of Sight, Out of Mind. Mental Health in Prisons.. UKPHA Annual Public Health Forum, 18-20 March, 2003, Cardiff.

[14] In one prison responsible prisoners used in data collection were given enhancement points for helping out the prison instead of a monetary reward.

[15] In one open prison the prisoners were instructed to return their questionnaires to a post box in the communal dining hall

their time during the day, where as in closed conditions prisoners spend a large amount of time in their cells. The closed prisons are of a higher level of security, either category B or C, whereby prisoners cannot be trusted in open conditions. In contrast open prisons are Category D (with the exception of the resettlement prison which is category C and D) whereby prisoners can be reasonably trusted to serve their sentence in open conditions.

Table 2.1

Response by Prison

	Sample	**Returned**	**Response**
Closed Local	946	266	28%
Closed Training	1157	339	29%
Open Training	916	187	20%
Open resettlement	122	29	24%
All Prisons	**3141**	**821**	**26%**

Compared to surveys conducted of the general population of the same area the response in prison is low. A 48% response rate was reached from people under the age of 75 in a survey conducted across Kent and Medway in 2001[16] and a 50% response rate was reached from people aged 18+ in a survey conducted in East Sussex, Brighton and Hove in 2003[17]. Both of these were postal surveys of the general population with two reminders. Whilst this level of response is low, it needs to be seen in the context of falling response rates to health surveys in the general population; and in the case of prisons we are dealing with a population where it is estimated that approximately 30% are unable to read and write, and there was greater concern about confidentiality and the sensitivity of some of the questions.

Despite a low response rate the respondents are quite representative of the KSS prison population. Table 2.2 compares the age breakdown of the survey respondents from the eight prisons with that of the whole population of the Kent, Surrey and Sussex male estate. Each prison in the KSS area was asked to provide information on prisoner age breakdown as part of a profile of all prisons in May 2002, for an earlier phase of the research project[18].

[16] Palmer A. (2003) A Survey of Health and Lifestyles in Kent and Medway – what have we learned? CHSS. University of Kent.
[17] Jenkins, L. and Palmer, A. (2004) Commentary on Health Counts Survey in 2003: Prepared for Eastbourne Downs Primary Care Trust. CHSS, University of Kent.
[18] Appleton, S et al, (2003) Identifying Prisoners' Drug and Health Needs, and Prison Drug Misuse Treatment and Health Care Services: Preliminary Findings. CHSS, University of Kent

Table 2.2

Response to the Survey compared to the KSS Prisons Population, by age

Age Group	Respondents		Prison Population (KSS) May 2002	
	N	%	N	%
18-24	106	14	830	16
25-34	255	34	1818	35
35-44	241	32	1455	28
45-54	86	11	676	13
55+	65	9	416	8
Total	**753**	**100**	**5196**	**100**

* Figures rounded to the nearest whole number
* Age not known for 68 respondents

2.5 Data Analysis

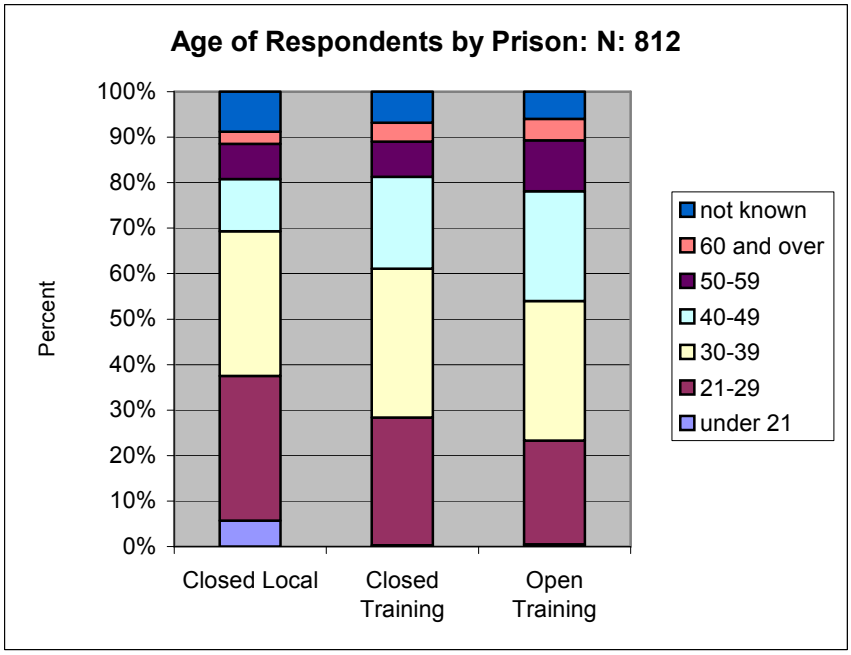
The data was analysed using SPSS for Windows version 11.5 software. Nine respondents had not completed their questionnaire sufficiently for the data to be entered into the SPSS database; 812 cases have been analysed. The number of respondents who didn't answer a particular question were included in the analysis and the respondents to whom a question was not applicable were excluded, unless otherwise stated. The questionnaire also included some open questions, which produced written text answers and were entered into an Excel spreadsheet for all 821 respondents for separate analysis. In the analysis by prison type the open resettlement prison is included in the open training category due the small number of respondents in this prison.

3. Respondent Profile

3.1 Socio-demographic profile

The survey collected socio-demographic data on age, ethnic group, marital status and housing tenure. Due to the restrictions of access the survey was conducted in male prisons only. Most of the respondents were aged between 21-29 (n:226; 28%) or 30-39 (n:259; 32%) and only 2% (n:17) were young offenders aged been 18-20 and 12% (n:101) were aged 50 or over. This is in general a much younger population compared to the general population. The age of 7% of the respondents is not known. The open prisons had the oldest population compared to the closed prisons which tended to hold younger prisoners. The closed local prisons also held the youngest prisoners, the young offenders, who were aged between 18-20 (figure 3.1). Results for the Young offenders are reported in this document for interest however these results have to be interpreted with caution due to the low response.

Figure 3.1



The majority of respondents reported their ethnic origin to be white (n:603; 74%), 14% (n:116) said they were of black origin, only 3% Asian (n:24), 1% Chinese (n:7), 2% other (n:17) and 6% did not report their ethnic origin. Compared to the general population in the UK the number of white origin is low and the number of black origin is high. In the 2001 census 92% of the general population were white and only 2% were of black origin.[19] The majority of the black ethnic groups in prison were in B/C cat, closed training prisons. Results are reported by ethnic group in this document for interest but have to be interpreted with caution due to low number of respondents reporting to be in an ethnic minority group. Only 35% of respondents said that they were married or were living as a couple, compared to just over half of the general population who are married[20]. 36% said they were single, and 21% said they were divorced. Only 11% of the general population are divorced[21] indicating a link between prison or crime and a breakdown in personal relationships. Before prison most of the respondents were renting accommodation (44%) and only 25% were owner-occupiers. This

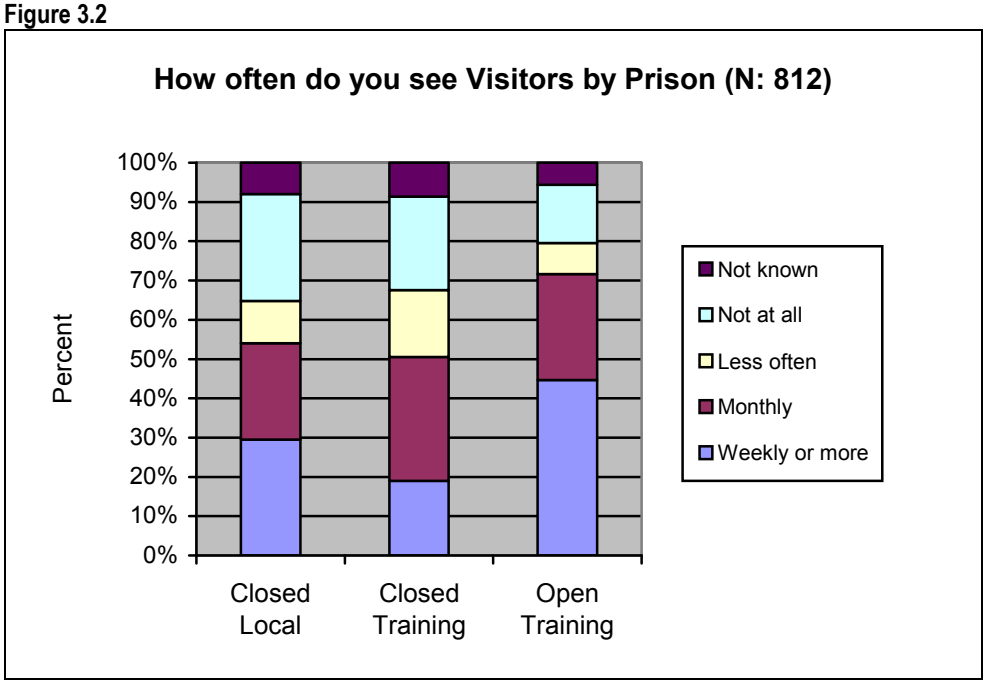
[19] Census, April 2001, Office of national Statistics. www.statistics.gov.uk/cci/nugget.asp?id=273
[20] Census 2001, Office of national Statistics. www.statistics.gov.uk/census2001/profiles/commentaries/people.asp#marital
[21] Census 2001, Office of national Statistics. www.statistics.gov.uk/census2001/profiles/commentaries/people.asp#marital

compares to 2/3 who are owners and 31% who rent in the general population.[22] 5% of respondents lived in bed-sit accommodation, 5% said they lived on the streets, 4% said they lived in a hostel or temporary accommodation, and 3% said they had recently arrived in the country. Most of respondents lived in the Kent, Surrey or Sussex area (38%) before they came into prison, but 28% came from London and another 28% came from other areas or countries.

3.2 Relationships with family and friends

Poor social relationships have been described as one factor that may contribute to substance misuse and also criminality.[23] Imprisonment itself is likely to put a strain on any relationship, but sustaining and having relationships in the community whilst in prison may be an important factor in helping prisoners decide to tackle drug problems or simply help get thought their time in prison. Before coming into prison 50% (n:405) of the respondents had been living with a partner or spouse, 12% with parents (n:95), 16% alone (n:131), 8% had no fixed abode (n:67), and 6% (n:52) were living with other family or friends. Only 40% (n:318) of the respondents said that they would return to their home on release from prison, but only 15% (n:123) said that they didn't have a home to go to. Respondents in the open prisons were more likely to see visitors on a regular basis compared to the closed prisons, but prisoners in closed local prisons were more likely to receive regular visitors compared to closed training prisons, which could be due to family and friends living close by (figure 3.2). 51% (n:170) of respondents in closed training prisons saw visitors monthly or more often, this increased to 54% (n:141) in local prisons and to 72% (n:154) in open prisons. Conversely it is the local prisoners that were more likely to report that they did not have any visitors at all (n:71; 27%).

Figure 3.2



The majority of respondents reported strongly that their friends and family do things to make them happy (n:461; 57%), make them feel loved (n:531; 65%) give then support and encouragement (n:501; 62%) and would see that they're taken care of (n:483; 60%). Despite their current situation the majority of respondents felt strongly that their friends and family

[22] Census 2001, Office of national Statistics. www.statistics.gov.uk/census2001/profiles/commentaries/housing.asp
[23] Crome, I. B. (1999) Treatment Interventions – Looking towards the Millennium. *Drug and Alcohol Dependence*, 55, p247-263

accepted them for who they were (n:458; 56%) and that their friends and family made them feel an important part of their lives (n:459; 57%). However some respondents didn't feel that they received much love and support from their friends and family: 12% (n:101) of respondents reported that they weren't made to feel an important part of their lives, and 10% (n:84) felt that they couldn't rely upon them. Unsurprisingly, respondents who receive regular visits from family and friends were more likely to feel loved and supported compared to those who didn't.

3.3 Prison experience

Most of the respondents reported that they had been in their current prison between 1-3 months (n:225; 28%) or one and two years (n:177; 22%). Only 4% (n:34) reported that they had been in the same prison for over two years. Most expected to leave prison within a year (n:309; 38%) or between 1-5 years (n:268; 33%) and 12% (n:98) didn't know when. This was the first time in prison for 46% (n:371) of the respondents. For those who had been in prison before this offence 30% (n:104) had been in prison once before, 37% (n:127) had been in been in prison 2-4 times before and 33% (n:113) had been in prison more than four times.

3.4 General health and illness

Prisoners were asked :-

'In general, would you say your health is good, average, or poor?'

'Compared to one year ago, how would you rate your health in general now?'

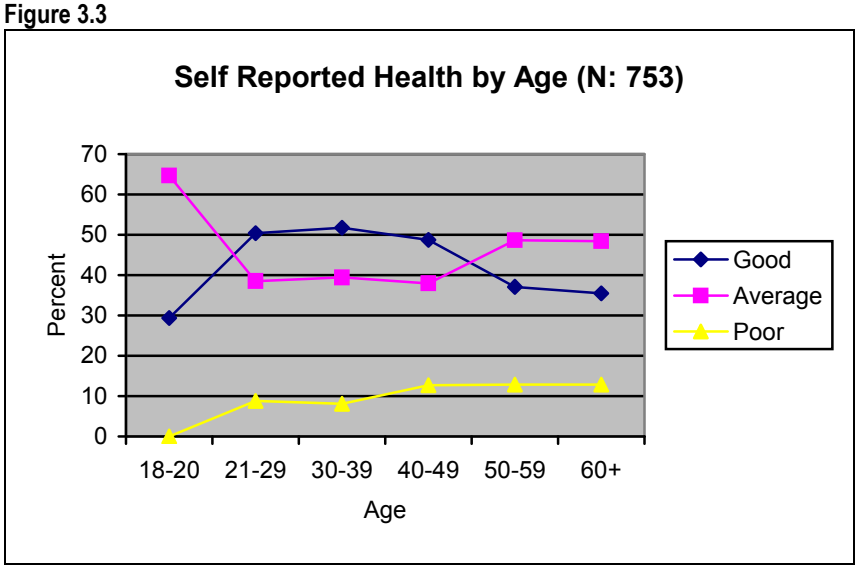
The same questions were also asked in the general population surveys in Kent and Medway and East Sussex. 48% (n:388) of the prisoners who responded said their health was good compared to 78% in the male population of Kent and Medway, aged between 18-74,[24] and 77% in the male population of East Sussex[25], which are older populations overall. This is a low amount of good health for a young population in prison as older people are generally less likely to report good health. 11% (n:86) of prisoners reported poor health compared to 6% in the Kent and Medway survey and 5% in East Sussex. 29% (n:235) of prison survey respondents said their health was worse than a year ago; 30% (n:246) said it was better and 38% (n:309) about the same. These differences in health between the prison population and general population are perhaps unsurprising as prison populations are skewed towards the lower social class profile compared to the general population. Inequalities between the health of people by social class are well known and the health of people in the lower social classes is increasingly becoming poorer with declining socio-economic position.[26] Those prisoners reporting poor health were more likely to say their health was worse than a year ago. The general health of prisoners was also related to age; with older people more likely to report poor health / least likely to report good health, compared to younger people, a similar trend found in the surveys of the general population (figure 3.3). However the exception is the young offender population (aged 18-20) who although do not report poor health, report a much lower rate of good health, only 29% (n:5) and a higher rate of average health (n:11; 65%) compared to older prisoners. These findings, however, have to be read with caution as only 17 respondents reported being between the ages of 18-20.

[24] Palmer A. (2003) A Survey of Health and Lifestyles in Kent and Medway – what have we learned? CHSS. University of Kent,

[25] Health Counts: A Survey of people in East Sussex, Brighton and Hove 2003. Conducted by CHSS, University of Kent

[26] Drever, F. and Whitehead, M. (1997) Health Inequalities. Office of National Statistics. Series Ds No. 15, London: The Stationary Office

Figure 3.3



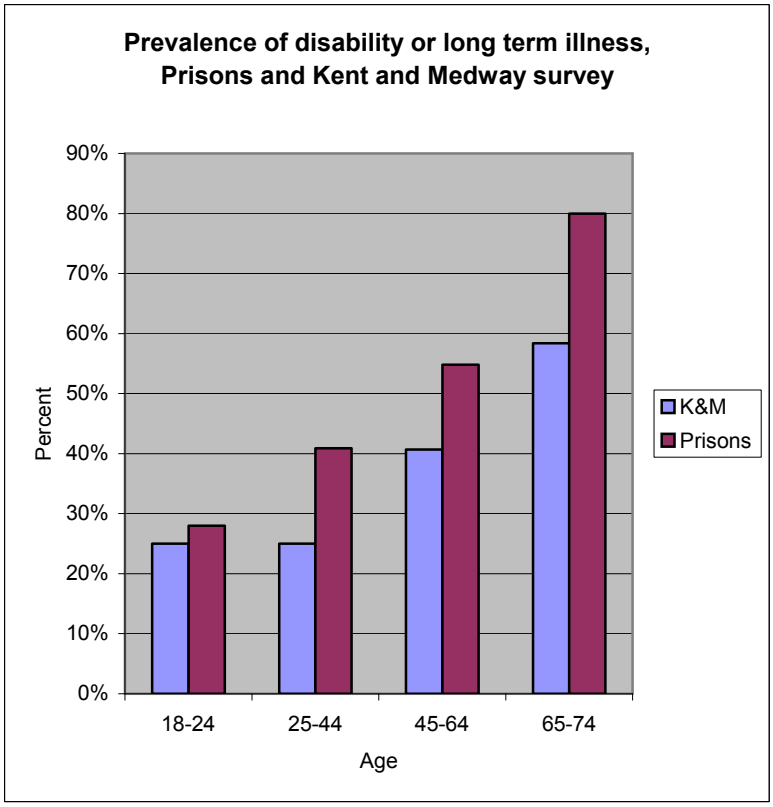
Self-reported general health also differed in relation to ethnic origin: more Asian prisoners reported poor health (n:6; 25%) compared to other ethnic groups, only 10% of white (n:60) and black groups (n:11) reported poor health. Similarly Asian groups were less likely to report good health. Black ethnic groups (n:67; 58%) were more likely to report good health. In relation to prison type good health was more likely to be reported in the open prisons (n:125; 58%) and more poor health was reported in closed local prisons (n:37; 14%). Similarly more prisoners in open conditions felt that their health had improved over the past year (n:81; 38%) than those in closed conditions, who were more likely to report that their health had got worse: 35% (n:88) in closed local prisons and 29% (n:96) in closed training prisons. The status of the prisoner is more likely to indicate their health profile. The higher level of reported poor health in the local prisons may be linked to the type of prisoner they hold. Unlike the other types of prisons local prisons hold remand prisoners who in this survey reported a higher level of poor health (n:14; 17%) compared to convicted prisoners (n:65; 9%).

The survey also asked prisoners about long-term illness or disability. The questionnaire asked :-

> *'Do you have any long standing illness or disability that has troubled you over a period of time, or that is likely to affect you over a period of time?'*

The self-reported prevalence of long standing illness or disability amongst prison respondents is higher than that found amongst men in the Kent and Medway survey in all age groups (Figure 3.4) but the trend remains the same for both surveys whereby long-term illness and disability increases with age. Those prisoners with long-standing illness and disability were more likely to report poorer general health.

Figure 3.4



The respondents were asked what their long-standing illness or disability was. Of the 342 respondents who said 'yes' to having a long-standing illness/disability the most common answers were: bodily pain, e.g. back pain (16%), depression (10%), asthma (10%), hepatitis B/C (5%), high blood pressure (5%), other mental illness (5%), diabetes (4%) and epilepsy (2%). The answers given to this question are very much determined by the respondents' interpretation of a long-standing illness or disability.

Other than social class, age, ethnic origin and prisoner status the survey indicated that there may be pressures within the prison environment itself that may affect peoples' health and well being. 11% reported that poor relations with prison staff may affect prisoner health, also a poor diet and food (5%) lack of contact with family (4%), inefficiencies in healthcare and long waiting times (4%) other prisoners: e.g. bullying and noise (3%) lack of exercise and other activities (2%) sharing cells/overcrowding (2%) and the uncertainties of prison life e.g. transfers to other prisons or cells (2%).

3.5 Mental health

Self-reported health revealed that mental problems, depression in particular, are long-standing illnesses troubling many of the prison population in Kent, Surrey and Sussex. The survey included questions from the Revised Clinical Interview Schedule (CIS-R), previously used in the Survey of Psychiatric Morbidity among Prisoners in England and Wales.[27] Variables of neurotic disorders were then calculated on sleep problems, irritability, worry, depression and anxiety. Table 3.1 presents the prevalence and severity of each of the five neurotic disorders[28]. Sleep disorder appears to be the most

[27] Singleton et al. (October 1998) Psychiatric Morbidity among Prisoners in England and Wales. Office of National Statistics: Social survey Division SS1417

[28] Presence or severity of symptom calculated from CIS-R scores. A score of '0' indicates no symptom, and a score of '2' or above regarded as severe symptom. Singleton, N. et al. (October 1998) Psychiatric Morbidity among Prisoners in England and Wales. Office of National Statistics: Social survey Division SS1417

common disorder to have severe symptoms (n:451; 56%), followed by depression (n:335; 41%) and Anxiety (n:328; 40%). This is a similar finding to the Prisoner Psychiatric Morbidity Survey in that sleep was also found to be the most prevalent and severe disorder[29]. However this was followed by worry, which is much lower compared to the other disorders in this Kent, Surrey, Sussex survey. The questions on sleep however, may have been interpreted by some prisoners as sleep problems due to the prison environment, e.g. noise during the night as the cause rather than a sleeping disorder, which would explain its high prevalence and severity compared to the other disorders. Perhaps the most interesting finding is that 72% (n:585) of the respondents were shown to have a severe symptoms in at least one of the five disorders and only 13% (n:103) had no symptoms at all.

Prevalence and severity of neurotic disorders (N: 812)

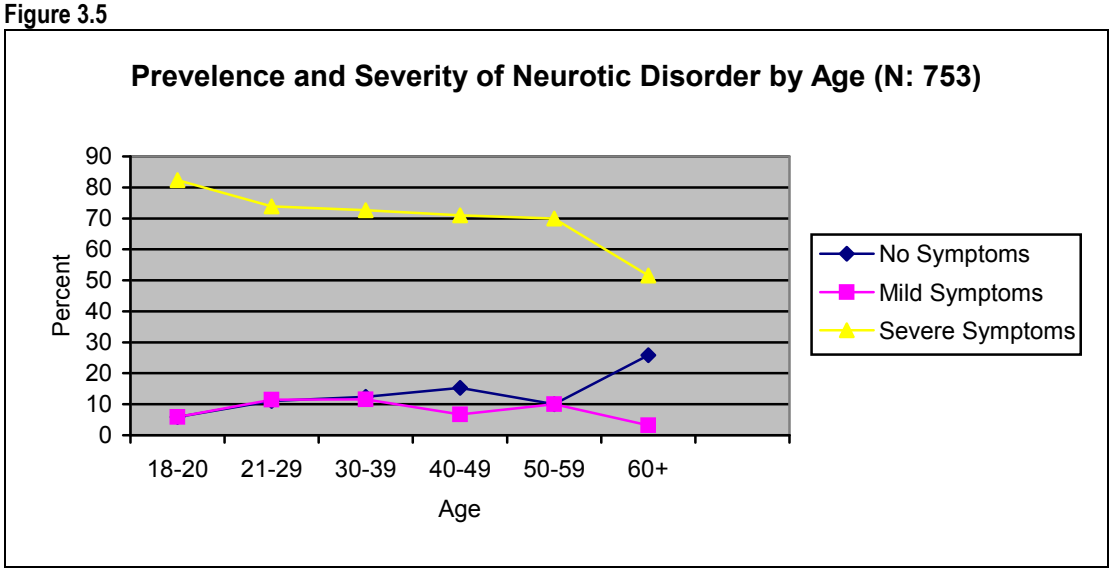
Table 3.1

	No symptoms	**Mild Symptoms**	**Severe Symptoms**
Sleep problems	33%	5%	56%
Depression	32%	18%	41%
Anxiety	42%	12%	40%
Irritability	52%	8%	37%
Worry	68%	8%	17%
Any Neurotic Disorder	**13%**	**10%**	**72%**

Closed local prisons were more likely to hold prisoners that showed severe symptoms of at least one of the five neurotic disorders (n:204; 78%) and prisoners' in the open prisons were least likely (n:134; 62%), although prevalence of severe symptoms were high in all types of prison. Also remand prisoners (located in local prisons) were more likely to show severe symptoms (n:53; 65%) compared to convicted prisoners (n:388; 54%). The survey indicates that age and ethnic group are also related to mental health. Younger prisoners were more likely to show severe symptoms compared to older prisoners. 82% (n:14) of young offenders aged 18-20, also located in closed local prisons, showed severe symptoms compared to 52% (n:16) of those aged 60 and over (figure 3.5). Again however results have to be taken with caution due to the small number of young offenders who responded to the survey. In relation to ethnic group, black ethnic groups (n:87; 75%) and white groups (n:434; 72%) were more likely to show severe symptoms compared to Asians (n:4; 58%) even though Asian groups were more likely to report poorer health.

[29] Singleton, N. et al. (1998) Psychiatric Morbidity among Prisoners: Summary Report. Office of National Statistics: www.statistics.gov.uk/downloads/theme_health//Prisoners_PsycMorb.pdf

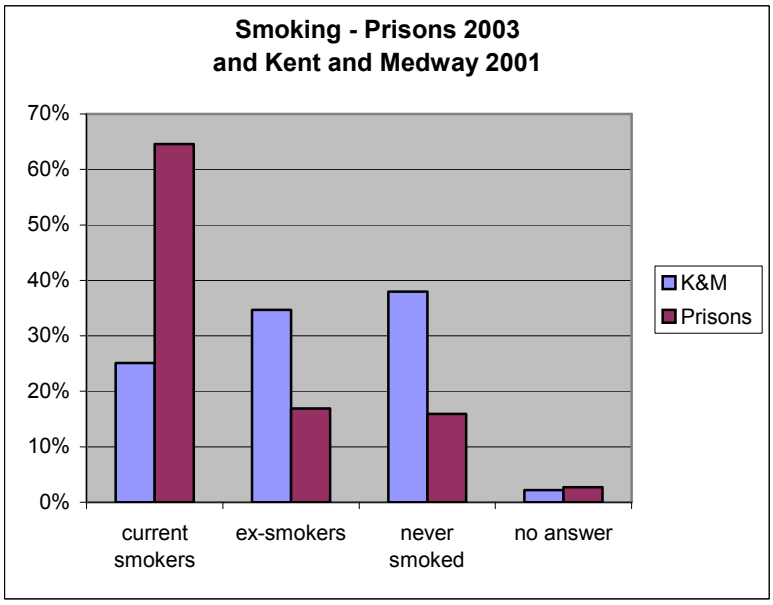
Figure 3.5



3.6 Smoking

The survey reveals that twice as many prisoners are smoking compared to the male general population. 59% (n:482) of respondents admitted to smoking daily, and another 5% (n:42) occasionally; this compares to a quarter of the general population of Kent and Medway and East Sussex who smoke[30]. 17% (n:137) of prison respondents said they used to smoke but don't smoke at all now. Only 16% (n:129) said they had never smoked; this compares to 38% in the Kent and Medway survey (Figure 3.6). Prisoners are more likely to be in a lower socio-economic group than the general population and smoking is class related, for example in the Health Survey of England 1998 [31] 38% of men in Social Class IV and V were current smokers, thus it is not surprising that more prisoners would be smoking than in the Kent and Medway population.

Figure 3.6



[30] Male population in Kent and Medway survey was aged between 18-74, population in East Sussex survey was 18 and over.
[31] Rainford, L. and Mason, V et al. (2000).Health in England 1998: Investigating the Links between Social Inequalities and Health. Office of National Statistics. London: The Stationary Office.

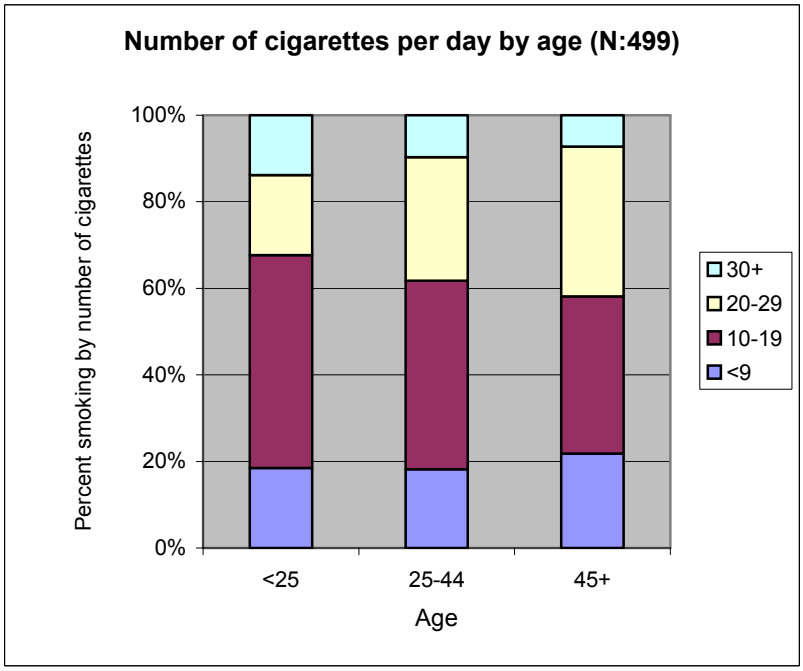
Respondents in closed prisons (n:195; 75% in local prisons and n:113; 63% in training prisons) or remand prisoners (n:60; 73%) were more likely to smoke than respondents in open prisons (n:116; 54%) and convicted prisoners (n:455; 64%). Smoking prevalence in the prison respondents is highest in the younger age groups; in the general population fewer men under 25 smoke.

Smoking by age:

- In Prison
  - 72% of those under 25
  - 68% of those aged 25-44
  - 50% of those aged 45-64 were current smokers
- In Kent and Medway
  - 18% of men aged under 25
  - 27% aged 25-44
  - 20% aged 45-64 were current smokers

Although the number of prisoners smoking is less in the over 45 age group, those smoking in that group are more likely to be smoking more than 20 cigarettes a day than younger prisoners (Figure 3.7). Conversely younger prisoners who smoke were more likely to smoke more than 30 cigarettes per day compared to older age groups. Like the general population white groups were more likely to smoke than Black and Asian groups. 55 prisoners (7% of respondents) said they had suffered from tobacco withdrawal symptoms since being in prison; the proportion was slightly higher in the closed prisons (10% in the local and 7% in the training prisons) but only 4% in the open prisons.

Figure 3.7



3.7 Comment

The profile has highlighted and affirmed that the male prison population is younger, less healthy, more likely to suffer from long-term illness and mental health problems, and more likely to smoke, compared to the general population. Although many differences may be attributed to the increased likelihood of the prison population being in the lower social classes, the survey has also shown that pressures within prison itself may be a contributing factor. For example prisoners in open prisoners are healthier than their counterparts in closed prisons, and receive more visits and emotional support from their family and friends. Closed local prisons in particular appear to hold more unhealthy prisoners, who include remand prisoners or young offenders, who are more likely to smoke and have poor physical and mental health. On the other hand open prisons also hold older prisoners, compared to the closed prisons, who also reported quite poor health. The profile of the survey respondents provides a platform in which to help evaluate needs and risks in relation to substance misuse in the context of a prison setting.

4. Needs and Risks

This section aims to identify the needs and risks of prisoners in the Kent Surrey and Sussex area in relation to drug misuse. It mainly describes the respondents use of alcohol and drugs prior to entry into the prison system and whilst they have been in their current prison.

4.1 Alcohol use before prison

The survey asked:

'In the year before coming into prison how often did you have a drink containing alcohol?'

There is a higher prevalence of heavy drinkers in the male prison population than in the general population. Amongst the prison population 17% (n:140) of respondents said they never drank alcohol; 56% said they were having a drink twice a week or more before coming into prison, and two thirds of these where drinking on four or more days a week. 37% (n:247) of those who drink were drinking above the recommended limit of 21 units per week. In comparison with the general population, 14% of men in Kent and Medway said they never drink and 6% were drinking more than 21 units per week. [32] However the Health Survey for England reported that 30% of men were drinking over 21 units and also that men in the lowest social classes, IV and V (likely to be high in the prison population) had a higher mean weekly alcohol consumption than other social classes.[33]

In the year before prison, on a daily or almost daily basis, among the respondents who drank (n:672):

- 35% were drinking 6 or more units, (and 27% on a weekly basis)
- 18% found they couldn't stop drinking
- 14% failed to do what was normally expected because of drink
- 16% needed a drink to get going after a heavy drinking session
- 9% had experienced a feelings of guilt or remorse after drinking
- 9% were unable to remember the night before

In addition 26% of respondents who drank said they or someone else had been injured as a result of their drinking during the last year before prison. Also 27% (n:180) said that someone had expressed concern about their drinking in the last year before prison. 66% of these were cases where someone had been injured as a result of their drinking. Almost half (n:118; 48%) of the respondents who were drinking over the recommended limit per week were under the influence of alcohol when committing their most recent offence, compared to 22% (n:181) of all 812 respondents.

[32] Palmer A. A Survey of Health and Lifestyles in Kent and Medway – What have we learned? CHSS, University of Kent, 2003

[33] Rainford, L and Mason, V. (2000) Health in England 1998: Investigating the links between Social Inequalities and Health, ONS: London: Stationary Office.

4.2 Alcohol use whilst in prison

Only 8% (n:53) of those who ever drink said that they were drinking now, whilst in prison, and 86% (n:580) said they were not drinking in prison; this is across prisons and does not reflect practice in any one prison. Across prisons a higher proportion of prisoners are currently drinking in closed prisons (n:45; 9%) compared to open prisons (n:8; 5%). Prisoners on remand (n:7; 10%) were more likely to drink in prison now compared to convicted prisoners (n:44; 7%). However response is low for this when looking at types prisons or prisoners. The respondents drinking over the recommended limit per week before prison were more likely to be currently drinking in prison (n:31; 13%) compared to light/moderate drinkers (n:22; 6%). Despite this finding, alcohol consumption is considerately reduced within the prison environment, even for the majority of heavier drinkers. Younger respondents were more likely to be drinking inside prison compared to older respondents. 11% (n:12) of under 25 year olds (a quarter of these young offenders) were drinking in prison.

9% (n:76) of all respondents said they have been suffering from withdrawal symptoms from alcohol since being in prison, and 32% (n:10) of the respondents drinking over the recommended weekly limit before prison said they suffered alcohol withdrawal. Prisoners in closed local prisons where more likely to have suffered withdrawal symptoms from alcohol (n:46; 18%) compared to closed training prisons (n:19; 6%) and open prisons (n:11; 5%). Remand prisoners are more likely to have suffered alcohol withdrawal since coming into the prison (n:15; 18%) compared to convicted prisoners (n:59; 8%); probably because they would have come into their current prison from outside rather than from another prison, unlike the convicted prisoners. However as Figure 4.1 demonstrates, it is not necessarily the presence of remand prisoners that makes the rate of prisoners with alcohol withdrawal higher in closed local prisons compared to other types of prison, as withdrawal is higher for convicted prisoners in local prisons also (23%).

Figure 4.1

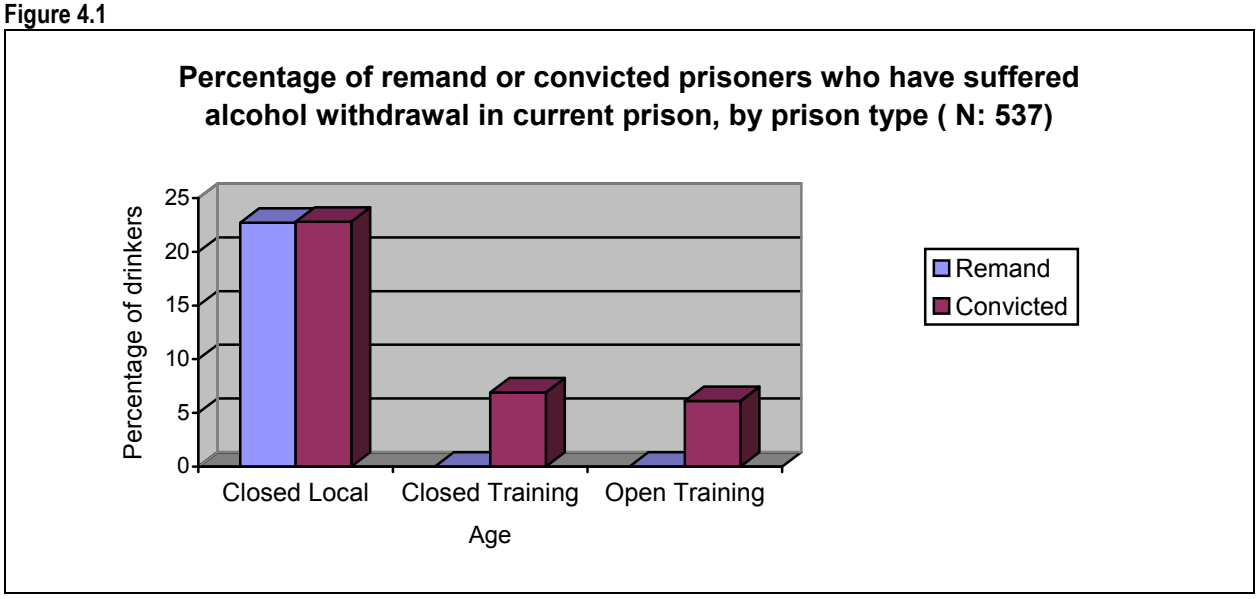
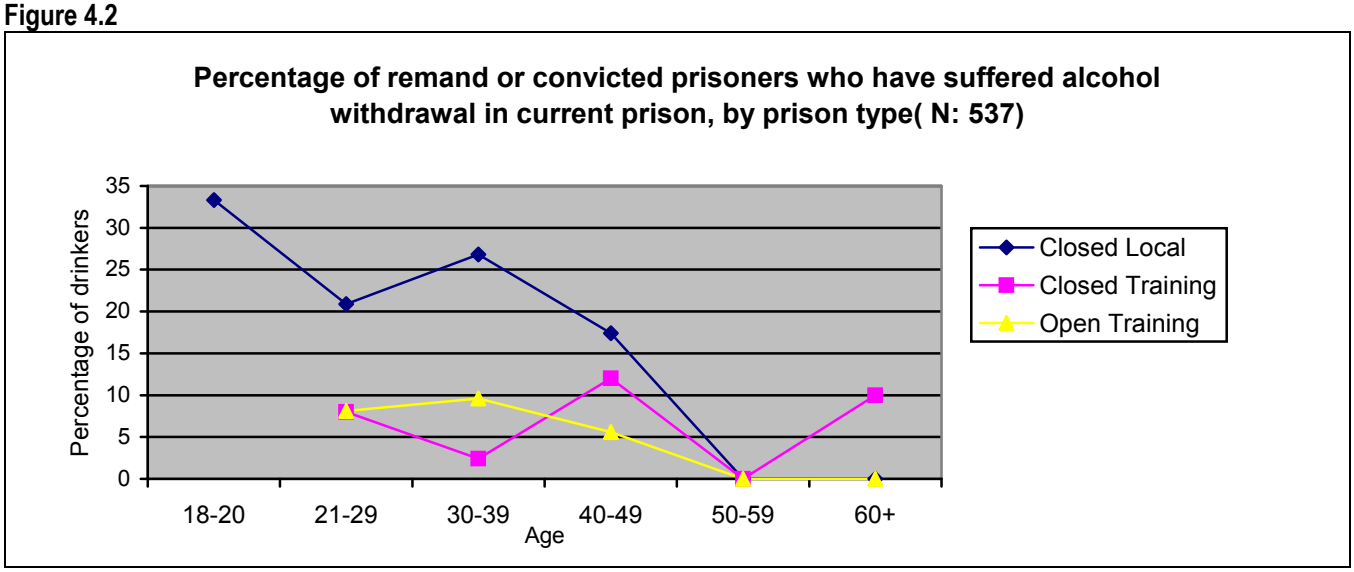


Figure 4.2 below, indicates that the presence of young offenders in the closed local prison may have an effect on the percentage of prisoners with withdrawal symptom and that the rate of alcohol withdrawal decreases with age across prisons generally. This however doesn't explain the higher percentage of withdrawal across age groups for the closed local prisons, which may be due to these prisons holding prisoners on remand. This is further investigated in relation to treatment and services provided in prisons in section 5 of the report.

Figure 4.2



4.3 Drug use before prison

The survey asked:-

'Which of these drugs have you ever used at any time in your life?'

Two thirds of respondents (n:542; 67%) reported that they have used drugs at sometime in their life. 30% (n:241) of respondents said that they had never used drugs. The most recent offence of 57% (n:464) of respondents was related to drugs in some way, underlining a link between drug use and offending. For most of these the offence involved the taking of drugs (n:180; 33%), or they were under the influence of drugs when they offended (n:170; 31%) or they offended in order to get money to buy drugs (n:112; 21%). Also 12% (n:65) had imported drugs, 10% (n:54) were selling drugs, and 8% (n:45) were drug dealers. The survey asked whether they had ever used a particular drug from a list; there were no drugs in the list that had never been used.

Of the 542 respondents who had ever used:

- 91% have used cannabis
- 69% have used cocaine powder
- 62% have used ecstasy
- 56% have used amphetamines
- 52% have used LSD
- 49% have used crack cocaine
- 42% have used heroin
- 27% have used solvents
- 24% have used prescribed tranquillisers
- 23% have used non-prescribed methadone
- 22% have used illicit tranquillisers
- 20% have used prescribed methadone

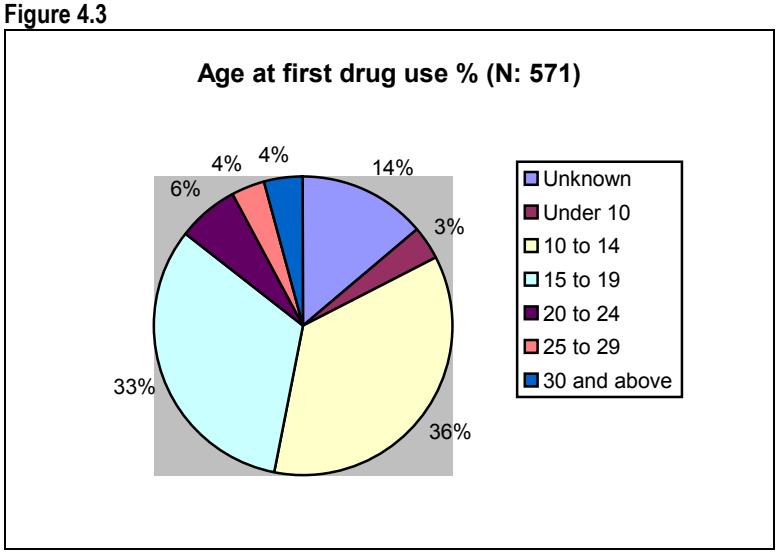
The majority of respondents who have ever used drugs, reported first using in their childhood and teenage years, between the ages of 10-19 (n:389; 68%). 4% (n:20) actually reported to being under ten years of age when they first tried drugs (figure 4.3). The mean age of first drug use was 16 years of age. 71% of those who have ever used (that is half of all respondents) reported using drugs more than 100 times in their lifetime. Only 9% have used less than ten times. Prisoners who were in closed prisons at the time of the survey were more likely to have ever used drugs (n:194; 74% in local prison, and n:236; 70% in training prisons) compared to prisoners in open prisons (n:112; 52%), and this applied to all of the drugs mentioned in the above list. Respondents were also much more likely to have used drugs if their friends (n:245; 94%), partner (n:74; 97%) or family (n:101; 94%) were users; compared to just half of respondent who were users but family and friends were not. Before prison, respondents who had no fixed abode were most likely to be using drugs at this time (n:58; 87%), compared to 64% (n:7) of those who lived with friends/flatmates, 59% (n:56) of those who were living with parents, 54% (n:71) of those living alone, 46% (n:184) of respondents who were living with a partner or spouse, and 44% (n:18) who were living with other family.

Younger prisoners were more likely to have using drugs at some time in their life compared to older prisoners. 87% (n:92) of under 25's reported to using drugs, compared to 72% (n:358) of 25-44 year olds and 37% (n:56) of those aged 45 and over. Younger prisoners were also more likely to have first tried drugs at a younger age compared to their older counterparts. Of those who have used drugs, 59% who are now aged under 25, and 40% who are now aged 25-44, had started using drugs under the age of 15. 87% of prisoners who started using drugs when they were under 15 were using daily before coming into prison, compared with 61% of those who were 15-19, 56% of those who were 20-24 and 48% who were older than 25 when they first used. This shows a trend of increased drug taking among younger age groups though time. A strong relationship between young people and drug use has also been underlined in the community in recent findings from the British Crime Survey.[34] The young offenders (18-20) were more likely to have used cannabis (88%), ecstasy (71%), amphetamines (59%), crack/rock cocaine (53%) and solvents (35%), compared to adult

[34] Condon, J and Smith, N (2003) Prevalence of Drug Use: key findings from the 2002/2003 British Crime Survey, Home Office.

prisoners. Adult prisoners, in particular, were more likely to have used heroin; 38% of 21-29 year olds and 34% of 30-39 year olds reported using heroin compared to 18% of young offenders. In relation to ethnic group, 7 in every 10 whites had used drugs compared to, 6 in every 10 black ethnic groups and 5 in every 10 Asians.

Figure 4.3



75% (n:429) who had ever used drugs reported that they had used within the 12 months before they came into prison this time. 69% (n:316) of users reported continuous drug use in the 12 months before prison, and 83% of these were using in the month before coming into prison, of which two thirds were using daily. Continuous drug use was also appears to be related to age: 75% of users aged under 25 had used for two weeks continuously before prison, compared to 70% aged 25-44 and 68% aged 45 and over. Of the respondents who had used drugs in the 12 months before prison quite a high number (55%) had felt dependent on the drug(s) they were taking. Less (38%) had tried to cut down their drug taking, but found that they could not; a similar number reported to having withdrawal symptoms. However, 54% had felt that they needed more drugs to get the same effect. The last offence of those prisoners who reported using drugs in the 12 months before prison was more likely to be related to drugs (77%) compared all respondents and prisoners who had ever used.

4.4 Drug use whilst in prison

37% (n:213) of users said that they had used a drug in their current prison, 12% (n:69) said they had not used in their current prison, but in another prison, and 45% (n:254) of users had never used in any prison. 61% of the prisoners who said that they had used drugs in the year before coming into prison this time have used in any prison (three quarters of them in their current prison only). 72% of those who have used inside any prison were using daily in the month before coming into prison, again three quarters of them in their current prison only. 21% of respondents who had ever used reported to having drug withdrawal symptoms since arriving in their current prison. Prisoners held in closed training prisons in particular were more likely to have used drugs in any prison and in the training prison they were currently in. Prisoners currently in open prisons were the least likely to have ever used drugs in prison or in their open prison (Table 4.1). Convicted prisoners were more likely to have used drugs in their current prison (n:195; 39%), to have been introduced to drugs in their current prison and taken more drugs, compared to remand prisons, who are less likely to have taken drugs in their current prison (n:12; 19%); a possible factor to explain this could be they had spent less time in

that prison, however they are still using despite this. This finding may account for the lower amount of drug use in local prisons, where remand prisoners are held. However, it seems more likely that it could be associated with less availability of drugs in this type of prison.

Table 4.1

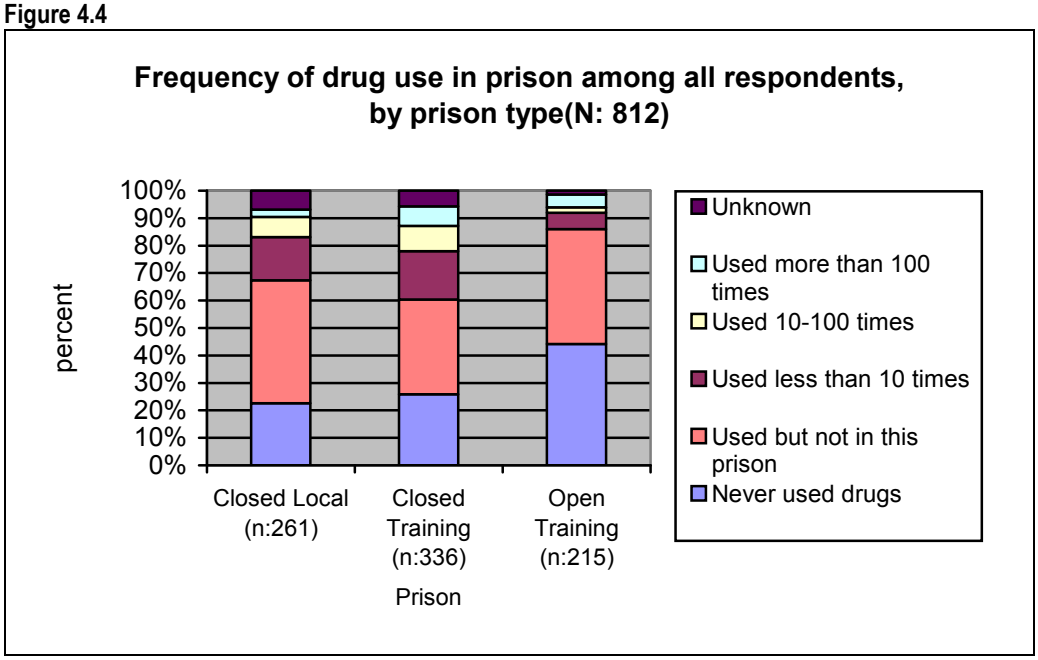
Drug use inside by Prison

	Closed Local Prisons (n:202)	Closed Training Prisons (n:249)	Open Training Prisons (n:120)
Ever used inside any prison	45%	60%	35%
Used inside current prison	35%	46%	23%
Used but not inside prison	48%	33%	63%

12% (n:25) of those respondents who said that they had used drugs in their current prison had used drugs for the first time in this prison. Prisoners were more likely to have been introduced to drugs in closed training prisons (n:18; 14%) compared to 7% (n:2) in open prisons and only 6% (n:5) in closed local prisons. This indicates that prisoners in local prisons could more likely to be users before they came into their current prison, as they were the prison type that held prisoners most likely to report that they had ever used. Out of those prisoners who have used in their current prison 17% (n:41) had used drugs more than 100 times, 22% (n:54) between 10-100 times and 46% (n:113) less than 10 times. 36% (n:76) of users in their current prison had experienced withdrawal symptoms in their prison, compared to 13% of users who hadn't used in their current prison. In relation to prison type, users in open prisoners had used the most in their prison, 33% (n:10) had used over 100 times in open prisons compared to 18% (n:24) in closed training prisons and 8% (n:7) in closed local prisons. However this finding has to be read in the knowledge that prisoners in open prisons were the least likely to have ever used drugs or used in prison, this in turn reduces the numbers of cases in the analysis and may have inflated the result.

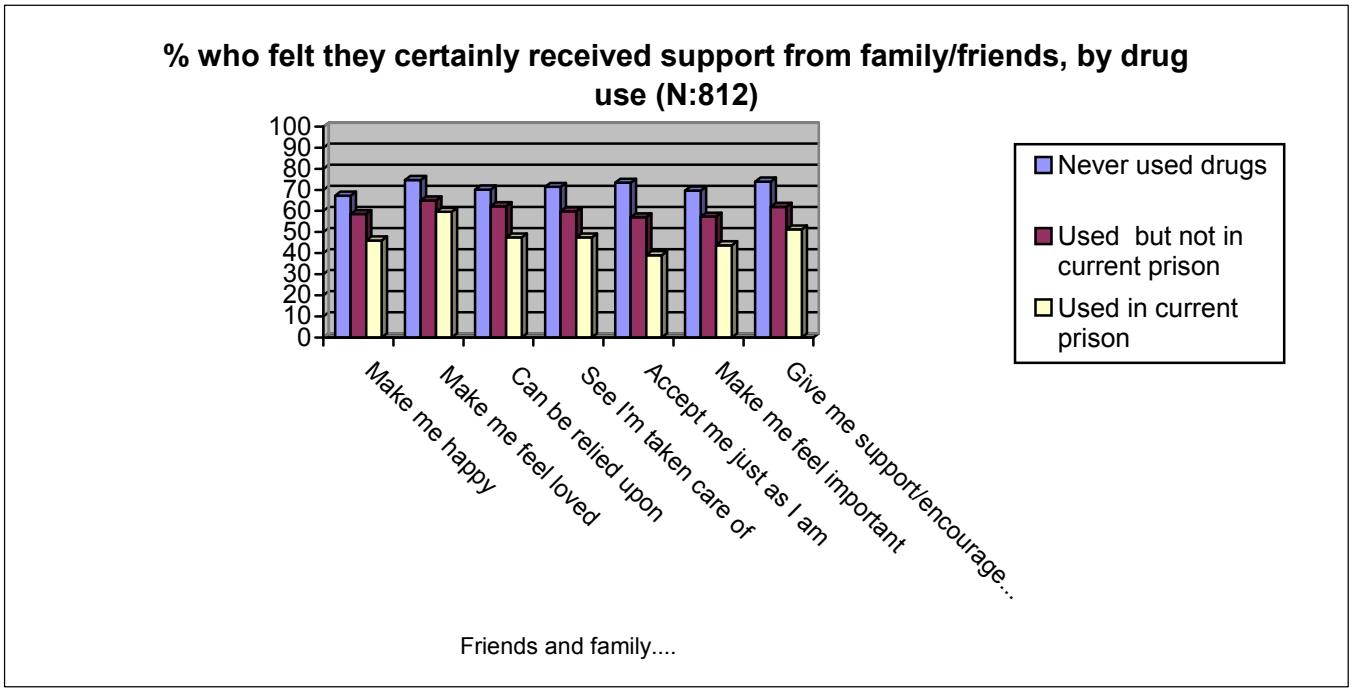
Figure 4.4 presents a picture of the frequency of drug use between prison types among all respondents, to give a feel of the amount of drug use (and those not using drugs) in each type of prison. This analysis shows that prevalence and frequency of drug use is highest among the population in closed training prisons compared to other types of prison. Figure 4.5 indicates that 40% of prisoners in closed training prisons are using drugs in their current prison.

Figure 4.4



Respondents who are currently using drugs in prison were less likely to feel that they had love and support from their family and friends, compared to respondents who had used but not in this prison, and those who had never used drugs who were more likely to feel they had love and support. Figure 4.5 demonstrates this by showing the percentage who answered 'certainly true' to a number of statements about their family and friends, in relation to their drug use behaviour.

Figure 4.5



Of the respondents who reported to using drugs in their current prison, 34% (n:73) were using at the time of the survey, and most of these were using daily or almost daily. Even though drug use in prison is more prevalent in closed training prisons, a higher proportion of users in the closed local prisons claimed to be using at the time of the survey (n:32; 38%) and using daily (n: 12; 26%). Users in their current prison who were using at the time of the survey were more likely to have used before coming into this prison, either in the community or in another prison (n:67; 36%) compared to those prisoners who have been introduced to drugs in their current prison (n:7; 28%). Drugs most commonly used by users in

prison were cannabis (n:187; 75%), heroin (n:122; 49%) and crack/rock cocaine (n:52; 21%); the trend remains the same for current users, who were using at the time of the survey (table 4.2).

Table 4.2

Drugs used in prison

	Ever used in current prison	Current users
Cannabis	75%	86%
Heroin	49%	66%
Crack/rock cocaine	21%	33%
Cocaine powder	16%	26%
Ecstasy	13%	18%
Illicit tranquillisers	11%	21%
Prescribed tranquillisers	11%	20%
Amphetamines	8%	13%
LSD	5%	11%
Non-prescribed methadone	4%	11%
Prescribed methadone	3%	7%
Solvents	3%	8%
Total	**n:248 (100%)**	**n:76 (100%)**

Of the 248 respondents who have used drugs in their current prison, 35% were currently using cannabis, a low proportion compared to the percentage that said they had used the drug at some time in their current prison. 41% were currently using heroin, which is the majority of those who said they had used the drug in their current prison at some time (Table 4.2). Although cannabis may be the favoured drug for most of the respondents in prison (and the outside community) the finding of a higher proportion of heroin use compared to cannabis currently may be unsurprising due to the existence of mandatory and voluntary drug testing in prison, because of the longer time that cannabis can be detected after use compared to heroin. Also a drug of choice may not be available in a prison at any one time, and so users may have to use an alternative drug or not use at all. However despite the restraints to use of a drug of choice, the choice of drug is still related to age in prison not just in the outside community. Users in prison under 25 were more likely to have used cannabis (n:36; 90%) compared to 25-44 year olds (n:126; 81%) and those aged 45 and over (n:15; 63%). They were also more likely to have used cocaine, ecstasy, LSD and amphetamines compared to older drug users. However, as in the outside community older users are more likely to use heroin; 56% (n:87) of 25-44 year olds reported using heroin compared to 45% (n:18) of under 25 year olds. The drug of choice or availability may also be related to prison type. Cannabis was used by the highest proportion of users in the open training prisons (n:25; 83%) compared to closed local (n:64; 75%) and closed training prisons (n:98; 74%) where as the proportion of heroin use was highest among users in the closed local prisons (n:44; 52%) followed closely by closed training (n:65; 49%) and then open prisons (n:13; 43%).

4.5. Change in drug use whilst in prison

It appears that patterns of drug use will change for many once they enter the prison system. As we have already shown, 53% (n:429) of all who responded claimed to have taken drugs in the 12 months before coming into prison this time, 26% of these reported to have used drugs in their current prison. Therefore the rate of drug use becomes less for many drug users once they enter prison. As already mentioned, some became introduced to drugs in prison, however among all respondents these are few (n:25; 3%). 67% (n:167) of those who had used drugs inside their prison said that their drug use had changed. Most of these (154 respondents) said that their use had either stopped or decreased; just under half of these said they had actually stopped. Use was most likely to have decreased or stopped among users in closed local prisons (45%) compared to closed training (40%) and open prisons (15%). However when looking more closely at just the prisoners who had stopped, this included more prisoners from closed training prisons in particular because of their attendance at the RAPt programme, which was set up by the Rehabilitation of Addicted Prisoners Trust (see section 5). These respondents were particularly enthusiastic about the help that this course had provided in terms of enabling them to come off drugs and seek a better, drug and crime free life:

Help of RAPt:

'I don't take drugs no more because I'm a recovering addict who is learning to live life without them due to doing a RAPt course' (ID402 Closed training prison)

'The RAPt course was my salvation. I realised I could face up to my feelings without using drugs to cope' (ID187 Closed training prison).

'I have been clean now for over a year down to my own will and the help of RAPt the 12 step programme, because I feel if I was to carry on as I was I would end up very dead' (ID447 Closed training prison)

In all prisons, but particularly the closed local prisons, their use had reduced since being in their current prison because drugs, or their drug of choice was not available. This may help to explain why users in closed local prisons are much more likely to have experienced withdrawal symptoms in their prison (n:41; 59%) compared to closed training (n:29; 25% and open prisons (n:6; 21%); prisoners in closed local prisoners were more likely to be users outside compared to other types of prison. The quotes below describe the unavailability of heroin, crack cocaine and cannabis in closed local prisons.

Unavailability of drugs:

'I don't do heroin or crack at the moment because it is unavailable' (ID773 Closed local prison)

'I haven't got a Roger Rabbit (heroin habit) now and heroin isn't available in here much anyway' (ID16 Closed local prison).

'My drug use has changed and made me more stressful as it is rare to get hold of and cannabis calms me down and chills me out' (ID54 Closed local prison).

The unavailability of drugs is not the only aspect of the prison environment that is changing drug use in prison or use of the drug of choice. The drug testing system in place in prison causes a major change in prisoner drug use. Many prisoners said their follow prisoners would use the harder option of heroin instead of cannabis in order to not get caught during testing. The availability of heroin could be greater in prison than cannabis for this reason. Some respondents admitted to starting to use heroin in prison because of the testing, even though they'd never used it outside. Of course this in turn, has the consequences of drug addiction, which may not have previously been a problem in the outside community for some prisoners. The quotes below show that such problems may be apparent, particularly within closed training prisons. It doesn't appear to be such a problem in closed local prisons where, as already mentioned, drugs appear not to be as available.

Use of heroin and drug testing:

'*It's hard to obtain cannabis because of the drugs system in place here, where as heroin is easier to get hold of and doesn't stay inside you for as long as cannabis, so it's less likely to get caught on a drugs test'* (ID314, Closed training prison).

'It was whilst in prison that I first took heroin as it is only in your urine for three days, as opposed to cannabis being present for 28 days. Heroin is therefore the safest drug to take whilst in prison (or so I thought). Urine testing has turned our prison system into factories for churning out junkies' (ID203, Closed training prison).

'I smoke less cannabis (my drug of choice) and I have used heroin (which I never use out of prison) but only very occasionally, because cannabis stays in your system much longer than opiates' (ID661, Open prison).

'I've stopped – I've had it (heroin) offered loads of times in here' (ID368, Closed training prison)

Even if drugs are available in prison some respondents felt that they had too much to lose if they were to start taking or carry on taking drugs. These things ranged from being penalised by the prison to letting down their family. Some prisoners simply felt that they needed to stop using drugs for their own benefit, and felt that the prison environment could help them do that. The high cost of the drugs in prison, compared to outside was also an issue for some.

Too much to lose:

'The reason it changed is simple in being tested for drugs I can lose the ability to buy things at prison canteen/or opportunity to watch TV on drug-free wing, as well as other things' (ID723, Open prison)

'I have realised they (drugs) *don't help, I have a wife and kids to think about and I've realised I need to live up to my responsibilities and be a better husband and father. For them reasons I've chosen to clean up and am doing well!'* (ID570, Closed local prison).

'Decided to stop using full-stop. It's killing my mind, body and soul' (ID820 Closed, local prison).

'I have not used for last 18 months and feel great in myself as I realised I had to stop as I'm now doing a long life sentence for murder and had to tackle the major issues in my life' (ID395, Closed, training prison)

'Stopped completely – I was just sick to death of it and prison is the easiest way to stop given the right care' (ID359, Closed training prison).

On the other hand it is still evident that the temptations to take drugs are still there in the prison environment. A common reason given for drug taking was the boredom of prison life; some were also tempted if drugs were offered to them in prison.

Temptation:

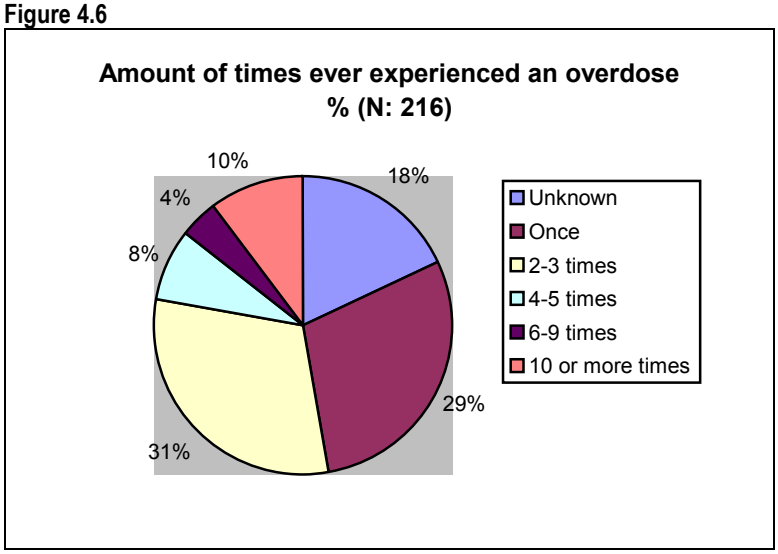
'I will get heroin or cannabis if I can to stop the boredom of prison life' (ID526, Closed local).

'I don't buy drugs and I don't want to take them but sometimes I am vulnerable when offered' (ID463, Open prison)

4.6. Drug Overdose

32% (n:181) of respondents who had ever used drugs in their lifetime had experienced an overdose at some time. Overdose was reported to be mostly accidental, with 19% (n:106) of users having experienced an overdose accidentally, 10% (n:56) deliberately, and 3% (n:19) both accidentally and deliberately. 62% (n:355) of users had never experienced an overdose. Just over half of those who have had an overdose reported having one on more than one occasion, with most experiencing one two or three times (n:66; 31%) but also a high number (n:22; 10%) reporting to have overdosed ten or more times (Figure 4.6).

Figure 4.6



The box below indicated that the frequency of overdose had been higher among those who have overdosed deliberately compared to those whose overdose was accidental.

***Of those who've experienced an accidental drug overdose*:-**

- 61% said they had overdosed more than once
- 24% more than three times
- 10% more than 10 times

Of those who've experienced a deliberate drug overdose:-

- 69% said they had overdosed more than once
- 39% more than three times
- 19% more than ten times

Of the respondents who said they have ever had an overdose 18% (n:17) had overdosed in prison this time; 7% (n:7) had overdosed accidentally, 8% (n:8) deliberately and 2% (n:2) both accidentally and deliberately. Interestingly, a higher percentage admitted to having an overdose deliberately compared to accidentally in prison, but the opposite was found to be the case when asked about whether they'd had an overdose accidentally or deliberately ever in their life (However the lower number of respondents having an overdose in prison should be noted here). When looking at prison type, a third (n:4; 31%) of respondents in open prisons who have ever had an overdose admitted to having an overdose in prison this time, compared to 18% (n:9) in closed training prisons and 14% (n:5) in closed local prisons. However this result has to be read with caution, as the numbers of open prisoners who had ever had an overdose was small, indicating that prisoners in open prisons are less likely to have ever overdosed compared to prisoners in closed prisons.

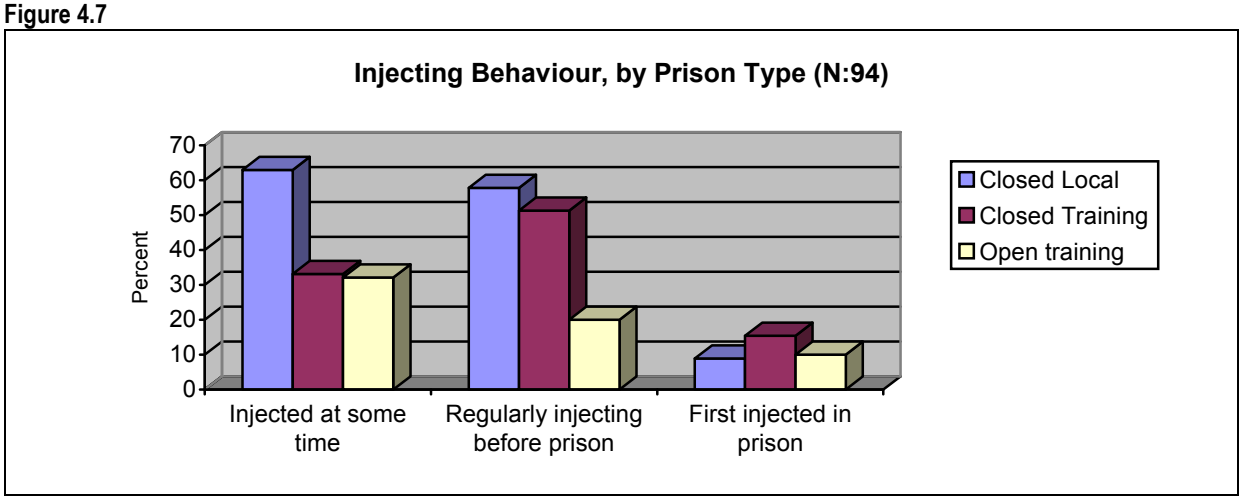
Overdose in prison is more likely to be deliberate in closed local prisons compared to closed training and open prisons. 33% (n:5) of the youngest prisoners (under 25) who have ever overdosed had done so in prison, compared to 10% (n:7) of older prisoners; even though the older the respondent the more likely they are to have ever experienced an overdose. Whilst in prison this time convicted prisoners were more likely to have overdosed (n:17; 19%) compared to remand prisoners (n:1; 14%). Also the more drugs a respondent had used in prison the more likely they were to have overdosed in prison. 35% (n:7) of those had used drugs over 100 times and experienced an overdose in their current prison, compared to 14% (n:4) who had used between 10-100 times and 9% (n:4) who had used less than ten times. For most of these overdose was deliberate, apart from the heavy users (using over 100 times) who had mostly overdosed accidentally. It is however important to note than the majority of users have not had an overdose in prison, whether they have used a lot or not.

4.7. Injecting of any drugs not prescribed by a doctor

28% (n:159) of users said they had injected at some time; 9% of these admitted to injecting inside their current prison. 37% (n:58) were aged between 15-19, 21% (n:33) were between 20-24, and 22% (n:35) were 25 and over when they first injected. A few also admitted to injecting before they were 15 (n: 10; 6%). For the majority this first injecting had

started in the outside community, 10% (n:17) of those who admitted to ever injecting had started in prison. 42% (n:67)of users had injected on a daily basis four weeks before coming into prison this time, 33% (n:53) had not injected at all. 14% of respondents who had injected in the four weeks before coming into prison this time admitted to using in their current prison. None of the respondents who had ever injected, but not in the four week before prison, had used in their current prison. Only 15% (n:7) of those regularly injecting in the month before prison had injected in their current prison. The majority of those who had injected in their prison reported to have injected in the last four weeks (n:12; 79%). Prisoners in closed local prisoners were twice as likely to have ever injected compared to closed training and open prisons, and were more likely to have been injecting regularly in the four weeks before coming into prison. However, prisoners in the closed local prisons were the least likely to have first injected in a prison (Figure 4.7). 47% of injectors had shared injecting equipment at some time; a third of these had shared in the four weeks before prison this time. 34% (n:12) of those who had ever shared equipment admitted to sharing in prison, two thirds of these had shared less than ten times in prison.

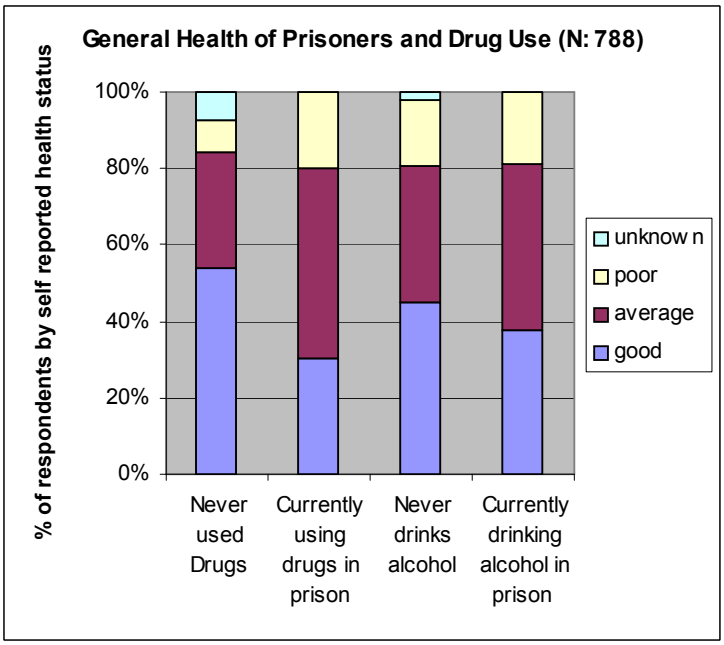
Figure 4.7



4.8. Health Status of Drug Users

Prisoners who had never used drugs were more likely to report good health (n:139; 58%) than those who have used or are using drugs. Among drug users, the lowest good health (n:23; 30%) and the highest poor health (n:15; 20%), was reported by those using drugs in prison at the time of the survey, this group also felt that their health had got much worse in the past year compared to those who weren't currently using drugs (Figure 4.8). Respondents who admitted to drinking at the time of the survey also reported worse health compared to those who never or don't currently drink. On the other hand the percentage of respondents that never drink, and who reported poor health (n:24; 17%), and the respondents that have never used drugs and reported worse health in the past year (n:81; 34%), is high. However further analysis indicates that this finding is probably age related, in that older people are more likely to have worse health and less likely to use drugs than younger people (Figure 4.8).

Figure 4.8.



90% (n:68) of respondents who were currently using drugs in prison, and 89% (n:47) of respondents who were currently drinking in prison, showed severe neurotic symptoms. This compares to 73% (n:344) of drug users who are not currently using, 72% (n:423) who are not currently drinking, 65% (n:157) who have never used drugs and 71% (n:100) who never drink. (Table 4.3). Table 4.3 shows that the use of drugs or alcohol is related to the increased likelihood of mental health problems. This was the case for all of the neurotic disorders tested, which were sleep problems, depression, anxiety, irritability and worry. A higher proportion of drinkers than drug users were shown to have severe symptoms in each disorder, apart from irritability. However, drug users had a higher proportion of severe symptoms overall, indicating that alcohol users were more likely to show severe symptoms in more than one of the individual disorders, but have a lower percentage of respondents showing any severe symptoms at all. It is also the case that some respondents reported currently using both drugs and alcohol, and all of these 19 respondents showed severe symptoms in at least one neurotic disorder. All of these showed severe symptoms in relation to sleep.

Prevalence of severe symptoms of neurotic disorder and drug and alcohol related behaviour (N:788)

Table 4.3

	Never Uses Drugs (n:241)	**Currently Using Drugs in Prison (n:76)**	**Never Drinks Alcohol (n:140)**	**Currently Drinking Alcohol in Prison (n:53)**
Sleep Problems	56%	71%	55%	81%
Depression	35%	61%	39%	62%
Anxiety	32%	62%	40%	66%
Irritability	24%	66%	34%	64%
Worry	13%	20%	23%	25%
Any Neurotic Disorder	**65%**	**90%**	**71%**	**89%**

4.9. Comment

The survey indicated and affirmed that the drug needs and risks are higher among those in the male prison population than in the male general population. There is a higher rate of drug and alcohol use ever among male prisoners before they came into prison compared to the general population. As mentioned previously this may be related to socio-economic class. The majority of respondents had used drugs at sometime and their previous offence was related to drugs. This is also a population who have started using drugs at a very young age and it is the younger prisoners who are using more now. Drug and alcohol use is reduced among this population once in prison, but it is still a problem, and prisoners are likely to continue to use more once they are back in the community. Drug use in prison appears to be more of a problem in closed training prisons, compared to the other types of prison. Also availability of drugs doesn't appear to be as high in other types of prison, but prisoners in closed local prisons were most likely to be drug users (and injectors) before prison and in turn were more likely to suffer from withdrawal. The availability of the drug of choice and drug testing in prison is resulting in a change in drug behaviour in prison, and many are using hard drugs (heroin) instead of their preferred soft drugs (cannabis) resulting in more serious needs and risks among the prison population in terms of increased drug addiction. Drug use and drinking in prison is also affecting the general and mental health of some prisoners. It needs to be noted that the survey may be underestimating the extent of drug use and subsequent needs and risks because this part of the research project is based on a self-report survey. Despite assurances of anonymity and confidentially many prisoners may not have admitted to drug and alcohol use within their current prison for fear of the data being accessed by the prison. Alternatively many drug users may have decided not to complete the survey, meaning that drugs users could be underrepresented.

5. Treatment and Service Provision (Drugs and Alcohol)

This section aims to identify the treatment and services accessed by alcohol and drug users' before prison, whilst in prison, and after prison in the Kent, Surrey and Sussex area. It also looks at this treatment and service provision in relation to prison type and level of drug/alcohol use in particular.

5.1. Treatment received before prison

A quarter (n:205; 25%) of all respondents claimed that they had received treatment, help or advice outside prison, because they were using drugs and/or alcohol; 45% of these had received treatment in the 12 months before coming to prison. A community drug team provided treatment for just under half (n:69; 48%) of the respondents who had received treatment in the 12 months before prison; a GP/doctor (or other practice staff) had provided treatment for 37% (n:54), a hospital 11% (n:16), and a residential rehabilitation unit had provided treatment for 8% (n:12). The respondents were most likely to have visited these treatment providers for counselling (n:61; 42%), advice and information (n:46; 32%) and detoxification (n:39; 27%). However some went there for substitute prescribing (n:34; 23%) a day programme (n:26; 18%) needle/syringe exchange (n:23; 16%) and a rehabilitation programme (n:18; 12%). The oldest prisoners, aged 45 and over, were the least likely to have received treatment before prison (n:23; 17%) compared to those aged under 25 (n:30; 31%) and those aged 25 to 44 (n:145; 32%); this was also the case for those receiving treatment in the 12 months before prison. Unsurprisingly, the heaviest drinkers and drug users were more likely to have had treatment before prison. Prisoners in closed local prisoners were more likely to have used treatment and advice services before prison (n:84; 35%) compared to those in closed training (n:90; 29%) and open prisons (n:31; 16%); they were also the heaviest users of drugs and alcohol before prison, but not inside prison. Despite receiving this treatment in the outside community only 30% (n:43) of respondents felt that the treatment they had received was successful; 45% (n:65) respondents felt that it was unsuccessful. Any information regarding the treatment before prison was unknown for 26% (n:37) of respondents. Younger prisoners were more likely to say that their treatment was successful (n:7; 50%) compared to older respondents.

The respondents were asked to elaborate on the success or failure of their treatment outside prison. Many found treatment was unsuccessful because of the lack of staff, long waiting time for treatment, or the help they were given was not enough. Others felt that drug substitute prescribing (i.e. methadone) was not helpful as they felt they were swapping one addiction for another. Some prisoners also felt that their treatment was unsuccessful because they were sent to prison before treatment was completed and their treatment was not continued in prison, it was unsuccessful for other individuals because they were not serious about giving up drugs, even though they were having treatment.

Unsuccessful Treatment:

'Was an over-worked drug clinic – no real time for them to do any real work just prescribed meth. Felt like they'd given up on us' (ID820, Closed local prison).

'*It was an alcohol detox program, by the time I got it I had already detoxed'* (ID500, Open prison).

'I was prescribed methodone for my heroin problem which was a substitute which was harder to kick than the drug itself' (ID528, Closed local prison)

'I wanted to stop not substitute' (ID475, Open prison).

'I didn't get a chance to be admitted although after a year of pure commitment I was locked up rather than treated – even after gaining a placement and £10,000 funding' (ID208, Closed training prison).

'I was happy with my drug taking and didn't want to stop' (ID435, Closed training prison).

However, some respondents also commented on the success of their treatment for drink and drug addiction before prison. Some felt that entering prison had helped as well, and others felt that they preferred treatment given outside prison than inside prison. For others, success didn't necessarily mean stopping use, but making sure that they were using as safely as possible. It appears that success or failure of treatments, despite their problems, was largely down to individual perseverance and willingness to want to kick a drug or alcohol addiction.

Successful treatment:

'I was using lots of heroin but the treatment and sentence helped me cut down slowly but surely from using everyday down to using once or twice a week' (ID607, Closed local prison).

'It gave me an understanding as to why I drink, to question myself the reasons for. To deal with situations rather than hide behind drink and to talk to relevant people as opposed to drinking' (ID594, Closed local prison).

'You have much better treatment outside and much qualified doctors' (ID527, Closed local prison).

'It didn't help me stop using I just used more cleanly + freely' (ID395, Closed training prison)

Over half the respondents who were in treatment in the 12 months before prison this time had used drugs in their current prison, and two in every three of these felt that their treatment was unsuccessful before prison. Only 11% of those who had been in treatment were drinking now in prison and most of these felt that their treatment before prison had been successful.

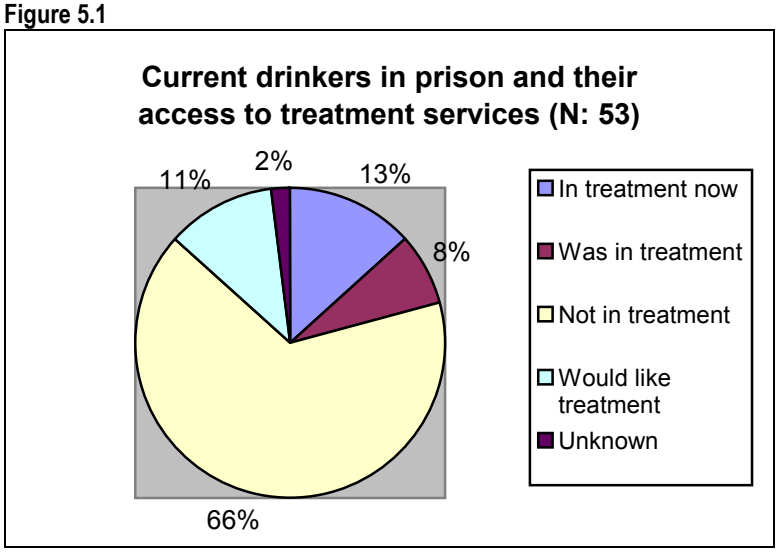
5.2. Treatment received whilst in prison

Only 12% (n:83) of those who drink said that they had received treatment for alcohol problems whilst in their current prison; 5% of those were currently receiving treatment and 7% had received treatment previously in their prison. However 5% said they had not received treatment but would like to. Drinkers aged between 25-44 were most likely to currently be in treatment for alcohol problems in prison (n:27; 7%) and to have previously been in treatment (n:36; 9%), even though younger prisoners are the heaviest drinkers. 5% (n:4) of those aged under 25 were current in treatment for

alcohol problems and 8% (n:7) had been in treatment previously. No one aged 45 and over were currently having treatment for alcoholism, and they were the least likely to want to have treatment. Younger prisoners (under 25) were the most likely to want to have treatment if they were not currently (n:10; 11%). As previously mentioned prisoners in closed local prisons were more likely to drink, to currently be in treatment for alcohol problems (n:16; 7%) and to want help if they weren't in treatment (n:18; 8%) compared to other types of prisons.

13% (n:7) of those who were drinking in prison at the time of the survey said they were currently in treatment for alcohol problems, 8% (n:4) had been in treatment previously, and 11% (n:6) who were drinking said they would like to have treatment (Figure 5.1). None of the respondents in the open prisons who were currently drinking were in treatment, or had previously been in treatment, for alcohol problems in their prison. Most of those who were drinking and currently in treatment were in closed local prisons, and most of those who where drinking and had previously been in treatment for alcohol problems were in closed training prisons. This indicates that treatment may not be so successful for alcohol problems in closed training prisons, and there were slightly more respondents drinking in these prisons compared to local prison.

Figure 5.1



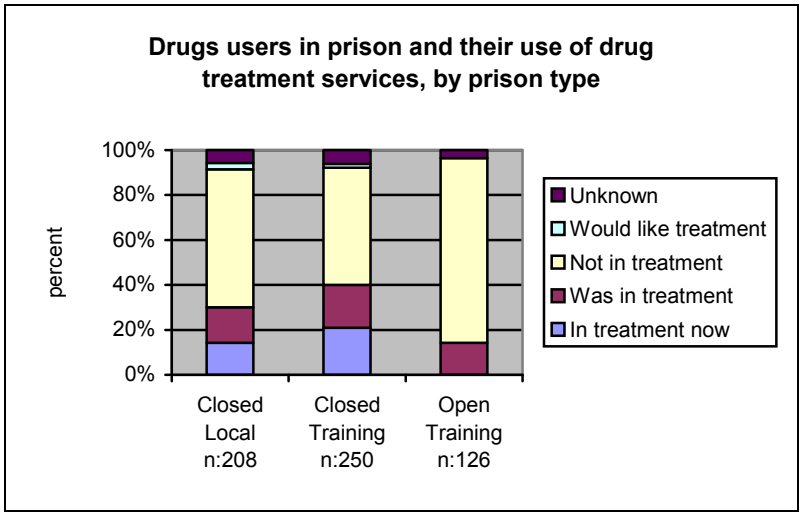
17% (n:100) of those who have ever used drugs said that they had been in treatment for drug addiction since they had been in their current prison; 8% (n:47) were in treatment at the time of the survey and 9% (n:53) had previously been in treatment. Only 3% (n:14) of those who had never had treatment would have liked to. A quarter (n:44; 25%) of those who had had treatment for drug addiction had received treatment from prison medical staff, and 21% (n:37) had received treatment from an outside agency. 13% (n:22) of prisoners mentioned that their treatment had been the RAPt programme. This programme, set up by the Rehabilitation of addicted Prisoners Trust, was the first specialised programme for drug and alcohol users in prisons in England and Wales.[35] However it is likely that many of the respondents who said they had received treatment from an outside agency may include other prisoners who have completed the RAPt programme. 7% (n:12) of respondents said they had received treatment from other sources.

[35] The programme requires total abstinence from drugs, and offers support to addicts to maintain recovery and live drug and crime free lives.

Similar to those with drink problems, drug users in treatment in prison were more likely to be aged between 25-44 compared to other age groups. 9% (n:34) were currently in treatment compared to 7% (n:6) of those aged under 25, and 5% (n:3) of those aged 45 and over. 11% (n:43) of 25-44 year olds had previously been in treatment in their prison compared to 10% (n:9) of under 25 year olds, and 2% (n:1) of those aged 45 and over. Again the younger prisoners, aged under 25 were more likely to want help if they had not already received any (n:3; 3%); younger prisoners are more likely to take drugs compared to older prisoners. The fact that a lower proportion of young prisoners are in/ or have been in treatment may be because most of these prisoners are held in closed local prisons, which had a lower percentage of prisoners reporting to having treatment for drug addiction in this type of prison, independent of age. A higher proportion of prisoners had been in treatment in closed training prisons, 13% (n:32) were in treatment at the time of the survey and 12% (n:31) had previously been in treatment, compared to 7% (n:15) currently in treatment, and 7% (n:15) previously in treatment in closed local prisons. There were no prisoners currently in treatment in the open prisons, but 6% (n:7) had been in treatment before, and no one reported they would like to be in treatment. Prisoners in closed local prisons were more likely to say they wanted treatment if they had not had any (n:7; 3%), probably because of the remand prisoners and prisoners with short-term sentences these prisons hold –these prisoners are more likely to be in the prison for a short period of time and so may not have the access to services that prisoners in training prisons receive, but they may still have drug problems that they will take back into the community again or into another prison. 72% (n:422) of those who were currently using drugs had never received treatment for drug addiction in their current prison.

Amongst the prisoners who said they were currently in treatment, 16% (n:12) were still using drugs. Another 16% (n:12) who were using drugs had been in drug addiction treatment previously. 3% (n:2) of current users who hadn't been in treatment said they would like to (Figure 5.2). Figure 5.2 presents this access to treatment service by drug users in prison, and prison type. As previously highlighted drug users in closed training prisons appear to be receiving more treatment compared to closed local prison and drug users in open prisons are currently receiving no treatment. This leaves a large number of prisoners who are using drugs and not receiving treatment, a high percentage in open prisons in particular. This is likely to be because drug users in prison who weren't receiving treatment in their current prison were most likely to be using cannabis compared to other drugs; particularly users in the open prisons, compared to closed local prisons and closed training prisons. The focus group phase of work, for the project, indicated that prisoners perceived there to be a lack of treatment services available for cannabis users in prison, as it is more focused on tackling 'hard' drugs.

Figure 5.2



There is a range of treatments and services to access in prisons for alcohol and drug problems – from education courses to detoxification. Many of these services in prison are provided by CARAT services[36]. These treatment and support services were launched in 1999 for drug and alcohol mis-users in prison and also link with service provision in the outside community. The most commonly used treatment and services for respondents with alcohol problems in prison were advice and information (48%), CARAT group work (45%), and education courses (43%). A high percentage of those in drug treatment had also used these treatment services, as well as counselling (51%), detoxification (44%) and rehab programme (43%); however most had used CARAT group work (66%). A low amount of those who have accessed drug treatment services had been given a prescription (25%) or needle/syringe exchange (4%) in particular, compared to the other treatments (Table 5.1).

Table 5.1

Type of Treatment Received in Prison for Alcohol and Drug Problems

	Been in treatment in prison for:					
	Alcohol problems		**Drug problems**		**Alcohol and drug problems**	
Type of treatment in prison	**N**	**%**	**N**	**%**	**N**	**%**
Advice / information	29	48.3	44	57.1	15	65.2
Counselling	22	36.7	39	50.6	20	87.0
CARAT group work	27	45.0	51	66.2	18	78.3
Prescription	7	11.7	19	24.7	4	17.4
Rehab programme	8	13.3	33	42.9	11	47.8
Education courses	26	43.3	24	31.2	10	43.5
Detoxification	15	25.0	34	44.2	6	26.1
Social and life skills	23	38.3	15	19.5	10	43.5
Vocational courses	12	20.0	11	14.3	5	21.7
Problem solving	20	33.3	12	15.6	7	30.4
Enhanced thinking skills	21	35.0	25	32.5	9	39.1
Offender behaviour courses	21	35.0	17	22.1	8	34.8
Key skills	16	26.7	11	14.3	6	26.1
Needle/syringe exchange	-	-	3	3.9	-	-
Other	11	18.3	15	19.5	8	34.8
Total N	**60**	**100**	**77**	**100**	**23**	**100**

When looking at the type of treatment received and type of prison, a higher percentage of respondents in treatment in closed training prisons had had access to counselling (n:49; 58%), CARAT group work (n:57; 68%), and rehab programme (n:39; 46%) compared to other types of prison. Prisoners who had accessed treatment services in closed local prisoners were more likely to have had a prescription (n:16; 31%) or detoxification (n:25; 48%) compared to the other prisons. Open prisons appeared to have more access to different educational (n:11; 46%) and vocational (n:7; 29%) courses offered, and also access to courses on social and life skills (n:10; 42%), problem solving (n:11; 46%), enhanced thinking skills (n:10; 42%), offender behaviour (n:12; 50%) and key skills (n:7; 29%), compared to other prison

[36] CARAT services stands for Counselling, Assessment, Referral, Advice, Though care.

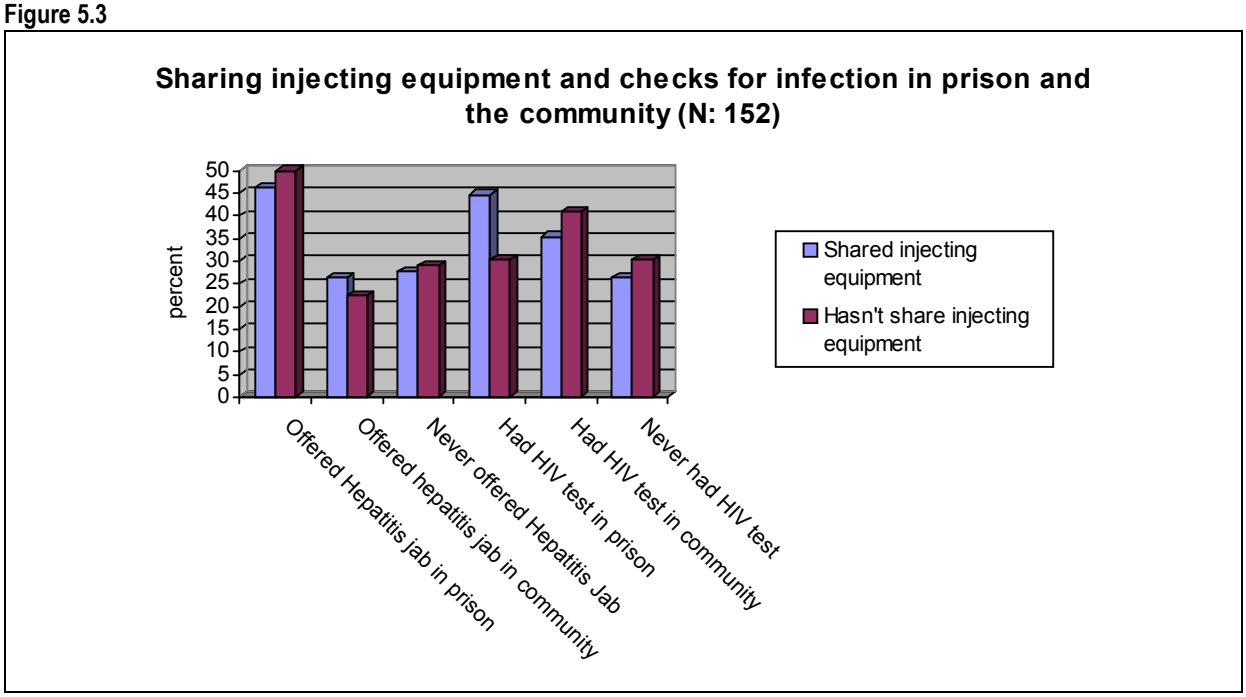
types. Advice and information had been given to the majority of prisoners who had accessing treatment services regardless of the type of prison they were in.

5.3 Injecting in prison: treatment and services

As we have shown, injecting in prison is lower than in the outside community, only 2% (n:15) of all respondents had injected in their current prison, but most of these have shared equipment both inside and outside prison. Only one fifth of these have had access to a needle/syringe exchange in their prison. 25% (n:39) of those who had injected at some time had been offered hepatitis immunisation in the community, 48% (n:76) had been offered in their current prison, and 28% (n:45) of those had ever injected had never been offered hepatitis immunisation. 40% (n:63) of those who had injected at some time had had a HIV blood test in the community, 37% (n:58) had had one in prison, and 29% (n:46) had never had a HIV blood test. Many prisoners, regardless of whether they inject drugs, claimed to have had a hepatitis jab in prison – 39% of all respondents, but most of these were in closed training prisons (n: 187; 56%) compared to open training prisons (n:68; 32%) and closed local prisons (n:60; 24%). In comparison only 10% (n:33) in closed training prisons, 11% (n:24) in open prisons, and 14% (n:36) in closed local prisons had been offered a hepatitis jab in the community.

Injectors who had never shared equipment were more likely to have been offered a hepatitis jab in prison (n:38; 50%) compared to those who had shared (n:35; 46%). The opposite was true in the outside community where 26% (n:20) of injectors who had shared had been offered a hepatitis jab compared to 22% (n:17) who had not shared . 28% (n:21) of those who had shared said they had never been offered hepatitis immunisation (Figure 5.3). This indicates that although prisons are immunising a higher proportion of injectors compared to the community, they are not always reaching those most at risk. A different story emerges in relation to sharing injecting equipment and HIV blood testing. 45% (n:34) of those who have shared have had a HIV blood test in prison, compared to 30% (n:23) who have not shared. In the outside community, a higher proportion of those who have not shared have had a HIV blood test (n:31; 41%) compared to those who have shared (n:27; 36%). 26% (n:20) of those who shared had never had a HIV blood test, compared to 30% (n:23) of non-sharers in the outside community (Figure 5.3).

Figure 5.3



5.4. Detoxification

The aim of detoxification is to reduce drug related harm and encourage withdrawal and abstinence from drug taking. Each prison is required to have a detoxification service and provide treatment for withdrawal symptoms[37]. The majority of respondents who reported receiving detoxification treatment in their prison, felt that the treatment controlled their symptoms (n:48; 52%) and a similar amount (n:32; 53%) felt the treatment was beneficial. The detoxification was more likely to have controlled the symptoms of those in closed local prisons (n:24; 69%) compared to closed training prisons (n:22; 47%), and then open prisons (n:2; 20%). The treatment was felt to be more beneficial by prisoners in closed local prisons (n:17; 66%) as opposed to closed training (n:13; 46%) and open prisons (n:2; 29%).

The respondents were asked to explain why, if they thought their detoxification treatment was not helpful for them. Most of these felt that the treatment was not long enough or the drug they were on was reduced too quickly. Respondents in closed local prisons appeared to be in detox for 14 days, for 12 days in closed training prisons, and only 10 days in open prisons, however this is only from the information received from respondents who wrote in response to their detox treatment being unhelpful, and not information given from all respondents who had been in detox in all prisons. In the following quotes, prisoners describe how their detox treatment was not helpful because it wasn't a long enough programme. The quotes also show how the treatment was not beneficial to other respondents because they were transferred to another prison and their treatment wasn't continued. Another prisoner felt that despite having the detox treatment the boredom of life spent largely in a prison cell draws prisoners back on to drugs.

Detoxification not helpful in prison:

'*My Valium detox was too short, I had fits and blackouts'* (ID548, Closed local prison).

'Two days of DF 118s, then nothing, how do you justify that I never slept for 14 days' (ID033, Closed local prison).

'It's only 12 days it needs to be much longer' (ID374, Closed training prison).

'Because they only give ten days detox' (ID726, Open prison).

'*Diazapam reduction course too quick. I suffered fits due to rapid reduction'* (ID572, Closed local prison)

'Half way through moved from one prison to another and did not get the same treatment' (ID203, Closed training prison).

'As soon as you finish the detox, you then get back on drugs to pass the time spent in your cell' (ID296, Closed training prison).

Detoxification in prison includes substitute prescribing, which are reduction programmes of chemical substitution to give relief from withdrawal by reducing doses.[38] The survey asked respondents about their use of methadone as a substitute prescription before and during prison. Of those who had been prescribed methadone, a high proportion (n:50; 37%) had been prescribed it in the 12 months before coming into prison this time. Of the respondents who had been prescribed

[37] National Treatment Agency (2002) Models of Care for the Treatment of Drug Misusers: Promoting quality, efficiency and effectiveness in drug misuse treatment services in England. London: Department of Health.
[38] National Treatment Agency (2002) Models of Care for the Treatment of Drug Misusers: Promoting quality, efficiency and effectiveness in drug misuse treatment services in England. London: Department of Health.

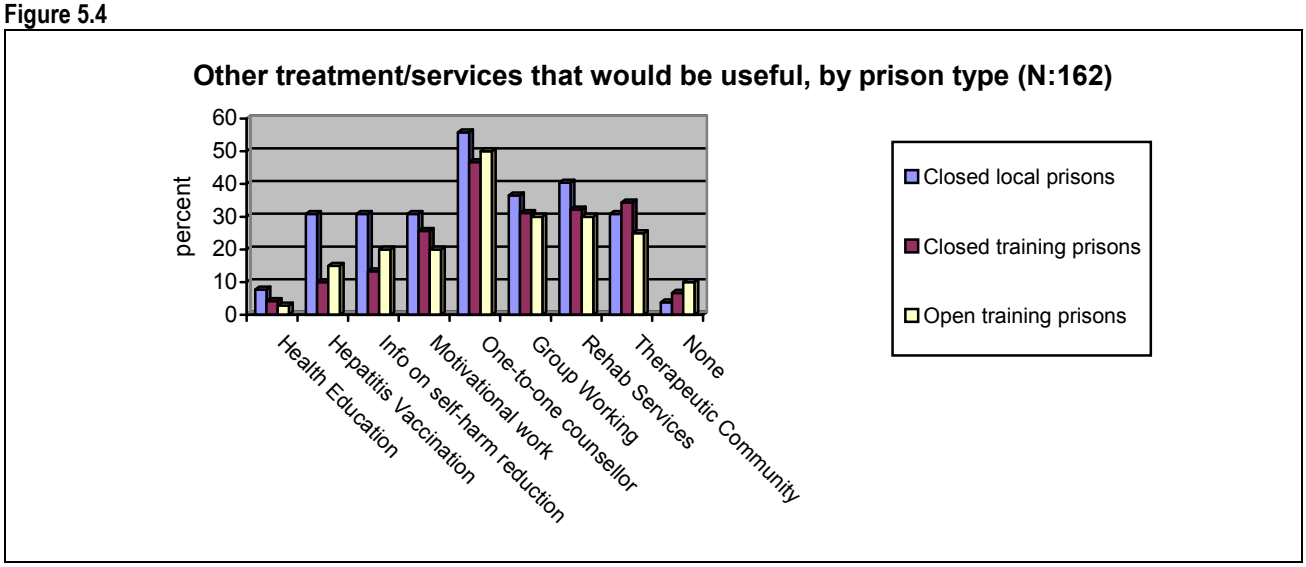
methadone in their current prison, only 10% (n:7) were prescribed methadone in the four weeks after they came into this prison.

5.5. Other treatment and services prisoners would like in prison.

The respondents who had experienced drug treatment services in their prison were asked if there were any other services that would be useful for them in relation to their drug problem. One to one working with a counsellor was regarded as a useful service by half of these respondents (n:81; 50%). Other services that were regarded as useful were access to rehabilitation services (n:56; 35%), group working (n:53; 33%) and access to a therapeutic community, which is residential treatment (n:52; 32%). Motivational work (n:43; 27%) and health education (n:40; 25%) were also popular choices; hepatitis vaccination (n:28; 17%) and information on self-harm reduction (n:32; 20%) were the least popular. Only 6% (n:10) felt that none of these extra services would be useful.

The access and usefulness of these services did vary by type of prison. Hepatitis vaccination and self-harm reduction may have been of low popularity overall but respondents in closed local prisons felt they would be useful compared to respondents in other types of prison. 31% (n:16) of respondents in closed local prisons felt that both these would be useful, and they were the least likely to report that they had received a hepatitis jab in prison. This indicates a need for increased hepatitis immunisation in closed local prisons. In fact the majority of services listed were regarded by a higher proportion of prisoners in closed local prisons as useful services that they hadn't received, compared to other prison types. The only exception was access to a therapeutic community, which was seen as most useful by respondents in closed training prisons (n:31; 34%). Our analysis indicates that a less of a need and use for these services is required by closed training prisons because these prisons already have more services available. Open prisons may have less of a need and use because there are less drug problems in these prisons, particularly with 'hard' drugs where they may feel treatment is more useful (Figure 5.4).

Figure 5.4



As well as the options listed, respondents were asked if there was any other help they would like to receive for their drug problem whilst in prison. Some wanted continued support from the CARAT services, HIV care, better detoxification services, and counselling with people who they think can help them, like people who have experienced drug addiction

themselves. The prisoners from closed training prisons, in particular mentioned the benefit of the RAPt course and that it should be more widely available for those who really want to be free of drugs.

Other help wanted for drug problems in prison:

'Regular talks with a drug counsellor as many outside are textbook counsellors, not ex-users as they are the only ones who understand' (ID512, Open prison).

'Allowing people who really want to change/come off drugs to do the "RAPt" and not just keeping up the numbers' (ID135, Closed training prison).

'Make RAPt available in all prisons' (ID172, Closed training prison).

When answering whether there was any other help they'd like to receive in prison, many drug users mentioned that it was help on release from prison that they needed more, to try and maintain abstinence from drugs once outside. Some said they felt a through care service was necessary, so that treatment is followed though on release. Others felt that they needed help with housing or funding to help stay free of drugs, or simply some information on outside agencies. Assistance for drug users on return to the outside community is explored further in section 5.6.

Help needed on release from prison:

'Through care upon leaving prison' (ID572, Closed, local prison).

'To receive secondary care and do the real rehabilitation outside' (ID385, Closed, training prison)

'A promise of funding on release. If not, a promise of accommodation safe from drug addicts' (ID204, Closed training prisons).

'Help with housing as nowhere to live, so drugs ease the problems' (ID529, Closed, local prison).

'Information about agencies who can help me stay clean on release' (ID192, Closed, training prison).

5.6. Assistance on return to the community.

10% (n:75) of respondents who had used drugs or alcohol said they had been offered links with local drug and alcohol services when they are released from prison. Only 28% (n:17) of those who have received treatment for alcohol problems, 31% (n:24) of those who have received treatment for drug problems, and 30% (n:7) of those who have received treatment for both drug and alcohol problems in prison, have been offered links with local services when they are released. However the majority of these were happy with the arrangements that had been made for them. 82% (n:49) of those who had received alcohol treatment, 75% (n:58) of those who had received drug treatment and 86% (n:20) of those who had received both, were happy with their arrangements.

In relation to prison type, prisoners who had been in treatment in closed training prisons were more likely to have been offered links with the local drug and alcohol services and these were also the prisons that offered more treatment services inside prison. However the majority of prisoners in treatment in all prison types haven't been offered links with outside services. 32% of closed training prisoners in treatment compared to 29% of those in open prisons and 27% in closed local prisons had been offered links. This is an interesting finding for closed local prisons as the population of these types of prisons are either on remand and are on short term sentences so are more likely to be going back into the community quicker and more frequently than prisoners in other types of prison. There was a relationship between the length of sentence left to serve and whether respondents been given links to local service once released. Of those who said they had been offered links 41% (n:31) expected to leave prison within a year, 31% (n:23) within 1-5 years, 8% (n:6) in 6 years or more, and 17% (n:13) didn't know when they expected to leave. However, despite a greater proportion of those leaving in a year receiving help on release this is still a minority of prisoners who are currently receiving treatment – only 35% of those who had received treatment in prison and were leaving prison within the year had been offered outside links.

Respondents were also asked what general assistance they would like when they return to the outside community to stay off drugs. The majority who gave an answer, said that help with finding accommodation (including hostels), employment, and regular counselling would be important to help stay drug free. Help to get the right kind of accommodation in the right area was also a concern, so they are not surrounded by other people that take drugs, and around friends who had been involved in their drug taking before prison.

Accommodation on release:

'To have the chance of an assured accommodation in new area to enable me to make new friends that are clean and far enough away from my old addicted acquaintances' (ID452, Open prison).

Rehab, away from old company and so called friends, don't need them as they have forgotten me since imprisoned. Different area' (ID175, Closed, training prison).

'Residential rehab, change of area outside' (ID6, Closed local prison).

'I don't know for sure but being released into a hostel environment is dangerous as you're surrounded by addicts and chances of relapse are seriously increased' (ID755, Open prison).

'Rehabilitation hostel for prisoners who have spent 10 years and over in prison, that would help with re-housing and finding work' (ID124, Closed, training prison).

Also important was continued support or through care – where treatment they had received in prison could be carried on in the community. Some felt that their family and friends would be there to support them, and others felt, particularly in the open prisons, that their experiences in prison and the treatment they had received had given them a different perspective on life and it was enough to see them not go back to drugs on the outside.

Assistance not needed outside due to help in prison:

'I believe I don't need assistance, just being in jail has assisted my problem and opened my mind' (ID640, Open prison).

'I have all the tools I need to stay off drugs, I've learnt so much from courses I've done that I won't be going down that path again' (ID755, Open prison).

Prisoners who had been in prison before were asked to comment on their experience of drug use when they returned to the outside community the last time they were in prison. Although some remained drug free or were happy with their drug use, others relapsed because of a lack of support to help with pressures of dealing with life outside prison. Again these pressures, as previously mentioned, are related to finding somewhere to live, finding employment, mixing again with friends and family who are involved in drug taking, and a lack of through care and continued treatment on release. Some returned to drug use soon after release.

Pressures that lead to a return to drug use on release:

'Pressures of finding work and keeping commitments with probation service and having somewhere to stay subsequently giving into it all, kind of resulting to drugs as a way out' (ID723, Open prison).

'Because release was unexpected and got released to having to lose my accommodation and having no money and family can't/won't help I was homeless, so when I got some money I got drugs' (ID607, Closed local prison).

It's the same for me every time. I don't get help with my drug taking and end up with another habit within a month of being out' (ID779, Closed local prison).

Basically you went out drug free but there was no follow-up service or being offered help from anyone. So you end up amongst your old friends again then before you know about it you are hooked again' (ID438, Closed training prison).

'Everyone I know on being released was on heroin as I drifted back into the scene although I did not want to' (ID526, Closed local prison).

Other prisoners mentioned the increased use of drugs, and availability of drugs, in general in the community as a problem when they were released. Many noticed drugs were more readily available and more people were using outside than before they went into prison, which made it harder for them to stay away from drugs when out of prison. It therefore seems increasingly important that structured through-care is given to prisoners on release and access to advice and support doesn't stop in prison, even for prisoners who have become drug free by the time they are released.

Drugs increase in the outside community:

'I come from a small town….Before I went down the last time you had to be an old school junkie, or know one to get hold of brown.[heroin] *But this time when I got out anyone could get hold of it. It was madness'* (ID401, Closed training prison).

'I found the "drug culture" more open and drugs more available' (ID310, Closed training prison).

'Plenty of drugs around to tempt back' (ID283, Closed training prison).

'Surprised how many people used and needed drugs to get though life' (ID288, Closed training prison).

5.7.Comment.

Nearly half of prisoners who had received treatment for drug and alcohol problems were receiving it within the 12 months before prison, and a lot less were receiving it in prison - the majority of drug/alcohol users in prison had not received treatment. This may suggest that many prisoners could be coming into prison with drug and alcohol treatment needs that are not met, which could be explored through further research. Prisoners in closed training prisons, who were more likely to use drugs, were also more likely to have received treatment for their drug use in their prison, include protection against infection from injecting drugs. However it appears that treatment provision for alcohol problems may need improvement in these prisons. Prisoners in closed local prisons seem to be losing out as they appear to not be getting the treatment services they need, as they are more likely to use drugs and alcohol outside prison and they were reported poorer physical and mental health. Some of the prisoners held in these prisons – young prisoners, remand prisoners and short-term prisoners were more likely to not have been in treatment for drug and alcohol problems in prison and they said that they would have liked to. Even though some of these prisoners may not be in the prison system for long they may still return to the community and have the same problems they had with drugs before they came into prison, and for many drug use may be linked to committing crime. Even though treatment services should be available and improved in prisons to tackle drug and alcohol problems, it is apparent that particular attention needs to be paid to prisoners' treatment needs when they are in the outside community. This includes treatment being received before prison is continued when inside prison as far as possible, transferred with prisoners to a different prison, and that through care is provided so that treatment is continued after release from prison. Apart from specific drug treatments, the survey indicted that other help on release from prison to set up a new life, such as help with appropriate accommodation and employment, is important to stay clear of drugs and crime, particularly if a prisoner does not receive support from their family and friends.

6. Discussion and Recommendations

The aim of this survey in prisons in the Kent, Surrey and Sussex area, was to identify needs and risks mainly in relation to drug and alcohol problems, and assess treatment services for prisoners in the light of these needs and risks. This survey is not likely to be representative of all prisons, as each prison has its own kind of population, and they differ in whether they are open or closed, what level of security they have, and the type of prisoners they hold. However, it is hoped that distinguishing prisons types by whether they are closed or open and local or training gives the best possible reflection of drug needs and risks and service provision within particular types of prison regimes. To look at prison type in more detail would mean that the interpretation of results would be difficult because of the smaller numbers. There would also be the increased risk that individual prisons would be identified, and the aim of this report is to identify needs and risks in the Kent, Surrey and Sussex area as a whole rather than at an individual prison level.

The survey may also not be representative of all prisons and prisoners, as prisons were sampled rather than individuals, the survey only targets male prisons, and the response rate is generally low – a characteristic of research with this social group, and health surveys in general have been attracting lower and lower response over the past twenty years[39]. However this survey achieved a 20% lower response rate than other recent surveys of the general population in a similar geographical area –in Kent and Medway, and East Sussex. Prison populations are skewed towards a younger age and lower social class profile compared to the general population, and it is quoted that 30% of prisoners have reading difficulties[40] which is likely to mean that there is systematic bias towards the more educated prisoners due to self completion and the detailed nature of the questionnaire. The experience of prison visits meant that the researchers learned of the anxieties the prisoners had over confidentiality and anonymity. All of these factors may have contributed to a negative response rate to the survey.

Despite problems with response, the survey has been able to pinpoint areas for concern and affirm existing ideas about what is needed to tackle the misuse of drugs in prison, and also in the outside community. The survey has highlighted some important social factors for why the prison population are at greater risk of being involved in drug and alcohol misuse, and poorer health generally compared to the general population; the mental health of the prison population is also of concern. Smoking is high in this prison population, even though smoking in the general population has decreased over time; in 1974 51% of men were smoking compared to, 38% in 1982 and 27% in 2002.[41] Smoking is implicated in a number of serious diseases including coronary heart disease, lung cancer and chronic bronchitis. The results of the survey in relation to alcohol are just as worrying with a high proportion of respondents admitting to regularly drinking above the recommended limit of 21 units per week or drinking more than six units in one day. Not only are the prison population themselves at risk of liver cirrhosis and portal hypertension, but a high proportion of these respondents admitted to the social consequences, such as not being able to remember what happened the night before, failure to do what was expected of them or cause an injury to themselves or others. The majority of respondents were using, or had used illegal drugs in their lifetime, this compares to a minority of the general population.

[39] CHSS experience with Apple a Day (1984-92), Health Quest South East (1992), Kent and Medway (2001) and Health Counts (2003) surveys.
[40] Personal communication by Geoff Cooke, KSS Drug Strategy.
[41] ONS(2004). Living in Britain; results from the 2002General Household Survey, HMSO. www.statistics.gov.uk/cci/nugget.asp?id=828

The survey indicates that a small number of prisoners continue to use alcohol and drugs whilst in prison, a lack of availability and/or drug of choice appear to be stopping others. The introduction of mandatory and voluntary drug testing in prisons has had an effect on the drug taking behaviour, with an increase of heroin use and a decrease of cannabis use among the respondents. Not all of the users in prison have taken advantage of the treatment programmes that are on offer, even though the services available appear to be of a higher standard in certain types of prison. However quite rightly, in most instances more services and programmes are available where the need is greatest, closed training prisons – but more needs to be done to stop the increased availability of drugs in these prisons in the first place. In other prison types, where use is less, there are still those in need of treatment before they go back into the community – particular those held in closed local establishments. As well as highlighting areas for improvement to treatment services inside and outside prison generally, the survey has indicated strongly the need for structured, accessible and sustainable treatment that is available before prison, whilst in prison, and on release from prison. Such a plan would need prison and outside agencies to work closely together in order to try and build better lives and work towards tackling the cycle of drug use and repeat offending.

Recommendations

1. The implications of the low response rates must be taken into account in interpreting the results; it is expected that associations between variables will be more reliable than any interpretation of individual prison results.
2. The results should be fed into the HIMP, Drug Strategy, other prison strategies and the Drug Action Team work.
3. Results should be made available to prison staff and to the prisoners themselves in a constructive and programmed manner
4. Results should be used to help educate prisoners about the problem and the effect addictive behaviour is having on their own health and to society as a whole
5. Treatment programmes are tailored to take account of the prevalence of smoking and alcohol problems as well as drugs
6. Increase ability of prison and outside agencies to work together to provide a similar treatment programme in prison and the outside community, and improve through care services.
7. Further investigation into the treatment needs of remand/ short-term prisoners, young offenders and prisoners with mental health problems.
8. The results are used in the Health Improvement Programmes to set targets for reduction of drug use in prison and more effective provision of drug and alcohol treatment programmes.
9. A similar programme of surveys should be rolled out across the prisons to enable others to position themselves in terms of the prevalence of health, alcohol and drug problems
10. The survey could be repeated in at least 3 years time to measure change.