SPS Strategy on the Management of Drug Misuse

Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention

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SCOTTISH PRISON SERVICE
JUNE 2006
Acknowledgements

We would like to give particular thanks to Dr. Jim Carnie, Scottish Prison Service, for his help, guidance, and support throughout this study. Thanks also to all members of the Advisory Group for the project. We would also like to thank Mr. Ed Wozniak for general advice. Finally, we would like to thank staff and prisoners involved in data collection for the research.

Contents

Chapter 1 – Introduction

Chapter 2 – Methodology

Chapter 3 – Drug use in Scottish prisons

Chapter 4 – Issues regarding the management of Drug Use in Scottish Prisons: A Survey of Addictions Teams.

Chapter 5 – Current SPS database for Referral, Assessment, and Intervention.

Chapter 6 – Assessment of drug problems and related health issues among the Scottish prisoner population

Chapter 7 – Drug Treatment and Interventions

Chapter 8 – Methadone Prescribing in Scottish Prisons

Chapter 9 – Drug Free Areas

Chapter 10 – Drug Testing

Chapter 11 – Relapse

Chapter 12 – Becoming Drug Free

Chapter 13 – Discussion and Conclusions

Appendix A – References
Chapter One - Introduction

The prevalence of illegal drug use and drug related problems in prisons in a number of countries has been widely reported (British Medical Journal, 1995; Fazel, et al, 2006; Shewan and Davies, 2002; World Health Organisation, 2005). Substantial proportions of drug users in prisoner populations have been noted in many countries. Hiller et al. (1999) report that in the United States 68% of all new admissions test positive for an illegal drug in urine screening, and similar findings have been reported across Europe, North America, and Australia. ENDHASP (European Network of Drug and HIV/AIDS Services in Prison, 1997) estimated that 46.5% of prisoners across Europe would be users of illegal drugs prior to imprisonment. According to EMCDDA Annual Reports for 1999 and 2000, between 15 and 50% of prisoners in the European Union have, or have had, problems with illicit drug use. In the United States this figure has been calculated as high as 70% (U.S Department of Justice, 2000). In Australia, Butler (1997) reported that 73% of female prisoners and 64% of male prisoners had used an illegal drug at some point, with 23% of females and 18% of males having used heroin (see also Dolan and Crofts, 2000). In continents such as South America and Africa the situation is less clear, not least because of the lack of systematic research in these regions (Dunn, et al., 2000; Ohaeri, 2000). In Scotland, the most recent figures show that 82% of the prisoner population had used an illegal drug in the twelve months prior to imprisonment, of whom 56% reported having used heroin. Overall, 27% of prisoners with a history of drug use in Scotland in 2004 reported having been in drug treatment prior to imprisonment (Scottish Prison Survey, 2004).

To a large extent, this is something that is inherited by prison systems through the well-established link between drug use and crime (e.g. Bean, 2001), the high prevalence of problematic drug use among the Scottish population (Drug Misuse Information Scotland, 2005), and the steady increase in the number of people held in Scottish custodial establishments (Scottish Executive, 2005), and also prevailing criminal justice approaches to drug possession and supply (Maden, et al., 1992; Shewan, 1996a). It is unsurprising, therefore, that there is a concentration in prison of both those who promote illegal use of drugs and those who consume them (Stover, 2002; Tomasevski, 1992; World Health Organisation, 1992, 1993, 2005). From both a prison management and a public health perspective, it is concerning that there is evidence that drug-related problems can be exacerbated within prison. A recognised example of this is the initiation of drug injecting in prison (Gore, et al., 1995), and increased risk of communicable diseases resulting from higher risk drug using behaviour. (Power, et al., 1992; Gore, 1995; Shewan, et al., 1994a, 1994b; Turnbull, 1991). Both of these issues represent a priority for prison policy and practice (WHO, 2005). More typical than an increase in risk behaviours among incarcerated drug users in Scotland, however, is an overall reduction in quantity, frequency and range of drug use, and a cessation in high risk factors such as injecting and sharing (Scottish Prison Survey, 2004, 2005; Shewan, et al., 1994a, 1995a). This represents an opportunity for the prison system to develop and maintain interventions aimed at reducing drug-related harm and encouraging behavioural change among drug users, including that of engaging in a drug-free lifestyle.
It follows on from this that prisons should not be assumed to be mainly reactive in dealing with drug issues. Indeed, it can be argued that after the main concerns of prisons have been established – security and the safety of those who live and work there – then the rehabilitative objectives of the prison system identify drug users as one of the main populations requiring intervention. (Scottish Prison Service, 1994, 2000, 2003).

**Drug Policy, Practice, and Research in Scottish Prisons**

The recent history of drug policy and practice – and the role of research - in Scottish Prisons is an interesting one. Motivated at least partly by fears in the mid-1980s that prisons had the potential to serve as an “epidemiological bridge” for HIV transmission (Harding, 1987), Scottish Prison Service was quick to put in place an independent drug research programme. The primary aims of this SPS-funded research were to examine the prevalence and nature of drug use and drug-related risk among the Scottish prisoner population (Power, *et al.*, 1992), and to study the factors underlying such risk behaviour in a prison setting¹ (Shewan, *et al.*, 1994a, 1994b). Aspects of drug policy and practice were clearly defined by the Scottish Prison Service (SPS, 1994).

The contribution of drug research continued throughout the 1990s, with a dual emphasis on assessing risk (Gore, *et al.* 1999; Taylor, *et al.*, 1995; Shewan *et al.*, 1995b) and evaluation of initiatives in service provision. The main focus of service delivery at that time was the Saughton Drug Reduction Programme, then described as an “[E]xample of good practice” [Advisory Council on the Misuse of Drugs, 1996, p.85]. An evaluation of this Programme showed that it had a reducing effect on levels of clients’ drug use within prison, and was also widely supported by prison staff. (Shewan, *et al.*, 1994c, 1996b). These findings were encouraging, yet similar evaluation of innovative developments in prison drug service provision has not been carried out since. However, in the Scottish Prison Service Annual report, 2002-2003, the need for ongoing development of drug services informed by research is clearly stated: “Drugs remain a significant challenge within prison and the Service is determined to provide opportunities for prisoners to change their drug taking behaviour. Initiatives continue to be developed and a programme of research on drugs assessment, referral and intervention is planned for the forthcoming year.” (Scottish Prison Service Annual Report, 2003).

One principle to be learned from the above summary is the importance and applied value of developing policy that is informed by research. Yet, while there exists a recent and ongoing range of research that involves prisons, such as investigating the prevalence of fatal drug overdoses (Seaman, *et al.*, 1998: Shewan, *et al.*, 2000b) and studying drug use and treatment contact after release into the community, there has been a decline in research based specifically on drug policy and practice developments within Scottish prisons. It is to be welcomed, therefore, that SPS have identified the need for research that assesses the coherence and efficacy of current initiatives and overall strategy. This would build on recently revised and updated strategies (Scottish Prison Service, 2000), and to further develop the role of SPS within the overall framework set down by the

¹ The research by Shewan *et al.* (1994), funded by Scottish Prison Service, was perhaps the first major study to look systematically at drug use and risk behaviour in prisons.
Scottish Executive (Scottish Executive, 1999). Informing these strategic and planning objectives was the overall aim of this study.

**Assessment and Treatment of Drug Use in Prison**
Rehabilitation in prisons has progressed a long way since Martinson’s (1974) ‘nothing works’ position of thirty years ago. There is now a general acknowledgement that small but significant reductions in recidivism rates can be achieved with good prison programmes. A recent review of ‘what works’ in the treatment of offenders identified substance misuse as one of the most significant predictors of re-offending (Harper and Chitty, 2004).

**Assessment**
Inherent in any effective treatment is the need for a thorough and accurate assessment prior to treatment. Without a reliable and valid assessment tool, treatment is unlikely to be effective and any evaluation of participant improvement is difficult to measure (Gravett, 2000). With regard to a general assessment of need, the focus should be on the identification of the specific criminogenic and learning needs of each participant. When criminogenic needs are considered, the misuse of substances is recognised as a significant and powerful predictor of recidivism (Gendreau, Little, and Groggin, 1996).

The use of standardised assessment tools to screen prisoners for substance misuse, their readiness to engage in treatment and their psychological functioning is central to any assessment process (Welsh and Zajac, 2004). Assessment should be an ongoing process rather than a one-off event. An accurate, informative assessment is at the core of effective service delivery as without this an effective treatment programme cannot be developed. The client should be involved in the process and it must be needs led rather than merely trying to match the client to the treatments available (Gossop, 1994).

There are a diverse range of assessment measures utilised by practitioners when assessing substance misuse problems. The Common Addictions Assessment Recording Tool (CAART) is utilised in the Scottish Prison Service (SPS) to identify the needs of those with a substance problem. A recent evaluation of the Transitional Care Initiative in SPS highlighted concern regarding possible inconsistencies in the application of the measure across establishments and questioned whether the resulting care plan was service-led rather than needs led (MacRae, McIvor, Malloch, Eley and Yates, 2004). Transitional care issues were not specifically addressed in the study, however and there is therefore a need for a more detailed investigation of the utility of the measure.

**Treatment for Drug Problems**
A period of imprisonment can be an opportune time to intervene with substance users and offer treatment in a controlled environment (Peters and Steinberg, 2000). Due to supply issues, imprisonment itself can have an impact on drug use patterns with either the volume of drugs used decreasing and/or changes to the type of drugs used (Farrell, Singleton and Strang, 2000). Prison can also provide an ideal opportunity for intervention with those who have had limited or no contact with drug treatment prior to imprisonment (Lipton, 1995). Within the prison environment the most commonly found treatments for substance misuse are environmental, psychological or pharmacological.
Environmental interventions include the use of drug-free areas, drug testing and therapeutic communities. Drug-free areas have been utilised with varying success by prisons. Used to provide an environment where the supply of drugs and exposure to those continuing to use drugs is limited, drug free areas have been adopted in a number of countries. Van den Hurk (1995) evaluated their use in the Netherlands and found fewer drugs were being used and those in drug-free areas were more likely to continue with treatment upon release from prison. However two years after release, no significant differences in drug use, recidivism and psychosocial functioning were found between those how had been in mainstream prison and those who had been in the drug-free areas. The long-term success of these areas in reducing substance use has therefore yet to be proven.

Drug testing is widely used in prisons in the U.K. Mandatory drug testing can fulfil several functions including being able to monitor the rate and nature of drug-taking. Until recently, there has been primarily anecdotal evidence suggesting that mandatory drug testing affects the choice of drugs used by prisoners. In particular it was suggested that a shift had occurred from cannabis use which can be detected for several weeks after use, to heroin which is only detectable for a few days after use (Farrell et al. 2000). Singleton, Pendry, Simpson, Goddard, Farrell, Marsden and Taylor (2005) surveyed prisoners in England and Wales and found that almost a quarter of all prisoners had tested positive for substance misuse at some time with the majority of positive tests being for cannabis. They suggest that the aforementioned anecdotal reports of a shift in use from cannabis to heroin may reflect variations in measurement rather than an actual change in pattern of use. They suggest that the rates of cannabis use may reflect prevalence i.e. the relatively long half-life of cannabis would enable an accurate assessment of number of users, while the heroin rates may reflect incidence i.e. the short-half life will produce assessments of frequency of use.

When a drug testing policy is implemented, it should be accompanied by a clear understanding of how a positive test should be viewed: either as a failure, to be punished through the deprivation of privileges, or, as a guide for relapse which would trigger increased assistance to prevent a lapse becoming a relapse. When a treatment approach is adopted, a thorough understanding that relapse is a common component in the process of recovery, is required by all those who work with the user (Marlatt and Gordon, 1985).

Therapeutic communities have not been widely utilised in Scotland and have limited empirical support. The concept of a therapeutic community, centres on addressing a diverse range of client needs including social, personal and moral needs through support groups and self-evaluation (Peters, 1993). The effectiveness of these groups for the general prison population has not been proven not least because most studies have a sample bias. In relation to the treatment of substance misuse, their use is predicated on the belief that recovery is a prolonged multi-faceted process and therapeutic communities

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2 Drug testing in Scottish prisons is now used solely for research purposes.
facilitate long-term support. However the utility of therapeutic communities has yet to be demonstrated empirically for the treatment of substance misuse (Peters, 1993).

**Psychological Interventions**

McGuire (2002) reviewed the findings of a number of meta-analyses and highlighted several basic principles that psychosocial interventions should adhere to. A cognitive-behavioural orientation to any psychosocial intervention was considered essential as cognitive-behavioural interventions have consistently demonstrated a significant effect on recidivism rates. There is little or no evidence for psychodynamic or purely medical interventions being effective and thus programmes should be based around a cognitive-behavioural model. Effective programmes should also maintain a high programme integrity whereby a standardised, consistent approach to treatment is delivered by highly trained staff (Burrows, Clark, Davison, Tarling and Webb, 2001). These programmes should focus on criminogenic needs i.e. they should focus on issues related to offending rather than more generic problems, with the use of evidence-based treatment - especially that which is manual-based, and which adheres to an accepted accreditation scheme - seen as ‘best practice’ (Cooke and Philip, 2001). Finally programmes should abide by the responsivity principle whereby the programmes should be adapted to the learning needs of the population they serve. This may necessitate tailoring programmes to different populations, for example young offenders and female offenders (Peters, Strozier, Murrin and Kearns, 1997).

In relation to substance misuse treatment, two further principles have been recommended which draw on Prochaska and DiClemente’s (1982) transtheoretical model. The transtheoretical model identifies six stages of change that users move through on the path towards abstinence namely precontemplation, contemplation, preparation, action, maintenance and relapse. The principles recommended, are the need to assess treatment ‘readiness’ and the need to establish a continuum of care (Taxman, 1999). Treatment readiness centres on matching the participants’ perception of their substance misuse i.e. their stage of change, to the appropriate intervention. Thus, for example, if a participant is in the precontemplation stage whereby they do not believe they have a problem with substances, they will not benefit from, or be motivated to participate in, a treatment programme centred on preventing relapse; education and harm reduction would be a more suitable intervention. A significant amount of research has been carried out to identify the most appropriate intervention for each stage and therefore any pre-treatment assessment should include an assessment of the participants’ stage of change (McMurran, 2001). With regard to the second principle namely establishing a continuum of care, this involves providing long-term support to the client (Taxman, 1999). As substance misuse is a ‘relapsing condition’ the need for long-term involvement is considered essential (Litman, 1980). This principle arises from research that has demonstrated that participation in and completion of aftercare, is one of the most consistent predictors of a favourable outcome in relation to substance misuse (Harper and Chitty, 2004).

Drawing on the aforementioned principles of good interventions, psychological treatment in prison primarily focuses on cognitive behavioural group therapy for substance misuse. The central tenet of this approach is that drug use is the product of prior experiences, emotions and thoughts. These treatments form the bedrock of interventions and have a
strong research to support them (Wexler and Lipton, 1993). As mentioned earlier these treatments need to be related to the stage of change of the user. The principle treatments used are harm reduction and education, coping skills training and relapse prevention. Group treatment is the primary form of delivery with treatment integrity being maintained through the use of structured, manualised group treatments which are evidence-based (Cooke and Philip, 2001). Although one-to-one treatment can be effective, in prison group treatment is the most prevalent (Gravett, 2000). While it has been argued that psychosocial interventions for substance misuse may be less effective in closed environments where substance use is limited than in the community, a meta-analysis of Relapse Prevention programmes found no significant effects for environment, suggesting prison programmes can be as effective as those in the community (Dowden, Antonowicz and Andrews, 2003).

Pharmacological Interventions
Pharmacological interventions for drug misuse have primarily centred on detoxification and substitute prescribing, with methadone being the predominant treatment (Bullock, 2003). Methadone can be used as either part of a reduction or a maintenance programme and in a recent review of the literature has been shown to be effective in decreasing the use of illicit opiates (Gowing, Farrell, Bornemann and Ali, 2005). In Scotland, the Saughton Drug Reduction Programme involved a reduction programme for methadone prescribing to a prison population. Shewan, Macpherson, Reid and Davies (1994) examined the level of drug use post-treatment and found those who had completed the programme reported significantly less drug use than the control group. The small sample size however hampers generalisation of this finding. It is generally accepted that while pharmacological interventions are effective in stabilising patients and may eliminate illicit use, it should not be viewed as a stand alone treatment but rather should be combined with psychosocial interventions (Stoever, et al, 2004).

Conclusions:

The above brief overview of the assessment and treatment of drug use in prisons has highlighted the potential for rehabilitation that a sentence represents and the importance of adhering to the principles for effective treatment, which include a thorough and ongoing assessment of criminogenic needs and stage of change. Appropriate interventions can then be identified. These may take the form of either environment, psychological or pharmacological interventions, or some combination of them all.
Chapter 2 - Methodology

Research design
Both quantitative and qualitative methods were used to gain an in-depth understanding of prisoners’ and prison staff’s experiences and opinions about addictions services, strategies and policies in Scottish establishments. The methods used consisted of:

- Data collated by SPS establishments
- Questionnaire survey
- Focus group discussions
- Semi-structured interviews (face-to-face and telephone)
- Content analysis of assessment tools

Quantitative Methodology
This included data collated by SPS establishments, a questionnaire survey aimed at addictions teams, and a content analysis of the current addictions tool - the CAART.

Data collated by SPS establishments
All establishments involved in the research were contacted for recorded number of prisoners using addictions services. The aim was to collect data relevant to:-

- Assessment (e.g. number of prisoners not being assessed within three days)
- Referral (e.g. number of prisoners using distinct referral routes)
- Intervention (e.g. number of prisoners entering and completing intervention)
- Continuity of care (e.g. number of prisoners attending post-release meetings)
- Health (e.g. number of prisoners on methadone)

Procedure
The proposed procedure was discussed with representatives of SPS. Establishments were then individually contacted and visits were arranged for the addictions teams to meet the researchers, get an overall understanding of the research objectives and discuss any issues or problems that may arise with regards to the procedure. Data were collected between March 2004 and January 2005. Throughout the data collection phase, various data resources were used to gather as much information as possible. These included correspondence and co-ordination where possible to:-

- SPS headquarters
- individual establishments, in particular
  - programme staff
  - addictions teams
  - clinical health care teams

Data management and analysis
Data were either provided in Excel spreadsheets or on paper. In the latter case, these data were standardised and entered into excel worksheets. Frequencies and descriptive
statistics were conducted. All data were stored securely and confidentially, in line with the Data Protection Act (1998) and research governance guidance.

Limitations
Generally speaking, all information collected was naturally dependent upon ready access to comprehensive data within individual prisons. SPS Headquarters were able to provide a vast amount of data collated in individual establishments. For instance, data was readily available on assessment, or number of prisoners completing interventions in accordance with the current Key Performance Indicator (KPI) standard required by the SPS. Individual establishments were contacted numerous times in order to complete the data obtained from SPS Headquarters, however, there appeared to be several limitations concerning the SPS recording system in individual prisons.

- **Lack of systematic SPS recording system**: It seemed that at the point of data collection there was no systematic tool or database for prison staff to record information, other than on paper. The previously used SMR-24 was found to be no longer in use. Its replacement, the PR-2 system was introduced in February 2005. Until then, individual establishments seemed to rely on staff members who knew how to set up a database. In these prisons, information was made available to researchers. However, these databases were rather individual, hence inconsistent in structure and depth of information recorded.

- **Inconsistent and wide range of data**: This resulted in a diverse range of data obtained. Intensive efforts were undertaken to standardise data from individual establishments in order to be able to draw meaningful conclusions at a national level. For instance, researchers explored all avenues available to get the information required by combining and standardising data from several sources.

- **Incomplete data**: Due to the problems outlined so far, the data obtained were very fragmentary, incomplete and inconsistent. Obviously, this is also due to the nature of data examined (i.e. referral, transfers) which are presumed to have an impact on recorded number of prisoners commencing and completing intervention. For instance, it was found that the number of prisoners recorded as having entered addictions intervention did not match up to the number of prisoners recorded to have completed the same intervention. It is not known to what extent transfers may have influenced these figures. For example, any prisoner who had started a group based intervention in one establishment and was transferred, during the course of this intervention, to another prison might have continued the intervention programme there. Presumably, this prisoner would not have been included in the initial record of prisoners entering that intervention. This is the case for women prisoners who started an intervention in Cornton Vale and, if being transferred to Greenock, could continue this intervention, without having to repeat previous sessions. Likewise, prisoners who refused an addictions assessment by Cranstoun\(^3\) might decide to be assessed three weeks later. This could have been recorded as a “refusal”, and possibly also as a “completed

\[^3\]The contract held by Cranstoun Drug Services at the time of the study is now held by Phoenix House.
assessment” three weeks later. In other words, the numbers as such are not static but flow into each other.

- **Communication**: Delays were experienced when the research team was required to wait for information a) that needed to be verified, b) that needed to be updated by a different source (e.g. programmes officers as opposed to addictions officers) or c) when incorrect contacts or information were provided.

- **Staff time, resources and perceived job capacity**: It further appeared that members of staff were not aware of the extent to which they were supposed to keep track of, for instance, number of prisoners entering intervention or waiting for intervention. In addition, during the qualitative data collection phase it emerged that addictions staff felt that due to lack of manpower or appropriate facilities most of their time was spent handling methadone or carrying out operational duties as opposed to addictions work. This may have had an impact on prison staff’s time and work schedule, so that the recording of prisoners’ referrals could not be carried out. In addition, it proved impossible to collect data on health-related research objectives as health teams, in particular, methadone nurses were unable to provide data. Where methadone clinics or nurses responded to emails, it appeared that the number of prisoners referred for methadone suitability assessments was unknown. Also, there seemed to be a prevailing lack of time and resources to collate number of prisoners on methadone over the last two financial years. This also seemed to be affected by a lack of a systematic recording system at the time.

**Summary**

Overall, it seemed that due to a lack of resources and facilities, most prisons were unable to provide the data required. Where information was available, it was recorded in an inconsistent way, and often on paper. In addition, due to lack of manpower or work commitments, some establishments were unable to provide any help in the first place simply due to lack of time. Thus, the data presented here only provide a snapshot of what was happening in Scottish establishments at the time of data collection. Therefore, findings are only tentative and need to be interpreted with caution. In addition, the research team’s contacts in individual prisons stated that data had been collated ad hoc as the establishment had never been asked to provide this kind of information before. On a positive note, most of the limitations outlined here will have a lesser impact on future research projects as the new SPS recording system PR2 has recently been put in place in all Scottish establishments.

**Questionnaire survey**

**Construction of questionnaire**

A questionnaire was designed informed by a literature review as well as preliminary outcomes of prison staff focus groups. The questionnaire covered addictions teams’ attitudes, experiences, opinions and beliefs about drug use in prison, referral routes into treatment, the effectiveness of these referrals routes and perceived effectiveness of
treatment available. All questions corresponded to the project’s research objectives. The questionnaire content was approved by a representative of the SPS.

**Procedure**
Data were collected between December 2004 and February 2005. All addictions co-ordinators were contacted per email and letter prior to sending out the questionnaires. Ten questionnaires were sent to each individual establishment along with pre-stamped envelopes addressed to the research team. Every questionnaire had an information sheet attached, explaining the scope and objective of the study in sufficient detail. In addition, all participants had the opportunity to contact the researchers if anything was unclear. If addictions team required more questionnaires, copies were sent via email. Where appropriate, reminder emails were sent as well as telephone follow ups.

**Ethical issues**
The questionnaire was anonymous. Participation was voluntary. If respondents agreed to participate in the study, they were required to give consent. All participants were informed that they had the right to withdraw at any point, and that they would not be affected in any way if they wished to be excluded from the survey.

**Data management and analysis**
Data from returned questionnaires were coded and entered into Statistical Package for the Social Sciences (SPSS, version 11.5). Respondents rated on a 5-point Likert scale the extent to which they agreed with given statements, or the extent to which they believed intervention programmes and referral routes to be effective. Responses ranged from 1 = strongly agree to 5 = strongly disagree, and from 1 = very effective to 5 = not at all effective. Open-ended questions were analysed to identify themes, and were also entered into SPSS. Frequencies, descriptive statistics and cross-tabulations including chi-squared tests were conducted where appropriate. All data were stored securely and confidentially, in line with the Data Protection Act (1998) and research governance guidance.

**Limitations**
- **Eligibility criteria:** The research team were contacted by several establishments to clarify who exactly was eligible to participate in the survey. While the researchers were intent on focussing on contracted addictions staff and Cranstoun employees (due to the range and scope of questions in the survey), some establishments included health staff and programmes officer on their own accord. These were also included in the analysis.

- **Change of SPS terminology:** Items were worded in accordance with the wording set out in the research objectives. For instance, due to changes in terminology over the study period, addictions support areas were also referred to as drug free areas. However, relevant questionnaire items contained both terms.

- **Response rate:** Overall, the response rate was good with 12 out of 14 prisons (86%) responding to the survey. However, the number of completed questionnaires returned varied greatly amongst establishments (ranging from one
to ten completed questionnaires per establishment). It is not known whether questionnaires were distributed to all members of addictions teams. It is also unknown to what extent the number of addictions staff on annual leave or on sick leave impacted on the questionnaires completed. Due to these reasons, no analyses at establishment level were conducted.

- **Sample size**: Although the overall response rate turned out to be good, the actual sample size was very small. Due to the small number of respondents, findings are tentative and are not assumed to be representative of, nor generalisable, to national level.

**Summary**

Despite these limitations, the questionnaire survey was received well and addictions teams were very helpful and co-operative with the research. Although the findings may not be representative due to the small numbers involved, the survey nevertheless offers useful insight into addictions teams’ attitudes and opinions on current issues in Scottish prisons.

**Content analysis of assessment tools**

In order to assess the consistency and utility of the CAART as well as the decision making process underlying individual care action plans, completed ‘real-life’ CAART forms were collected from several establishments to design three generic CAART cases.

**Procedure**

Between two and three completed CAARTs were collected from six establishments. All CAARTs were anonymised by SPS staff in order to ensure anonymity of prisoners’ identity. Three generic cases along with matching case profiles were designed according to recurrent themes and characteristics identified in the real-life CAARTs – one female prisoner (short term), and two male prisoners (short term and long term). The case studies were sent to all Scottish establishments involved in the research. The two male case study were slightly modified in age or background characteristics to meet the function different establishments in Scotland fulfil. For instance, for HMYOI Polmont, one case study’s age was slightly modified in order to be eligible for a young offenders’ institution. All addictions co-ordinators or principal contacts in individual establishments were contacted in advance to sending out the case studies. Each prison received a prisoner profile or case outline along with a completed CAART, and detailed information as to the scope and objective of the exercise. Addictions teams were encouraged to discuss the generic CAART and case study at a multi-disciplinary meeting in order to design an appropriate and informed care action plan. Establishments were further encouraged to contact the research team should there be any queries.

**Ethical issues**

Participation in this exercise was voluntary. All addictions teams were informed that they had the right to withdraw at any point, and that they would not be affected in any way if they wished to be excluded from this task.

**Data management and analysis**
All data obtained were content analysed. Emergent themes were grouped and entered into Statistical Package for the Social Sciences (SPSS, version 11.5). All data were stored securely and confidentially, in accordance with the Data Protection Act (1998) and research governance guidance.

**Limitations**

The methodology employed allowed the generic CAART and case study to be modelled on ‘real people’ and therefore are presumed to have been realistic to addictions teams. There were, nevertheless, many limitations. For instance, because hypothetical cases were used in this exercise, addictions teams were unable to draw information from external sources such as health teams as they would probably have done in a real life case meeting. Indeed, some information in the hypothetical case studies required to be confirmed or elaborated on by establishment’s health team, mental health team, personal officer or keyworkers as well as community sources. While this may be a limitation to the current approach, it nevertheless served to highlight addiction team’s resourcefulness, and the importance of good working relationships internally to health teams, and externally to support agencies and community initiatives.

- **Response rate**: The response rate was good with 11 out of 14 (79%) establishments completing the exercise. One establishment was unable to complete the CAART exercise as at the time of data collection as there was no addictions co-ordinator assigned to oversee the task.

- **Consistency of responses**: While the overall response rate was good, responses were very inconsistent across establishments. Responses to the generic CAART and case studies varied considerably in depth and explanations as to why interventions were proposed.

- **Decision making process**: Unfortunately most establishments failed to indicate why they prioritised certain actions over others. However, it seemed that overall actions taken were heavily depended on best practice guidelines.

- **Sample size**: The overall number of generic CAARTs assessed was too small. Therefore findings need to be interpreted with caution and should not be considered representative or generalisable.

- **Methodology**: Using a more diverse methodological approach to carry out a more thorough examination of the CAART as an assessment tool would be beneficial for future research but was beyond the scope of the present project.

**Qualitative Methodology**

The qualitative component of the project employed a combination of focus groups and individual interviews in order to explore in more detail the views of staff and prisoners.

**Focus Group Discussions**
Focus group research involves organised discussion with a selected group of individuals to gain information about their views and experiences of a specified topic or topics. Kitzinger and Barbour (2001) identify a number of strengths of this technique for qualitative research. By providing a group context, and allowing participants to direct the flow of conversation amongst themselves, the active involvement of the interviewer/researcher (and therefore the influence of their preconceptions) can be minimised. As a discussion, the focus group also allows us to see more of how individual perspectives might interact in an everyday context, making participants more likely to rationalise the statements they make to each other. This technique is particularly suitable for gaining access to multiple views on the same subject, and some studies have successfully employed this interview technique in previous addictions research (e.g. Agar and MacDonald (1995; Stead et al., 2007)). In this research it was seen as highly appropriate for gathering a broad range of opinions from prisoner and staff groups. Since prisoners or staff follow up each other’s contributions, the discussion follows their line of thought rather than simply responding to the interviewer’s questions one at a time, and allows them to qualify others’ views and offer alternative accounts.

A schedule of topics for discussion was derived by the researchers from objectives identified for this study; the main areas of discussion were:

- experiences of assessment
- programmes and interventions
- drug free areas
- health and continuity of care
- factors associated with relapse and patterns of escalating drug use (in terms of frequency, amount or category of drug)
- factors associated with becoming drug free
- patterns of drug use within prison

Recruitment

In-depth qualitative data were collected at six establishments, chosen to provide a range of age, gender, sentence category, and geographical location. Researchers conducted focus group interviews with both prisoners and staff at the six establishments in the study. Random sampling was not appropriate because of issues around consent within a prison setting. However, as an unstructured, qualitative interview technique, focus groups do not require that those taking part are statistically representative of some larger population; there should instead be criteria for considering them to be among those with whom the research is concerned. Homogeneity within each group is seen as facilitating group members in participating fully and equally.

Prisoners who were known or suspected of using drugs or who had been in touch with addictions teams were considered eligible to take part in the qualitative phase of the research, and possible volunteers for the focus groups were approached by staff members according to these criteria. A contact person on each addictions team was also asked to recruit between four and ten team members for one staff group, and between four and ten residential or other officers from the prison for the other staff group.
In this way, 14 focus groups with prisoners were arranged: 2 in each of the 6 establishments involved, plus an additional 2 focus groups in order to represent the views of young offenders and protection prisoners. 2 groups were sought in each establishment involving one each for addictions staff and residential staff respectively. However, one establishment were unable to arrange a group of residential staff, citing staff shortages and timetabling difficulties. 11 focus groups in all were therefore conducted with prison staff. The numbers taking part in each group ranged from three to ten, with an average of six participants in each group. Figures were not available on how many, if any, of those approached to take part were unwilling or unable to do so.

**Prisoner focus group**
Four (29%) focus groups were carried out with protection prisoners. One focus group consisted primarily of non drug users, with only one drug user present. Several focus groups included young and adult offenders; short-term and long-term prisoners; prisoners who had just received their induction and prisoners who had been in the system for several years. Groups were also found to vary in the number of prisoners being prescribed methadone.

In relation to the total sample (N = 82), 45 (55%) prisoners were classified as mainstream adults, while 10 (12%) prisoners were young offenders, and 27 (33%) were identified as protection prisoners. Of all focus group participants, 65 (79%) prisoners were male and 17 (21%) were female. All protection focus groups consisted of male prisoners only. Further demographic data are provided in table 2.1.

**Table 2.1 - Focus group prisoners’ background information**

<table>
<thead>
<tr>
<th></th>
<th>Age mean (in years) (sd)</th>
<th>Minimum (in years)</th>
<th>Maximum (in years)</th>
<th>Mean sentence served up to date of interview (in months)</th>
<th>Mean sentence length in total (in months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult prisoner (N = 63)</td>
<td>31</td>
<td>20</td>
<td>64</td>
<td>20</td>
<td>61</td>
</tr>
<tr>
<td>Young Offender (N = 19)</td>
<td>19</td>
<td>17</td>
<td>20</td>
<td>17</td>
<td>40</td>
</tr>
</tbody>
</table>

When asked whether participants had attended addictions interventions (group work based) during the current sentence, the majority (N = 51, 62%) indicated that they had not attended any programmes. Less than half (N = 39, 48%) of the sample further indicated that they had attended a drug free area during their current sentence. Of these, two in five prisoners (N = 15, 41%) indicated that they believed that drug free areas may be effective in preventing them from relapse in the community. Of the remaining 43 prisoners who had not attended a drug free area, the majority (N = 30, 73%) believed that drug free areas had the potential to prevent relapse in the community. Statistically, prisoners who
had or were attending a drug free area were less likely to believe that these were effective and might prevent relapse in the community than prisoners who were or had not attended a drug free area before \(_2 = 8.484, \text{df} = 1, p = 0.004\). However, these findings are only tentative due to the small number of participants involved. Further in-depth data on the perceived value and effectiveness of drug free areas from prisoners’ as well as prison staffs’, perspective is presented in the results section.

**Prison staff focus groups**
Focus groups with prison staff proved to be more difficult to conduct due to staff shortage, and subsequently lack of time. In total, 11 staff focus groups were conducted with an average of 5 participants in each group. These focus groups comprised 32 members of addictions team, and 23 residential officers. The majority of focus group participants were male (N = 40, 73%). This was most prominently the case for focus groups with residential staff (N = 18 male c.f. N = 5 female). Within the addictions staff sample, 24 (75%) respondents stated that they were members of addictions team before they were assigned to their current role. Of the residential staff, one person (4%) indicated that he had been a member of an addictions team at some point. All focus groups varied in what roles and responsibilities participants held. When asked to provide information on role, participants gave mixed responses as to what pay band they were working at, or what their job title was. For instance, more than half of the overall sample (N = 30, 55%) indicated that they were classified as D or D+ band officers. Further responses included hall manager (N = 1, 2%), manager (N = 1, 2%), MDT officers (N= 2, 4%), addictions nurse (N = 1), B to E+ band officers (N = 9, 16%), members of external agencies (N = 3, 5%) as well as 6 (11%) participants where information regarding their role is not known. Further demographics are provided in table 2.2.

**Table 2.2 - Focus group prison staff background information**

<table>
<thead>
<tr>
<th></th>
<th>Age mean (in years) (sd)</th>
<th>Minimum (in years)</th>
<th>Maximum (in years)</th>
<th>Total time worked within SPS (in years) (sd)</th>
<th>Total time worked in current role (in years) (sd)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions staff (N = 32)</td>
<td>42 (6.5354)</td>
<td>29</td>
<td>56</td>
<td>11 (6.9471)</td>
<td>3 (2.7151)</td>
</tr>
<tr>
<td>Residential staff (N = 23)</td>
<td>39 (6.8012)</td>
<td>30</td>
<td>55</td>
<td>14 (4.8942)</td>
<td>9 (6.8301)</td>
</tr>
</tbody>
</table>

Focus groups were also asked whether they felt that the introduction of addictions teams improved the way drug problems were dealt with in prison. In both staff groups, the response pattern was almost identical with 26 (81%) members of addictions teams and 18 (82%) residential officers agreeing to this statement. Participants were also asked to indicate whether they had received any drug awareness training since working in the SPS. While the majority of addictions staff (N = 30, 94%) stated that they had attended addictions awareness training, approximately 6 in 10 residential officers felt that they had
received training in drug awareness. However, these figures may vary considerably depending on how individuals defined the term “drug awareness training”. Perhaps individual interpretation of this term may account for the two members of addictions teams that indicated that they had not been provided with any drug awareness training. Overall, these findings are only tentative due to the small sample size.

Conducting focus groups
Each group had at least one moderator and a note taker from the research team. All participants attended as volunteers. A full explanation of the purpose of the study and ground rules regarding confidentiality was given at the start of each focus group, and consent sought from each participant. In addition, the moderator of the group made clear that all material would be anonymised. All group members agreed to the discussion being taped. In keeping with Kitzinger and Barbour’s methodology (2001) the agenda and specific topics covered were to be at the discretion of participants as far as possible. Interview materials were therefore kept to a minimum. A range of non-leading questions pertinent to the research topics were drafted by the researchers; these were to be utilised as prompts to stimulate discussion only if the moderator felt the discussion was stalling or becoming sidetracked.

The interviews took place in Link Centres as well as prison areas used by the addictions teams, during their working hours, between June and November 2004. Since staff groups were generally more problematic to schedule, prisoners groups were largely completed in advance of staff ones, often on separate visits. Each group lasted approximately 45 minutes to 1 hour; aside from occasional interruption or questioning to redirect conversation, the participants were left to discuss issues relating to drug use in general and relevant services within the prison amongst themselves. No prison staff attended the prisoner focus groups and vice versa. A few of the staff participants had to leave early or arrive late, depending on contingent circumstances in the prison that day. In general, both prisoners and staff expressed enthusiasm regarding the opportunity to express their views afforded by the groups.

Limitations
Further practical limitations arose when conducting focus groups with prisoners and staff members as a result of the accommodation provided. Fontana and Frey (2000) note that the interaction between individuals and the environment within the qualitative process is a critical consideration, as responses may be affected by this social dynamic. As such, it was considered important that accommodation used for interviews and focus groups minimised the possibility of interruption or distraction. Though staff members liaising with researchers made every effort to provide appropriate accommodation, problems were encountered with interruptions and excessive background noise when groups were conducted in semi-public areas (e.g.: office space), which in some cases led to portions of data being lost during transcription. In addition, some groups were somewhat curtailed by the exigencies of moving prisoners and staff timetables; and one prisoner group was arranged in a room where a CCTV camera was installed (those prisoners expressed some reservations about the possibility of their lips being read by staff). Given the recruitment process, it might also be expected that those who took part would have been among those more interested in, and therefore more positive towards, addictions work. However, we
are confident that the broad range of both positive and negative views expressed in these data area suggest a limited bias in this direction, if any.

The influence of the focus group context itself was also deemed important to bear in mind, since the social setting of such an interview may have some effect. For instance, younger prisoners might have felt less inclined to contradict what appeared to be a consensual opinion among older members of the group; and staff may have felt uncertain about speaking out on procedural or employment issues in front of their colleagues or superiors. During analysis, these focus group data were therefore examined with all the above factors in mind; they were treated as an expression of what views and opinions circulate among inmates and officers, and how these are expressed. A series of follow up 1-to-1 interviews were also carried out to set aside these data, to tap into individual expression that may not have been able to be voiced in the social setting of the groups.

**Semi-structured interviews with prisoners and addictions staff**

Individual interview data were also gathered from both prisoners and staff. With prisoners, this was seen as means of exploring their addictions issues in greater depth and from a more personal perspective. As noted above, staff shortages at one establishment meant that multiple staff members could not be spared simultaneously for the purposes of a focus group. In order to ensure that the views of residential staff members within this setting could still be included in the analysis, individual interviews were also conducted with four officers as a means of generating supplementary data. The four residential staff interviewed on a 1-1 basis were identified by the addictions coordinator for that establishment as having expressed an interest in the study. Individual interviews were eight prison addictions staff members. These interviews took place as a means of enhancing the data obtained in prison staff focus groups, particularly regarding continuity of care, which was not felt to have been sufficiently explored in staff groups, and procedural and policy details within each establishment.

**Recruitment**

Using the same selection criteria as for the focus groups, staff members approached prisoners to enquire if they would be willing to take part in a face-to-face interview with the researchers. In total 31 participants (19 male prisoners, 8 female prisoners and four male young offenders) were interviewed.

**Conducting 1-1 interviews**

An interview schedule for prisoners was developed in line with the objectives provided by the SPS specification for the project. The primary areas of enquiry mirrored those explored during the focus groups but gathered additional evidence on more personal or sensitive topics. The schedule was used in each interview to ensure consistency whilst the use of a semi-structured interview format allowed the researchers greater flexibility when conducting interviews, allowing questions to be reordered according to the natural flow of the conversation. This technique and the use of probe questions can facilitate a more in-depth exploration of the topics of interest by encouraging a more relaxed and open interview context. Residential staff were interviewed using the guide questions drafted for the focus groups as an interview schedule in the same way; a separate schedule was devised for the addictions team interviewees.
Data collection was conducted from July to November 2004. A single interview session was conducted with each prisoner participant lasting on average 40 minutes. Prisoners selected by staff members were interviewed by one of three researchers in accommodation provided by each participating establishment. The researcher explained the purpose of the interviews and outlined the terms of the consent form and confidentiality agreement and the nature of disclosures which would be considered a breach of the agreement. With the consent of the prisoners, all interviews were audio-taped.

Staff interviews were conducted either face-to-face or on the telephone dependent on the availability of the staff member. Three face-to-face interviews with residential staff took place in the staff room of the hall they were supervising; the fourth, and all the addictions team interviews, were conducted by telephone. Where telephone interviews were employed, consent was obtained by post and later confirmed verbally when the interview took place.

Analysis of qualitative data
All focus group and interview tapes were subsequently transcribed using minimal transcription conventions. Data were stored in a password-protected computer file and analysed using theory-led thematic analysis supported by NVivo software. Hayes (1997) endorses this approach as allowing rich data and interpretation to be brought to bear on specifically targeted research questions. In this case, the topics generated by the research team for the discussion were taken as broad categories for primary analysis of all data. On repeated reading of the transcripts, three researchers coded the focus group, individual prisoner and individual staff interviews respectively under these devised categories. Subsequent coding followed the guidelines offered by Frankland and Bloor (2001), whereby each researcher identified emergent themes under the given headings for their part of the data. These fine-grain codes were then compared and discussed, in particular examining divergences in data from different interview routes; this allowed the coding to be refined into a coherent system for analysis taking account of the data as a whole.
Chapter 3 – Self-Reported Drug Use and Scottish Prisons

Prisoners, staff, and addiction experts were asked to comment generally on what they felt were the reasons for drug use in prison and more specifically why some individuals chose to maintain their drug habit without seeking help in the form of support from staff or other interventions. Thus, in this section, reasons for ongoing illicit drug use, barriers to making contact with SPS drug services, and alternative means of coping in the absence of intervention were explored.

Availability of drugs
At several prisoner groups it was attested that “you could get anything in here”, though this was sometimes qualified with the view that choice was determined by what was available at a given time:

P1: It depends what you’re just going to use whatever drug comes, [mm-hm] whatever you’re offered you just take it. [aye]
P6: Personally I just take what’s offered me, you know, take whatever. [male prisoners group].

In every adult establishment, as well as reference being made to an element of polydrug use, cannabis and heroin were cited as the main drugs being used.

I would say there’s just as much of everything... it’s mostly hash and heroin. That’s the most common drugs in here [male prisoner].

Well the main thing’s smack [heroin] eh, but there’s always hash [cannabis], and then but that will be the main thing basically, sometimes coke, [cocaine] but mostly it will be smack if it’s anything, you’ll get the odd valium going about here and there like, but just basically smack and hash [male prisoner].

The prevalence of heroin use, but also the ongoing problem of poly drug use, was also raised by this addiction expert:

...heroin is probably the biggest problem, but I suppose on top of that it’s poly drug misuse, a lot of these guys will take virtually anything that is going... they’ll take virtually anything that has a sort of an effect on them. [addictions co-ordinator].

Addiction staff also perceived a trend from the use of soft drugs in the past to hard drugs. Cannabis, no longer appeared to generate the concern among some staff it once had:

Cannabis isn’t as dangerous, so I’m not as concerned about cannabis, as I would be about heroin [addictions staff].

Cannabis was not seen as creating high levels of conflict, since there was less money involved; trade in heroin, in contrast, was seen as tied to significant financial interests outside, and therefore the source of some violence. One addiction expert interviewee
acknowledged a negative impact of heroin-related activity on the lives of everyone in prison:

There’s not so much gang warfare going about cannabis use than there is with heroin. Heroin’s big business and controlling the heroin in prison involves – you know, if you’ve got different prisoners from different areas in Glasgow, there may be fighting outside over controlling certain areas in relation to selling drugs. They come into contact with other prisoners and it’s a hell of a problem. So heroin has caused a lot more problems than cannabis [addictions co-ordinator].

It was also pointed out that although all drug use was seen by the addictions team as eligible for treatment, they were unlikely to be approached by prisoners for help with cannabis-related problems. Another interviewee stated that, in the context of working with heroin users of long standing, their addictions team would “accept cannabis to a certain level” and would not seek to punish its use; however, they cautioned that this could create uncertainty for prisoners if they saw themselves as being punished for testing positive for cannabis in a random drug test:

It really, really depends because we have people on various, eh, amounts of cannabis then it becomes just a habit, they’re doing it out of habit, they’re no doing it because they needing it but they think they need it... Then sometimes that’s when we have to be careful because the mixed message, ‘well you’re alright about it so why am I getting punished for it?’ Y’know, we have to watch that...[addictions staff].

Young offenders’ heroin use was seen as less common, though addictions staff who dealt with them said that some individuals could come in with substantial drug habits:

But there are a whole lot of young people who come in here with serious habits: 13 years of age they start to inject heroin, £130 £140 a day heroin habits; one guy I spoke to: 3 grand a week crack habit; but you know we’re being told that there isn’t any addicts in here, they’re just experimenting [addictions staff].

The young offenders’ discussions of heroin, though, implied that not all were familiar with it:

P1: See rattling is it dodgy man, is it terrible aye?
P2: Get sore legs and that.
P3: Fucking experience that shit. How many actual people in here took it?[General muttering]
P4: I’ve never touched it.
P3: You ever touched it?
P5: Never touched it [name]?
P2: Oh fuck no, offered it loads of time but, don’t want to get into the state I’ve seen cunts in with it, man. It’s true man, it’s ripping right out of you man. [laughter] Isn’t it man, pure buckled teeth and everything, man! [young offenders group].
Professing never to have touched heroin could be a socially desirable response here; but asking others what ‘rattling’ was like suggests a genuine lack of knowledge. The view that young offenders were less likely to use heroin was also expressed by an adult prisoner from a different establishment:

 Mostly hash up there [YO Institute] and eckies [ecstasy] and that, there was some kit [heroin] and all but basically I’d say it was basically hash. [I mean what’s the difference?] I think they’re all just still weans up there, don’t want try to take it. Down here they’ve been on kit for years, so they know, it’s all weans up there who’ve probably not tried it yet [male prisoner].

Like other adult prisoners, however, he felt that it was likely that such experimentation would occur when the young person entered the adult system, in his opinion due to the greater availability and acceptance of this drug within these jails.

 [Is it kind of, is there, would there be a problem with folk coming from [YO Institute] then?] Aye, if they’ve not been taking kit, they’ll go off with a charge they’ll take it, aye, cause they’ve no had anything before that, but most of them do [male prisoner].

Where participants in some adult jails discussed a heroin supply which was “abundant”, young offenders described availability as dependent on “what somebody gets”.

 [What’s going about that you get hold of in the hall?] What I can get hold of? Hash, hash, vallies [Valium], DFs, [Dihydrocodeine] heroin, cocaine, ecstasy... every drug going, just depends what somebody gets, eh? One day somebody might get heroin, somebody might, somebody the next day somebody might get a bit of hash, the next day somebody might get a bit of cocaine, just depends eh? [male YO].

Heroin was usually mentioned as the principal drug available and used by adult prisoners. It was not clear, however, whether this reflected how often these drugs were seen to be used, or whether cannabis was regarded as less of a ‘problem’ drug and therefore sprang to mind less readily.

 The hash is nothing, ken. That’s not a problem... It’s the heroin that’s the problem [male prisoner].

Some prisoners described routine use of cannabis, for instance:

 Cannabis that’s... basically, see me I smoke cannabis constantly. [male prisoners group].

Yet others in the same prison downplayed cannabis use, and emphasised the predominance of heroin use:
I2: Is it mostly smack that’s the problem in here?
P7: Aye.
P1 It’s the only drug you get in here [male prisoners group].

Some prisoners specifically identified an increase in use of heroin:

[Have there been any changes in what’s been available?] Aye. Heroin is getting more acceptable, I mean heroin’s just everywhere...[female prisoner].

This prisoner, while emphasising the wide range of drugs available in prisons, described what he saw as stability in levels of use of cannabis and heroin over his time in prison:

[Are there any kind of changes in drug use that you’ve noticed over time?] No, no. It’s always hash, eh, cannabis and heroin... you do get Valium in the jail, ecstasy, cocaine. You get every sort of drug in the jail, but heroin and cannabis are the main ones [male prisoner].

Other prisoners, particularly long-term prisoners and those who had served multiple sentences reported that they had observed a change over time in the availability of drugs in prison. These individuals reported a shift away from other drugs, including cannabis, and the restricted use of heroin among isolated groups of prisoners, towards the wider availability and use of heroin.

When I was younger it wasnae so much heroin, know what I mean, it was mostly Valium and Tems [Temgesic] and hash, know what I mean, maybe the odd bit of coke but, like heroin wasnae as bad when I was a young offender, than what it is now. It’s rife now, know what I mean [male prisoner].

There were conflicting claims made about the cost of heroin in prison. At one of the prisoner groups, it was suggested that the drug was cheaper in the jail than outside:

P4: You can actually buy like an eighth of an ounce of kit [heroin] in prison, cheaper than you can outside in some jails. 175 quid outside, you get for 150 in jail [male prisoners group].

At another establishment, the prisoners argued the opposite:

P2: you wouldn’t imagine it, but there can be guys in here that can be very wealthy, through a five year sentence mate.
P3: You get £70 worth of heroin coming in right, you could make £300 out of that £70, know what I mean, outside you can double your money, in here you can treble it, even quadruple it, aye [male prisoners group].

Some staff pointed to the decreasing cost of hard drugs (such as heroin) in recent times:
S4: *I think that just mirrors outside, that the harder drugs have come in they’re cheaper, they’re getting flooded on the streets, and we are a mini society, and what goes on outside, comes in here [residential staff].*

The majority of prisoners felt that the current prevalence of heroin within prisons was also a reflection of developments in the community. Prisoners felt that changes arose from increased numbers of arrests and convictions of heroin users in the community which then skewed the prison population in the direction of larger numbers of heroin users, who would in turn arrange for more of this particular drug to be brought in.

_There seems to be a lot more smack, heroin going about in the jails than what there used to be eh. Before it was mainly, like, cannabis, there’s more heroin and that now. [Why do you think that is?] Well, I think it just reflects the way it is outside now… I mean when I was younger if you were taking drugs you’d be smoking cannabis at the weekends or something. All the young people are into heroin now that’s the way it seems to be the drug outside now and it’s just followed on down here [male prisoner]._

_Do you know or - why do you think that is?] Why has it altered the type of drugs that are available?] It’s just what’s on the streets. What I mean, what people are bringing in. It’s what’s on the streets. What they’re using on the streets, so when they come in here they’re straight on the phone, right bring me that up, I want that. Whatever they were using outside that’s what they’re wanting in. [So it’s just like a reflection of what’s going on outside?] Yes [male prisoner]._

Some addiction staff interviewees seemed almost resigned to the presence to some extent of drugs in their establishments. This was partly attributed to the prevalence of drugs in society at large. However, the changing demographic profile of the prison population was also highlighted. Interviewees described the prisoners they worked with now as overwhelmingly being from areas of social exclusion, and families affected by generations of poverty and substance misuse:

*I’d say by far the majority of people that come into [here] are folk that are just from a poor background and the chances of living a life that is drug free and not coming into contact with drugs is pretty low anyway [addictions staff].*

High rates of mental health problems among prisoners were also mentioned as increasing the demand for drugs as a coping strategy:

_There are a lot of women who use drugs to mask other things and to cope with other things, you know... [addictions staff]._

Though many long-term prisoners felt that the prevalence of heroin had increased dramatically in Scottish jails over the last decade, prisoners in one prison also noted that this situation had appeared to have levelled off to some extent in recent years. One participant for example, contrasted the demand for heroin he had observed two years
previously to the current situation in the prison, which he felt was much improved since the introduction of methadone.

Every Hall in the jail was wanting it [heroin] then, you know? You could get it twenty four seven, you know what I mean? If I wanted it at ten o’clock at night I could get it, know what I mean. It’s no as bad as that now. It’s like if you want charge the now, right, say I went back to the Hall and I wanted a charge, right? I probably couldnae get one right there and then, whereas before you could, right? You’d maybe need to go to about twenty guys and maybe one would give you a couple of lines, you know what I mean, that’s how bad it is now. Whereas before you could go to they twenty guys and get maybe ten bags, ten bags off each of them, you know, so that’s the difference, you know what I mean [male prisoner].

However, demand for heroin did not appear to have decreased in another short-term prison. According to the prisoners there, the prevalence of all drugs in jail was instead felt to be greater than previously.

Well I’ve been coming in and out of here since 1998… was the first sentence I did in here, right, and I think that it’s always been bad up here, but now it is, it’s the worst I’ve ever seen it in here. I think. I mean that’s just my personal opinion, like [male prisoner].

Prisoners and staff did not tend to elaborate or speculate on rates of heroin use; however, some mention was made. What references there were to levels of individual heroin use ranged from “near enough a half gramme of kit [heroin] a day” to a weekly use. One prisoner described injecting two or three times a day. At one prisoner group, three of the seven present claimed to have smoked heroin that morning.

The increase in heroin use was frequently accounted for by prisoners with reference to its property of leaving the system relatively quickly, making it less likely to be detected.

Well, I’m 36, well nearly, I’m 36 in a couple of days and eh, when I, when I first came to prison, when I went through my Young Offenders and things like that, it was all cannabis that was in the jail, there was nay heroin or anything so, this is my first time back in prison from when they started drug testing and when I came in, it really opened my eyes to how much heroin is actually in prisons nowadays. Way back then, you never got heroin and guys who did get heroin, it was kept in that wee particular group, no? Eh, but it’s the drug testing that’s knocked guys from smoking cannabis onto heroin because cannabis is in your system for 28 days after you’ve had a smoke, whereas smack ye can, well, I can take a burn of smack the now, go back to ma cell, drink 3 litres of water, get drug tested and it’ll no be in ma system, whereas if I do that with cannabis I’d still get done, know whit I mean? So a lot of people are turning to heroin for that, for that reason, you know? [male prisoner].
Some prisoners went so far as to claim that drug testing could lead to first time use of heroin in prison:

So guys are saying I’m in the jail naebody’ll know, I know guys that’s actually come in, he disnae take smack outside, well respected guys, eh, come into prison and started taking smack and ended up with a smack habit in prison for the simple reason is because it’s easier to for tae get smack out your system than it is cannabis [male prisoner].

Some of the, aye, like some of the young lassies that come in here with life sentences and stuff, it they just fall into it because, because I think they do. It’s like, come in here and say you only smoke dope, dope’s in your system too long, so you turn to smack cause it’s out your system in three days, do you know what I mean, it’s mental [female prisoner].

Few other reasons were offered for heroin’s predominance. It was seen by these prisoners as the easiest drug to get into prison:

Cannabis is harder to get the hall because it’s so bulky, a lot of people don’t like bringing it in here. It’s [heroin] just easier to conceal, you know what I mean, you’ve got a wee package like that, it’s size of a one pence or whatever, that’s three quarters of a gram maybe know what I mean, and seven or eight people will be well stoned [male prisoner].

Very rarely you’ll get somebody with cannabis, very rare, because it’s big and bulky. It’s mostly all heroin that comes in at visits. After that, I’ve no seen anybody with a bit of hash in here for seven weeks I’ve been here. This is remand [and] I’ve no seen any hash at all. And normally if there’s a bit of hash I’ll be chasing it [male prisoner].

A member of addictions staff also took the view that heroin was easier to smuggle into prison:

Heroin is easier, it’s probably the easiest drug to smuggle in, simply because it comes in such tiny quantities [addictions staff].

One prisoner specifically highlighted what he saw as heroin’s capacity for giving a sense of release:

P3: Smack’s the number one problem.

P2: Aye, smack is the drug of choice in here because it’s... it takes you away. [male prisoners group].
Cocaine and crack were also mentioned, their use occasionally linked to the sex industry. They were still seen by both staff and inmates as being used relatively little in prisons (one member of addictions staff described crack in particular, as “not a prison drug”):

> I suppose what would be greater problem would be... if someone managed to get some crack cocaine in and they started sharing that, but crack cocaine doesn’t lend itself to imprisonment... it would be very stupid prisoner who would lock himself in his cell and take crack cocaine, really, because it really doesn’t lend itself to being locked in prison [addictions staff].

Though there were some reports of an increase in the use of these drugs:

> S4: There’s a couple, a few cocaine users, that’s creeping in more and more, don’t get much [unclear] any more.
> S3: You get the odd one, maybe two.
> S4: Aye, but there’s a few more now.
> S3: Three more, there maybe used to be maybe one or two, because it’s not a drug you can, well it wasnae a drug you came across in jail... But now it’s creeping in every now and again... [addictions staff].

Staff groups differed as to whether they saw such an increase as a fluctuation or an ongoing trend:

> Somebody had a cocaine scale recently... there’s, there seems to be, cocaine seems to be something that if it happens, it happens suddenly, and a lot of it, and then you tend to find that it doesn’t... it doesn’t crop up again, probably. [addictions staff].

This prisoner indicated that cocaine and crack were less freely available than heroin because more effort or particular contacts were required to gain access to this drug.

> [And anything else, how about crack or cocaine, is that easy to get in here?] Nah, you get it aye, but you’d need to know who, who to go to get it from [male prisoner].

The disruptive effects of crack in particular were described by this prisoner:

> I’ve used crack in here and coke, all sorts aye, once you’ve used crack you can’t really get it again in the jail. [How’s that?] Cause it just sent everybody nuts, we were all going off our head, half of them ended up in suicide cells, [laughs] I mean... Cause crack’s a kind of cocaine too, it’s like an upper, it makes you hyper but it can make you really, really aggressive too, and all your thoughts and everything just changes, and you become more paranoid on it, really aggressive, so the officers and that just don’t like to see it in the jail...[female prisoner].
The same prisoner even went so far as to suggest that some prison staff would ‘prefer’ heroin use to use of crack in prison:

They [staff] prefer heroin than crack to be honest. Cause that’s a downer you just smoke it, you just sit about and you’re fine [female prisoner].

While staff did not concur with the opinion of this prisoner regarding heroin use, this member of staff expressed a similar view on influence of crack on prisoners’ behaviour:

I know in [names Hall] we had a few girls and I think it was crack that they had been using, because their personalities can get really violent and aggressive, and the difference that we saw in those girls was, it must have been crack that they were having [residential staff].

Obtaining drugs in prison
Addictions staff groups did not discuss in great detail how drugs came into prisons, although this issue was raised by addiction staff during interviews. Residential staff and prisoners in the groups almost always pointed to visits as the main means of bringing drugs in. This was described by both officers and prisoners as the first thing that a drug user would try to arrange on arrival:

They come in and all they want to do is try and arrange to get stuff in. They’re no interested in changing their habits or anything. They try and get what they can in here… [residential staff].

But in saying that, I mean you come in, the first thing you do, you get on the phone, you say to somebody, ‘come on and see us’. Now you, the only thing you’re looking for is a parcel, you’re in here, you’re strung out [male prisoner group].

Residential staff also pointed out that a prisoner who was less likely to be suspected, or one getting more visits (such as a remand prisoner), might be coerced or persuaded into arranging to bring drugs in for a ‘main player’.

However, one prisoner group claimed that only a minority of drugs came in through visits, which were only suitable for “getting a wee bit for yourself”.

P3: see the amount that would come through the visits, it wouldn’t be a third of the amount that’s come through in other ways, cause we wouldn’t, there’s other ways instead of the visit room eh? The drugs come in right, right you see them coming like maybe....

P3: Comes in lump sums, that will last you a good...
P5: A grand’s worth or something or...
P3: Things like that, and they’re hitting the visits hard and they think it’s the visits, it’s no’ that, know what I mean? [male prisoner group].
Some addictions staff suggested that allocating greater resources to tackle trafficking at visits might be successful, but would have too great a negative impact on all prisoners’ visits:

*I mean if you could put, if you could put 20 staff in the visit room, you could probably stop drugs coming in, but then the visitors, prisoners wouldnae have very nice visits so... it’s about really, what you can realistically do...*  
[addictions co-ordinator]

Prisoners did not elaborate on other means of smuggling drugs into establishments. Nevertheless, other options were mentioned at other groups. Admissions were identified as a route for bringing in drugs internally. Officers at one staff group described arrangements by dealers within the prison for someone to be sentenced for non-payment of a fine so that they could bring drugs in, on the understanding that the fine would then be paid allowing the individual to leave the prison again:

*S4: They actually come in and what they find is, I’ve got fine to do, somebody will say to them: go and do the fine, hand yourself in, back to your cell and we’ll pay your fine. So they’ll come in on the Friday morning packed, and at half eight at night somebody will come up and pay their fine, but by that time all the stuff’s out, it’s round the jail...*  
*S1: Distributed.*  
*S4: Distributed and they’re getting out again...*  
[residential staff].

Obtaining drugs was described as a substantial feature of daily life for users in prison:

*P4   ...it’s every second guy you talk to is, I’m saying this wee hall we’re in the now, it is alright, you’re not getting guys waking up and chasing, but you go into any other hall, and speak to every single con, who’s on a visit, who’s getting, who’s holding?*  
[male prisoners group].

The rush to find who had drugs and buy them was described as ‘mayhem’. It was described how this level of activity could fill in a day itself for prisoners. Some said that new arrivals would be targeted for the sale of drugs almost immediately upon arrival. One group of prisoners also described a cartel for the purchase and use of drugs:

*P2: In our hall there’s not much smack right, but it’s either a famine or a feast, there’s either a lot or there’s none, so right for talking sake me, [name] and [name] and [name], we could be sitting and, say smoking a half gram maybe right, and every four days or something, so you’re not really feeling, the full effects of the withdrawal you’ve got something, there know what I mean*  
[male prisoners group].

As well as the incentive of financial reward, dealing could be a means of currying favour.
If you’re getting visits, if you’re scoring you’re in with all the top boys, getting them to score and that, they’ll be your best mates, man [male prisoners group].

For other prisoners, dealing was viewed as an unavoidable consequence of excessive pressure from other prisoners:

P4: I know. Start selling it cause they’ve got no money.
P1: Because of constant punishment. And - they might, they might have done it anyway. But it was still another option. I’ve got no option but to get the stuff in and earn myself dosh. That does happen, believe me [female prisoners group].

Staff Awareness
Prisoners were also asked to indicate to what extent they felt that staff members were aware of dealing and use within the prison, and how action taken by staff impacted on the extent and manner of drug use within the prison population. In general, prisoners felt that staff could not fail to be aware of drug use due to obvious physical signs.

[How aware do you feel that the staff are of what you’re taking?] Oh, very aware, very aware, very, very aware. They can tell right away if you’ve had a charge. Obviously your eyes go pinned and you’re full of buzz. I’ve had a charge this morning, I’ve had a charge about an hour before I come in here, so you can tell somebody’s had a charge. They can also tell what, two days later when there’s nothing in the Hall and you can tell when somebody’s lying rough, you know what I mean. You just look at them, you can tell they’re rough so they know, when there’s something in the Hall they know when there’s nothing in the Hall. They know who’s taking, who’s no taking [male prisoner].

Similarly, prisoners perceived the signs of dealing to be self-evident and therefore unlikely to be missed by staff members.

There’s so many people in the hall that you know get heroin at their visits eh? When they come back from their visit, it’s like a train of people after them, you know what I’m talking about? Talking about eleven or twelve following one guy about, screws know he’s got it... [male prisoner].

The extent to which staff could be expected to stop drug use and supply was questioned by this prisoner:

I think in all honesty, I think in all honesty, they know exactly what’s going on in that Hall... But there’s nothing they can really do to stop it [male prisoner].

A view which was to some extent reciprocated by this member of addiction staff, who acknowledged the perpetual struggle against drugs coming in, and also reported an increase in attempts by dealers to bring in mobile phones as something else to combat:
Well, we do our best just to try and stop all the avenues that we can, but as soon as we stop one avenue, then another one opens so, we have to be constantly on the alert for drugs. Also prisoners are now beginning to smuggle mobile phones into prison, which also helps the drug dealers and makes our job even more difficult, er, incredibly difficult [addictions staff].

As far as what action staff members were likely to take regarding their knowledge of drug use, most prisoners felt that staff ‘did their best’ to tackle the drug problem in Scottish jails. At the same time, staff were considered to be at a serious disadvantage in this endeavour due to:

(a) to the sheer volume of drugs passing into and around jails:

Obviously they’ve, they try to do as much as they can to stop it, eh? I mean like they... every way it’s coming in, they try and get them out. Stop it, know what I mean? They’ll use all they can really but, it’s only really ever going to get worse, eh? I cannae really see it getting better, know what I mean? They’d have to put everybody on closed visits and they’d have to put a cover over the whole entire jail or, not let anybody out like on placements or anything, stop it coming in, but of course that will never happen eh, so it’s always going to be...[male prisoner].

(b) the efforts of prisoners to conceal their supply:

They’ll no turn a blind eye, if they know there’s something there they take the damn hardest to get it off you but... we’re too good for them, we’re one step ahead of them [male YO].

and (c) the lack of manpower available to make the task of challenging drug use in prison a viable goal.

Some nights you go about the hall and you hardly see any staff at all. [Do you think they are trying to control it though?] They do their best with...as I say, they can only do so much with the levels of staff they’ve got. If one of them got heavy with users to try and do it I think it would just cause a big disturbance to do it. You know what I mean? I think because of the staffing levels that they kinda turn a blind eye to it [male prisoner].

It was also claimed that variation existed between individual staff members as far as their response to drugs was concerned. Prisoners were observed that, though some staff members would take a hard line against drug use in the halls, other officers were more tolerant, at least when prisoners made efforts to conceal their use.

[I wanted to ask about, what are the staff attitudes like towards you guys, people that are users?] Some of them just turn a blind eye, but some of them are right, right against it, like clamp down on you, some of them can’t be bothered though, and just turn a blind eye, as long as you’re not doing it openly in front of their faces or anything like that [male prisoner].
The belief that staff would tolerate drug use as long as it remained concealed from sight was common to numerous accounts from prisoners. Previous experience of staff inaction and more direct communications from officers that such use would be ignored, confirmed to many prisoners that drug use which was hidden would not be challenged by staff.

Some people do, do it when they’re there and they see it. It’s just a case of opening somebody’s eyes and you know right away, so. It’s a case of waiting until they go away and they tell you that they tell you that themselves if they come in and smell it that’s, you know, that’s the first thing they say, ‘fuck’s sake wait until I go away’ [male prisoner].

To be honest with you, see just a few weeks ago I was sitting in my room, and... I had foil and that and I was burning heroin, and I took a line, and I just kinda well it seems to like you draw a fag, you inhale it you hold it and you blow it out, well it’s the same with heroin so I just inhaled it. And one of the officers, I won’t say any names, but she’s opened the door, and I was sitting there still holding it in, and she was looking like that, but eventually she was talking to me I just couldn’t hold it any longer I was just laughing and blew it back out. But she goes like that, knowing that I was just sitting taking drugs in your room, she just walked away, she just left me to it [female prisoner].

As prisoners understood concealed drug use as having limited consequences, most indicated that they were willing to hide their drug use. One prisoner explained how this ‘arrangement’ worked well for both staff and prisoners in maintaining a peaceful prison environment. Like others, this participant did not feel that staff willingly condoned drug use, rather he felt that staff viewed their tolerance of drugs as a necessity if levels of disruption were to be controlled within the jail.

If they catch you, you burn, and that’s it. But it’s like everything else if you’re mad with it you just want an easy time, don’t you? You don’t want any hassle. You know what I mean. So you would rather keep it quiet. To be honest if you’re working in here, what would you have? Every guy strung out screaming the face off you constant, or somebody lying mad with it in a pater [cell] who won’t give you any hassle. It is an arrangement, but then it’s no. You know what I mean? They know, they’ll no fucking search on a Saturday night when they know there are drugs in the prison and they also know without the drugs it would be a hell of harder here. But they know that as well as we do, right. But they can’t turn round and say ‘look we condone drugs’. They cannae do that, you know what I mean, cause they’d get sacked and get their arse kicked, you know what I mean. But they know there needs to be a certain amount of drugs here for everything to run. You know what I mean? The jail cannae run if there were no drugs in it, let’s be honest, that’s how bad it is... Without drugs in the place then the place would a nightmare. It’s a way of controlling it eh, in a way, you know. If you’re sitting full of the drugs right and I’m sitting no full of drugs, right, and I’m rattling, right, now I’ll maybe just rattle for maybe a night then I’m getting the next morning. But if I know I’m no getting any drugs, right? Telly’s getting smashed, puts you up in the air doesn’t it? So although they do their damnedest to
try and stop it, but there’s always ways in as we all know, you know. So when I’m mad with it, I’m no interested now in going about with them or smashing up knowing that, know. So it’s what people want in it, you know what I mean, its an easy life for every cunt, you know what I mean. Although it’s no accepted, you know what I mean, it’s no a case of ‘ oh you’re mad with it’... get the fuck out and leave it [male prisoner].

The limits of staff attempts to detect and prevent drug use were acknowledged by this member of staff:

_Some of them have massive drug misuse, some of them have are probably occasional users, I find this myself in the course of it, there’s different levels of usage you know, and we probably don’t know the true picture, because the majority of prisoners; they don’t take drugs openly, it’s usually done behind their cell door or, you know when there’s no, no staff member about, you know? And it would be difficult I think if we were doing it by the exact but we’ve got a good idea_ [residential staff].

While one residential staff group did highlight the difficulty of patrolling all the cells:

_S4: Yes it’s normally a group, it’s normally in a group, two or three in a cell, and again you’re sitting there with 226 cells you cannæ watch them all the time and er... it’s a problem_ [residential staff].

Some felt that getting to know prisoners over a long period of time made such behaviour changes all the easier to spot. Prisoners at one group who were not users themselves also described being very aware of when other prisoners had been using drugs from their behaviour:

_[What kind of impact does it have on you? Do you, you know if there are drug problems in the hall?]_  
_P2: Well it makes you nervous and that, you don’t know how they’re going to react, you know, not being a drug user and seeing some of these guys, you know and it’s like when they’re off drugs, they seem to be quite normal, but when they’re on drugs they’re, you know they’re high and they’re, you know flying about all over the place and you know, you just don’t know what reactions, when, always on your guard all the time you know._  
_P1: People on drugs their actions become erratic_ [male prisoner group].

One officer also described awareness of increased coming and going around a particular cell as another signal of drugs being taken. Acting on such suspicions might involve a significant input from the officer

_If you see a prisoner that you think’s under the influence, one you go and get a nurse to check him, for his own health; two you’ve got to go and start searching,
to see if there’s drugs in his cell; three you’ve got to fill a drug test, suspicion form in: so there’s actually there’s more work to be done if a prisoner’s actually going about with glazed eyes, whatever it may be [residential staff].

In fact, residential staff groups in some establishments described blatant use of drugs, or situations where it was perfectly clear to them that a prisoner had taken something; but complained that they felt unable to do anything about it:

S1: There’s days you walk, you walk through the halls and you feel as if you’re under the influence of drugs, there’s that much. [Yeah?]
S1: Yeah, so, and there’s nothin’ you can do to stop it [residential staff].

S3: I used to take it quite personally when they used to smoke hash in front of me, you know you can smell it, and you’d go in and they’d be smoking it, I used to take it quite personally, then I was: why? They’re not going to do anything about it anyway in here so…. I used to take it off them and that’s all you can do [residential staff].

At some of the prisoner groups, a corresponding view emerged that drugs could be taken with impunity in certain situations:

P6: …it depends who you are, say like he was in a peter right, having a chase with [unclear] right, he would go and get more screws, open the door, boom: open the door right, take his chase off him. Say like me and the boy were sitting in a peter and there were 6 other people, top dogs in the jail, they wouldnae come in trying, even thinking about taking your chase off you … [male prisoners].

Alternatively, this could be interpreted by prisoners as variations in attitude towards drugs between staff:

P1: Ah but some of the screws don’t care if yer fuckin’, see, I’ve had a couple of screws that have known we’ve had hash, man. Shut the door again man, cause you know it calms you down, know and you don’t really bother about it, some other screws think: ‘ah fuck it man, no give them nothing man, know what I mean, don’t let them do anything like, know what I mean so…

P2: It would be better if all of them were like that man... [young offenders group].

Staff and prisoners in some establishments equated a perceived rise in drug use in prison with the end of the policy of taking off remission as a punishment. It was argued that those using drugs were not put off by the punishments that were now in force:
It doesnae deter guys from taking drugs now, it maybe used to when they could take remission off them, and stuff like that, you know if they were for an a positive for something, they would have been punished in the Orderly Room and they would get maybe seven days added to their sentence, but now that’s all done away with now, it’s now a case of maybe losing recreation for seven days or... maybe wages, and that doesn’t deter them.

That’s the tellies now in their cells anyway, they don’t need to go to rec [recreation], so now they’re watching the telly and we’re sticking DVDs for them to watch anyway, so...[addictions staff].

Given prisoner views on the low impact of punishment for testing positive for drugs, this belies the argument that prisoners will take heroin rather than cannabis to beat tests; one MDT officer did point to statistical evidence from test results of resurgence in the use of cannabis after a temporary increase in heroin use:

Yeah the three classics are the cannabis, opiate and benzodiazepines, those three, they often get prisoner’s telling you that we’re chasing them from cannabis to heroin, but that’s not so, I think I can prove that with my own statistics, cause they use both... a lot of them... we did have a little spate where heroin or opiate use was higher than cannabis but it seems to have flipped back over again [addictions staff].

Some mention was made by residential staff and prisoners of the impact of drugs on the prison environment. The pressures of dealing and scoring were seen as increasing conflict:

And it’s like running about, and then they’ve got to worry about having to pay for it, so they’re worried about that and if it just escalates and escalates and escalates out of control, just cause somebody wants a burn, you know what I mean? So then that causes friction between them and they all start arguing and fighting with each other, then they start telling stories and telling lies with each other and...

It does cause a lot of trouble does drugs, and then people are seeing them with it and people are always... you know if they’re in this little group and they’ve got a supply, and they haven’t... so then it causes fights and things, it does have an affect on how the block is [residential staff].

A couple of prisoners mentioned individuals on medication being bullied for their prescriptions. Officers in one group suggested that bullying and debt often led to greater pressure on family members outside than the drug user themselves:

Is the debt a big problem then?
No I don’t think it makes any difference to them.
It’s the families outside that get the chap at the door [residential staff].
A few prisoners also mentioned this impact on families:

P5:  *I’ve seen guys screaming down the phone at their people at home: ‘get money in to us, get money in to us’* [male prisoner group].

Both residential staff and prisoner groups were characterised by frequent references to the all-pervading presence of drugs in prison: it was “drugs, drugs, drugs all the time”, there were “loads everywhere”. For staff, drug-using prisoners were described as the bulk of their responsibility:

S4:  *Have you got many in your block that don’t take drugs?*
S2:  *Um not that I could name… off the top of my head, no; whether they’re being prescribed drugs or whether they’ve got a drug addiction problems, I mean that’s the problem these days is drugs.*
S4:  *Yeah it is* [residential staff].

Prisoners routinely asserted that 80-90% of inmates were involved with drugs in some way:

P4:  *See to be honest man everybody in the jail takes drugs, every everybody does so, know what I mean so, [no] so there’s only a certain, there’s only…*

P2:  *There’s only a couple of folk in here that doesn’t do it.*

P1:  *A few from that, up in that thingmys, up in [names Hall] but the rest I don’t think [unclear] anyway.*

P2:  *I don’t know that’s just the way it is…[young offenders group].*

Both populations saw this as a reflection of conditions in society at large. Among the residential staff, such statements often accompanied a sense of resignation, or of drugs being inescapable:

S5:  *It just mirrors what’s happening outside in the areas that they, that most of them have come from… there’s just heavy drug usage and there’s not really much you can do to stop it if they want to take it. And they are, most of the halls, most of the prisoners that we see residential are, they’re using drugs to some degree, whether in recreational at the weekend or, heavy every day. It is happening and two members of staff on a gallery, that’s… [residential staff].*

The fear of violence and disturbance was another reason prisoners felt that staff failed to act upon their knowledge of drug use. In certain prisons, prisoners felt that staff shortages left officers outnumbered and aware that they would be unable to cope effectively with disturbance should it arise.

[What would happen if they did clamp down?] *There’d be trouble. There’d be stabbings. Officers would get stabbed and… Cause there’s two of them in the Hall. There are probably 280 prisoners, know?* [male prisoner].
They’re just not prepared to do anything about it eh? [Why’s that?] Because if somebody tried to try to take kit off a junkie, he’ll fight to the death for it eh? Especially if he’s just had a visit, you know he’s been looking forward to it all week, starting to feel ill and that eh? And he knows that five minutes later he’s going to be better eh? So, the officers will no approach somebody like that, cause they’re likely to get done in eh? There’s 85 of us and there’s only 6 officers right? [male prisoner].

That violence was a possible response to being detected was claimed in the account of this prisoner, who suggested that her response, had she been challenged further by a member of staff who discovered her using drugs, would have been to physically assault her.

All she had to do was just walk in and open my box and she would have seen me exactly, it was obvious I was up to something and she knew what I’d done and what ever else, she just left me to it. [Why?] Because sometimes it’s more hard than it’s worth for them, the way they’ll see it. Cause if she’d come in there I’d of I’d of physically fought with her, to hide that, or to get rid of that, do you know what I mean, I think she’s knows that herself so she’s went like that… just leave her [female prisoner].

Though the concealed use of drugs was felt to be tolerated to some extent by certain staff members, prisoners felt that in general staff would be more inclined to respond to signs of dealing.

[And what’s their general response, I mean, when they do know (about dealing)?] Then, they maybe seen that the person’s getting away with selling drugs, if that’s what we’re talking about but, always, they always come down on top of them. I’ve never seen somebody been in the Hall for a long time and getting away with it or seem to be getting away with it. It just doesnae happen [male prisoner].

However, participants described how the time taken to pinpoint the source of a supply meant dealers had the opportunity to remove their supply through the cooperative effort of several prisoners. As a result, though staff were seen as being more willing to prevent dealing, their efforts were felt to have little impact as dealers were always a step ahead.

You just get out the door and get it away or whatever then when they come in you’ve not got it, you know what I mean. Ken, in the Peter [cell] three guys are just walking it away by them who arenæe in the Peter they’re away with the gear. So they’re hoping to come in to get the stash and its (laughs) no there, you know what I mean? So although they try their best but it’s just no there for them. You know what I mean? Don’t get me wrong they do catch people obviously, they do catch people, you know but very few and far between in the Halls I mean. Don’t get me wrong they catch you at the visits, you know what I mean? I got caught not long ago, you know what I mean, and just, they do catch you at visits [male prisoner].
Staff members were viewed as being highly aware of both drug use and drug dealing in the halls. Though participants reported that more drugs were being stopped entering the prison through visits, action taken against covert use of drugs in the halls was viewed as minimal, with prisoners reporting that some staff would ignore the use of drugs as long as it was sufficiently concealed from sight. By contrast, more open use was felt to be likely to result in punishment. Staff responses were thought to be linked to the awareness of staff that the presence of drugs was necessary for control and a ‘quiet life’. Though some participants felt that prison officers were forced unwillingly into this arrangement, other believed that their lack of response was indicative of laziness and disinterest. Prisoners also felt that staff chose not to challenge drug use because they were fearful of the consequences of such actions i.e.: possible disruption and/or violence. Prisoners felt that this was exacerbated when staff were aware they were heavily outnumbered by prisoners and thus incapable of controlling unrest should it occur. This was recurrent theme across accounts though was notably absent in reports from one prison, where both drug use and dealing were described by prisoners as ‘blatant’. The openness of these activities was related in reports to the failure of staff to act upon their knowledge, regardless of the manner in which drugs were used. Thus, the awareness that negative consequences were unlikely to result from illicit behaviour led to more confidence among prisoners that they could use drugs with impunity. Staff were viewed as more willing to act on their knowledge of dealing in the halls, however, prisoners felt that staff were unlikely to succeed to any great extent due to the willingness of prisoners to help each other in order to evade detection.

Thus, it appeared from accounts that heroin was considered to have increased in prevalence in recent times. Prisoners felt this could be explained by: the advent of drug testing within the prison service; the increased difficulty of smuggling in drugs which were not in powdered form (due to improvements in detection systems) and the increased prevalence of heroin use in the community which influenced supply and demand in prison by causing alterations to the composition of the prison population. Though reports suggested a boom in the availability of heroin in the last decade some prisoners noted that this had levelled out to some extent (largely due to the introduction of methadone into Scottish jails). However, in one jail, prisoners felt that heroin remained freely available. Young offender groups were seen as the only exception as far as trends in supply were concerned, in that heroin use among this population though present, appeared less freely available than among adult prisoner groups. Adult prisoners felt this was due to a lower demand for the drug among young offenders. More concerning was their claim that with an increased exposure to heroin in the adult system, young offenders may be more likely to use. Reports of cocaine use were rare. By contrast accounts indicated that crack was available within prisons, although the majority of reports suggested it was still at the present time less easily accessed than heroin.

**Injecting**

This sub-section is intended to provide an overview of participants’ experiences and attitudes towards injecting and sharing of injecting equipment in prison. The information presented in the following section includes a range of views including those of non-injectors, those who had injected in the community but not in prison, those who had only injected during previous sentences, and prisoners who were currently injecting. The
views of addictions co-ordinators, addictions staff, and residential staff are also included in this sub-section. Specific results and discussion of this aspect of prison life as it relates to general health issues and methadone prescription are covered in those respective chapters.

This section begins with an exploration of injecting in prison according to perceived prevalence, staff awareness, attitudes of prisoners and staff towards injecting and sharing, and the practical issues of injecting whilst in jail, specifically gaining access to injecting and equipment and methods of harm reduction. Following this, psychological and social risk factors for injecting are presented.

Prevalence of Injecting and Staff Awareness

Participants were asked how prevalent they believed injecting to be within the prison setting. Analyses revealed a degree of variation between establishments, although all establishments contained a high proportion of people with a history of injecting prior to incarceration:

[Is there anyone in here that does inject?] No. They have outside but soon as they come in they stop it. I was up in [name of prison] and there was folk injecting all the time, and down here...I’ve never known one person injecting [male YO].

It’s hard for lassies to get works in here for a fix. Since I’ve been coming into the jail I’ve never seen, never when I’ve been in, has anybody injected, or I’ve never heard of needles being in going about neither [female prisoner].

One prisoner focus group saw injecting as “rife” in their prison:

P3: Sometimes two three hits a day, and then...
I: Was that in inside the jail?
P3: Aye, oh it’s normal, you know what I’m saying, there’s loads of people like that
[male prisoners group].

Some staff described organised groups of injectors in prison:

So I mean we do have a problem with injecting in the prison, there’s no doubt about that, because we do find syringes and stuff, people do come up with abscesses in their arms, their groin, whatever through injecting [addictions staff].

Low levels of injecting within some establishments were linked by staff to difficulties in obtaining injecting equipment:

Okay you get the odd person that does, use needles in jail, but not many. [How come?] They’re hard to get in, they’re hard to come by, a set of works, it’s hard to get. And it would be hard to get in on a visit, or whenever [male prisoner].
The rate at which injecting equipment was discovered in the halls was thought by staff to provide a good estimate of the prevalence of injecting. Whether or not they had injected drugs outside one establishment, it was thought that almost all heroin users would smoke the drug while in prison:

But very rarely do we come across drug-injecting equipment, very rarely any cell searches or hall searches. It just doesn’t happen that often. [So it’s mainly smoking [heroin]? Yeah [addictions co-ordinator].

Staff groups in most establishments usually described injecting in terms of a trend that had diminished greatly over recent years, in the wake of concern over blood-borne viruses, and took the view that very little of it went on:

S1: I think they’re wised up to the risks they’re taking when they inject, I think most of them
S2: I think most of them smoke it now, I think in [another prison] because the guys, even though they don’t do it a lot in here, there is the harm reduction side of it that there are leaflets and that going about and that and I think that was it... [addictions staff].

Perceived Health Risks

The majority of those who reported having chosen not to inject whilst in prison cited the health risks of injecting as a major deterrent. This applied to both those individuals who had never injected and also those who had previously injected in the community.

Snort it or smoke it all day long, you know, but never jagging, no [inaudible] have been that bad, you know. Couldnnae move off the floor and seen people jagging and I still wouldnae do it, you know. Pals like that, ‘oh you’ll be brand new’, I says no, fuck it. I just wouldnae go down that road. [What is it that you’ve seen, you see what I mean, in general what is it that you’ve seen that puts you off so much?] Och, I’ve seen people outside, you know, dying with it. My pals have died with it, as I’ve just told you [male prisoner].

This was largely because prisoners equated injecting with sharing, and in turn, associated sharing with infection.

I wouldn’t inject when I was in prison, I wouldn’t inject again. [What are your reasons for that?] Eh, in jail, if you were injecting in jail, a lot of people would have to use the same, same set of works because they’re hard to come by. [So it’s the health risks?] Aye [male prisoner].

Other reports suggested that injecting was much reduced from previous levels due to increasing difficulty in gaining access to injecting equipment, but more generally due to a decreased desire among prisoners to inject whilst in prison, which in turn was linked to increased awareness of connected health risks. This increased awareness was common among older prisoners who had previously injected.
There’s virtually hardly any injecting now. [How come, how did that, cause obviously it sounds like it was pretty...?] It was, it was rife at one time, it was, it was rife. It was pretty bad at one time. I remember it very well. [I mean is it that they’ve done something about it or folk don’t want to?] It’s no as if they’ve done something about it. It’s just that nobody wants to use them [injecting equipment] in the jail. [Why is that?] It’s just a different culture, growing up and getting wiser I think. People are getting wise to it and saying well I’ve got this far in life so no going back to that carry on. [Is it the health risks, or is it just generally?] Just people generally valuing their life and no wanting to catch any diseases. Cause people as they get older they get wiser you know, I think that’s what it’s basically down to [male prisoner].

A small but significant minority of participants felt that awareness had been raised through prison-based educational programmes.

There’s been a few times, couple of times over the years that heard whispers that there’s been needles found or... [yeah] but it’s not very often, I don’t think. Lasses are too feared of catching things I think. ‘Cos a big population of people that do inject have got Hepatitis C so... [Do you think that’s ‘cos, I mean is that... awareness?] there’s a lot of awareness on it now in here, it’s like, I didn’t know anything about Hep or anything like that before I came in here, I mean it’s like you being a 21 year old [unclear] and you’re learning a whole lot [female prisoner].

Consequently, most of those who had injected on the outside but who had used clean needles were unwilling to take this risk. Instead these individuals substituted injecting with smoking heroin.

I do feel strongly about disease and all the rest of it. To be honest I think I would just put it in the foil and just smoke it and hope for the best. Because when it comes to using tools that every Tom, Dick or Harry’s used then I wouldnae, I honestly wouldnae do it. I wouldnae. And I know that probably sounds hard to believe but I wouldnae, I’d probably snort it first, know, and just that way I’m still getting it into my body as best as I can. Getting the best dint off it, as they say [male prisoner].

Among female prisoners, observations of other women who had inflicted permanent scarring or undergone amputations as a result of blood clotting resulted in fear of similar consequences for those who still retained their health.

Cause it’s really dangerous. Now I know more about it, it’s really dangerous. There’s folk in here hopping about on one leg that with hitting up [injecting], it’s dangerous. [How have you found out more?] Just with like, with my friends and mates, talking to them. They’ve had blood clots or abscesses and just through friends. There’s never been anybody come and tell me what happens, it’s just finding out from somebody else’s experience [female prisoner].
Concern over potential and existing health risks from injecting and sharing were identified by staff. One addictions co-ordinator thought that those who injected in prison were those who were most likely to be infected with blood borne viruses, and suggested that the scale of the problem as a public health issue had not been fully addressed:

The main problems are simply a matter of resources, above all addictions, especially for those opiate misusers who are injecting. It’s a public health issue and it really is a massive health problem... for instance we tend to, I estimate there are 2500 problematic drug misusers who pass through here every year, a lot of these guys will use needles for instance, those who use needles will generally speaking tend to be either HIV positive or have Hepatitis C, or some other blood borne virus, so there’s a huge health care issue which I don’t think is being adequately addressed here [addictions co-ordinator].

Participants from some locations described a widespread anti-injecting culture, often linked to a majority view of injecting as a high-risk activity which necessitated sharing and thus exposed individuals to blood borne viruses. Concerns over discarded injecting equipment were also raised:

If you start to hear of somebody injecting, the first thought you would think about is what you’re doing with they needles when they’re finished with them. I mean... discarded needles, you can get infections or anything eh? So I think that would be the first thing you’d think of [male prisoner].

Some residential staff described a strong stigmatisation of being an injector within the community of prisoners.

S1: And you’ve got other inmates who’ll come up and say ‘I don’t want to share a cell with him, he’s a jagger’ [injected]. Y’know, I mean he [prisoner] might be out his face on smack, but, no, if you’re a jagger they don’t want you in, so they’ll come up and tell you that, so there’s all that sort of thing [residential staff].

For prisoners, this attitude was also attributed to staff:

P7: Oh, as soon as they hear there’s tools [injecting equipment] in the hall they’ll run them off... they hate them... And they do, cause they can get stabbed, you know what I mean? There’s guys down there with the virus and all that. All it takes is for one of them to get blood, you know what I mean, and bang it into a screw and that’s them fucked up [male prisoner group].

Descriptions were given of what appeared to be an active movement against injecting, where those who were suspected of injecting were discouraged through pressure from others.

They have [injected] outside but soon as they come in they stop it... Don’t know why that is cause when folk come in and they’re like that, we go like that to them:
Jagged before? ‘Aye’ ‘Oh that’ll be right for you, junkie this and that.’ And they think different about going off [and injecting]...[male YO].

Although this view did not appear to be linked with an overall anti-drug culture, including attitudes towards heroin.

If I see somebody jagging up, I’d be like that, ‘that’ll be right for you doing that, you shouldn’t be doing that’, but if I go and see somebody having a burn [smoking heroin] I’d be like that, ‘oh fair enough, pass it, I’ll have a burn’ [male YO].

A view was also expressed that the move towards limiting the prevalence of injecting was motivated by the belief that the presence of injecting equipment in the halls would bring unwanted attention from staff. In order to avoid the disruption associated with cell searches that were intended to locate injecting equipment, participants reported that coercion was employed by the majority in order to encourage injectors to dispose of their injecting equipment, thus allowing life in the hall to continue relatively undisturbed. Again, this was not linked to an anti-drug view.

The way a lot of guys like see it but, see once the tools [injecting equipment] are on board and they know, they [the staff] come right down on top of every cunt, it doesnae matter who you are or what you’re doing. It just disrupts every cunt’s life, you know. I’ve... seen a couple of drug dealers going to the guy with the tools and saying look, give us your tools and I’ll give you a few bags, know, just to get them to fuck, they smashed them up and I’ve seen that a few times, you know [male prisoner].

In another account the desire to keep needles out of the halls was explained as a measure taken to ensure that staff did not disturb drug dealing.

It’s no good for business having these sets of works because then they’re shutting our business down because then they’re jumping on us and then we cannae get ourselves our products [drugs] It’s [injecting] just a no, no and that’s simple as. And if somebody comes up with a set of works in our hall that somebody will be fucking told there and then and given a choice... he’ll either get rid of them or you get rid of them and you usually find that ninety nine percent of the time they get rid of the set of works [male prisoner].

This participant placed the disruption caused by staff searches due to the suspected presence of injecting equipment in a broader context.

It’s attention you don’t need because, ‘cause see when you go into a guy’s cell, whey you go into my cell... I’ve got things set out nice the way I want them, so when somebody’s coming in and turning your cell over, know what I mean, they’re ripping it apart, so you don’t want people to come into your cell and rip it apart, know? [male prisoner].
This aspect of an anti-injecting culture was associated with what could be described as a surprisingly high level of prisoners sharing information with staff about injecting activity.

I’ve known gangsters in Glasgow that’s turned round and collaborated with them [prison staff] and went listen I’m no telling you who they are but the needles are there, take them, get them out of the Hall [male prisoner].

It was claimed by several staff that many prisoners themselves were likely to hand in sets of works themselves, with the intention of keeping injecting out of their hall:

S3: They’ll hand them in because some of them just don’t like the idea and they’ll class them as junkies so… ‘junkies’ and ‘drug takers’, they class them differently… [residential staff].

Nevertheless, one residential officer stressed the need for vigilance, even where prisoners appeared to be cooperating in deterring injecting:

S4: People will come and say to me ‘there’s one or two needles in the hall, I’ll try and get them back for you, because I don’t like people injecting it basically causes HIV’, but when they tell you that ‘there’s one or two needles in the hall, there’s normally five or six needles in the hall, and they’re giving you two to get you off their off their trail basically and there’s still three or four left. Um, so you’ve got to be very wary when they tell you that… [residential staff].

Participants were asked to what extent they believed staff to be aware of injecting in the halls. Interestingly, in contrast to reports of staff awareness of drug use in general (which was often considered to be well-developed), injecting was felt to go largely undetected. Concealing injecting from staff was felt to be relatively easy both by those who had injected in prison and those who had observed others do so. Participants agreed that identifying injectors was difficult as the visible signs of intoxication were the same regardless of the method of use employed by the individual. Thus, the only way to distinguish between those who injected heroin and those who snorted or smoked the drug was to physically examine the individual for needle marks. Accounts typically suggested that such examinations occurred very infrequently, or that they were somewhat superficial and thus unlikely to reveal signs of use, particularly as those who chose to inject, frequently chose to do so in locations on the body that were unlikely to be thoroughly examined.

[Do you think it’s difficult to conceal injecting in here?] No, not really because the biggest majority of guys that jag know how to get into their groin, you know what I mean? Take off your T shirt, know, give them [staff] it, they’ll search it and then they’ll give you it and you put it back on and then you pull down your boxer shorts, and just shake them see, to your knees and pull them back on. So you’re like that, you know what I mean, you’re bent over like that pull them down and shake them, put them back up so they’re not getting to see everything, you know what mean. Unless a nurse comes in and tells you to strip and looks at you and
Three of the four individuals who reported having injected in prison were known drug users but had not been identified as injectors by prison staff. One participant claimed they had kept two needles for over three months by concealing them in the toilet area and “wearing baggy jumpers”. This prisoner described how lack of thorough physical examinations - despite the fact that he had been admitted to prison with needle marks - allowed this participant to continue using injecting equipment until the needles became blunt and were disposed of.

**Sharing of injecting equipment**

In three locations, participants reported sharing of equipment as a more significant problem than was apparent in accounts from other prisons.

*Aye some times there’s like ten, eleven, twelve going about the one hall, there’s 85 bodies; sometimes there’ll be one set, sometimes there’ll be none. But they do get so blunt that, you not get a hit off anything, know what I mean, there’s no way to sharpen them or anything so just get binned eh? [male prisoner].*

Accounts indicated that an anti-injecting culture was less prominent in these establishments. Instead injecting appeared to be accepted to a certain degree, even if not approved of. At an individual level, prisoners in these locations still expressed a desire to distance themselves from injecting and injectors.

*[I mean what’s your opinion of injectors?] I don’t mind them as long as they stay away from me. [Alright, so as long you don’t see it?] As long, oh no, it’s not that, I wouldnae associate with them. I do mind it, but... as long as they stay away from me when they’re doing it or whatever [male prisoner].*

One officer described confiscating equipment as likely to drive a determined injector to share a needle with someone unfamiliar:

*S3: I think they have to admit at some point that there is a strong problem within prisons and, you know we’re compounding the problem by taking away the like, for instance syringes, because then they’re really sharing with people they don’t know backgrounds with, because they’re forced to...Um, so we’re actually encouraging the spread of some of the things that we’re trying to... to reduce [addictions staff].*

Indeed, one residential staff suggested that the level of coveryness involved in secreting injecting equipment was tied in with a sharing ‘group culture’:
S1: It’s difficult to find them as well because, I’ve known in the past I mean if there’s a syringe in the hall, you’ll find someone’s holding the plunger, someone’s holding the casing, someone’s holding the needle...
S4: It’s all separated up.
S1: Separated up, it’s rare if you find a set of works you’ll find it in tact.
S4: Bits and pieces and that’s what they mean, but the actual barrel is kept up their backside, so they’re never going to find that anyway, [yeah] needle in haystack obviously, and they’ll just get together when they want and put it all together and bingo use it.
[residential staff].

A few residential officers attested to the poor state of such injecting equipment as was recovered, as evidence of extensive sharing, and the lack of concern of some who injected:

S1: Yeah. I mean, the last needle I got was off guys that were cousins, that were sharing it with a stranger... the needle was all bent and everything... [residential staff].

One prisoner group, despite having described injecting as prevalent, thought that very few needles were involved, and that it was likely that individuals infected with blood-borne viruses were involved in their use:

P4: There’s only two or three sets of works in the hall, some of these people I know, frae like [jail] or [jail] like are full of HIV, they’re using that needle... And then leaving it, in this jail, every junkie in this jail that’s using needles has got to end up being HIV... [male prisoner group].

At two prisoner groups, injecting was described as taking place among a group sharing equipment:

P6: And he is because there’s normally like 8 people in one peter, sitting having a chase or a hit...
P2: Aye there’s 8 people trying to get into one spoon.
[Male prisoner group].

A view also expressed by this prisoner:

I know five guys who share the same needles, set of works in the hall, umpteen times. And I’ve been told, they’ve been round the block that many times, the needle’s blunt [male prisoner].

This group observed that while some effort may be made to reduce the risks associated with sharing equipment, there are still dangers involved:

P5: Any one that is, any one that is using needles or that, they just share them with their mates, know what I mean? [unclear]
Participants observed that sharing involved the cooperation of several prisoners, commonly referred to as a ‘camp.’ For example, one interviewee described how the scarcity of needles and supply led to increased numbers of individuals sharing equipment.

You’ve got one guy with a needle, right, you’ve got another guy with the drugs, you’ve maybe got the guy in between that kens who’s got the needle, right. So the boy with the drugs he dinnae ken who’s got the needle, right, then you’ve got three people, right. So the guy with the drugs he’s got to feed two just to get a shot of the needle. And in between getting to that two, right, he’s maybe gonnae pick up a couple of stragglers that find out he’s got drugs, right, [laughs] so he ends up with six people, right. This is what happens. You end up with six people in a cell, one needle [male prisoner].

This participant described his own involvement in sharing injecting equipment during his current sentence:

[Is there loads of sharing going on here?] Well, when I first came in, right, I got a bit of heroin off somebody, right, but I didn’t use a needle. I was in the cell, right, and there was about ten people in the cell, all sharing this one set, waiting. Right, I’ve used it now, next... Ten people...[male prisoner].

Gaining Access to Injecting Equipment

According to prisoners, injecting equipment could be accessed through a number of routes. Clean equipment was smuggled in from the outside by the individual himself, thrown over the wall or brought in at visits. Alternatively prisoners could trade for what was professed to be sterile equipment, which had been brought in by others (most often remand or remission prisoners) or stolen from the health centre. The final option (which also carried the highest risk) was to trade for previously used needles that were to be discarded by the current owner or to become one of a ‘camp’ of individuals who shared equipment.

Participants agreed that when clean injecting equipment entered the prison it was most likely that remand prisoners were responsible. These individuals were claimed to hide injecting equipment during the process of arrest and imprisonment.

Most of them will have, when they’re out screwing to get their money for their drugs, most of them will have a set all wrapped up, parcelled up and maybe cut down into wee ones and planked in their trousers so that if they do get caught they
can get through the police station with it and through, through here and through that and into here with it [male prisoner].

This was felt to be facilitated by what were considered to be inadequate search procedures upon entry into prison.

[How do prisoners manage to get needles in though? Do they not get searched?] Rub down, just a wee rub down, that’s all the kind of search. Do you know what I mean? Even there’s guys come in with mobile phones and all the rest of it. I’ve seen them kicking about the Hall [male prisoner].

A similar view with regard to prisoners at admission was expressed by this member of staff:

S4: All the guys that are coming in doing fines, best to call them mules, they’ll come… they’ll have the needles up their backside but all well wrapped up obviously, and the only person that can do an internal is a police surgeon, so once they’re past that, there’s nothing we can do...[residential staff].

Generally however, options were limited with regards to gaining access to clean injecting equipment, with sharing being much more common among injectors. In one prison a participant described how equipment could be obtained from the Health Centre. Trading for needles smuggled in by other prisoners was another option, although most participants were deeply suspicious of assurances that needles were sterile and unused and, with possible health risks in mind, rejected offers of injecting equipment on this basis.

It just depends on whether the needles are available eh? We’ve, a lot of guys like myself, wouldnae use one unless they see, they come with see the seal properly if somebody says to you ‘these are brand new’ and they’re not in the packet... ‘They’ve never been used’ I wouldnae take their word for it [male prisoner].

Health Risks and Harm Reduction

There was some evidence that those who had shared equipment had made at least some attempt to sterilise their needles. Sterilisation tablets were used when available. Participants reported gaining access to sterilisation tablets through legitimate means but where this was not possible tablets were either stolen or accessed through passmen. If sterilisation tablets were not available, prisoners relied upon hot and cold water rinses for the purposes of harm reduction. In general those who had injected in jail were aware that available methods of sterilisation were inadequate and were no guarantee of safety. Although this participant seemed unsure about some aspects of sterilising injecting equipment:

We get sterilising tablets and... you always put them in boiling water eh? Put them in a kettle and just leave it, put the lid up so it just keeps boiling and boiling and boiling. That’s the closest you’re going to get to sterilising. People try to
take precautions. Obviously they rinse them out and maybe draw up sterilising fluid and leave it lying in there for ten minutes before they use them eh? But it’s no guarantee, cause I got sterilising tablets and that, but they’re no guarantee to sterilise stainless steel, and that’s what the needle’s made out of. To sterilise the plastic bit, the only way you can do that is by burning it with a lighter but you cannnae really do that, will just melt all the plastic, it can’t be done [male prisoner].

This participant had shared equipment in prison and had since been diagnosed with Hepatitis C. He described why he felt that attempts to sterilise injecting equipment were ineffective in reducing the risk of Hepatitis C but more reliable in eliminating the HIV virus.

*Hepatitis C is a really hardy virus. You can heat it up to two hundred degrees or you could freeze it to minus a hundred degrees but it goes back to normal, cut yourself, stick it on it and you catch it. If you wash you’re sterilising equipment just a tiniest bit little bit you can catch it. It’s a really hardy virus. It’s no like HIV. HIV only lasts a matter of seconds outside the blood as soon as it reaches a certain temperature it dies. It’s a lot harder than that but it’s no so deadly as that. [So even if you have sterilised them, what…?] It might have helped, but it might not have helped [male prisoner].*

*Psychological and Social Risk Factors for Injecting*

Participants were asked what they believed motivated individuals to inject in prison. Respondents indicated that the likelihood of injecting inside jail was influenced by a number of risk factors that included: previous injecting; availability of supply and equipment and ‘having nothing to lose’. It was suggested by some prisoners that the state of mind induced by withdrawal also increased the risk of injecting through decreasing consideration of the long-term consequences. One ex-injector noted that the tendency to think primarily in terms of the present moment was a key factor in decisions to share needles with others.

*These people are so desperate for their hit. Half the time, right, they’re coming off that DRP and they’re getting strung out and somebody says to them you want a charge they’ll take it, ken. They dinnae care, ken what I mean, they just want to feel better that day. They dinnae worry what’s gonna happen a few years down the line, ken. That’s the thinking of a drug, drug user, ken. These people, right. They’re no thinking about the pros and cons of any situation, right, they just want a hit, that’s the bottom line. These people are addicts and they just want a fucking hit, ken, they just want to do anything to beat the time. They want to be wasted, ken. If that means using somebody else’s needle fucking right they’ll do it. They cannnae help themselves. That’s what you’re dealing with [male prisoner].*
History of Injecting

All those participants who reported injecting whilst in prison had injected previously in the community. For these individuals, injecting most often occurred as a means of maintaining a previously established habit.

_I don’t know what it is for other people but I inject in here coz I did on the outside_ [male prisoner].

_[what were you reasons for injecting, rather than smoking or...?] Cause when I was smoking it, it was getting to the point where I needed mair smack to get the hit that I needed, and I started injecting it cause it just went straight to my brain, and once I started that that was it, know what I mean there was no going back after that. And once you get that once you get that, once you get that hit that’s the only way you want to do it, know what I mean...[male prisoner]._

Ex-prison injectors explained how they felt this was linked to a high level of tolerance for heroin.

_Because if you’ve a heavy habit, and you’ve got maybe five quid’s worth of gear, um, if you use a needle you’re guaranteed to get stoned, whereas if you burnt it, it might just pull all together eh, but you need, depending on your habit and your tolerance you need to smoke, like five times the amount as you would...mainlining it. It’ll probably mean a better rush, that’s why people have done it with the needle. I’ve been using needles for years_ [male prisoner].

The efficiency of injecting as a method of use meant that it was also viewed as more cost effective by those who needed to maintain a habit that would otherwise be unaffordable inside prison.

_Smoking it, right, you’ll maybe just get a little buzz, ken, but if you inject it ken then you’re phewww bingoed! So then, of course if they tried smoking it and they’re not getting their hands on enough of it, which they probably arenae, then they try injecting it like whoa what a difference, ken. So then they’re injecting it. Why? Because it works better than smoking it. You understand what I mean?_ [male prisoner].

This was a view also expressed by an addictions co-ordinator:

_People that smoke heroin – obviously it’s more expensive if you smoke heroin. You don’t get such a strong hit as you do if you inject it_ [addictions co-ordinator].

This addictions co-ordinator also focused on the practical aspects of a prisoner being more likely to smoke than inject heroin. Specifically, it being seen as easier to conceal a sheet of foil than a set of injecting equipment:
It’s difficult to hide needles in a prison but if you’re smoking the likes of heroin, all you need to do is get rid of the foil and all of them hide the foil inside books because it’s lot easier to control it, whereas if you’re injecting it you need somewhere to hide the paraphernalia. So most people will smoke it even though it’s more expensive [addictions co-ordinator].

Having ‘Nothing to Lose’

Having ‘nothing to lose’ was a recurring theme throughout accounts from current and previous injectors. This was described in relation to a lowered concern over consequences either through loss of family support, positive diagnosis of viral infection, or depression with regard to a long sentence. One female prisoner reflected on the situation of her close friend who was facing a long sentence which she found overwhelming in the light of losing contact with her children.

My pal’s only eighteen year old, she’s doing a lifer and she’s started doing it, and I know for a fact she’s gonna, she’ll be HIV positive soon, and I’ve spoken to her about it, and she just starts greeting and all sorts, but she still does it. She just feels as if she’s lost her life, that’s what she says to me, she just says: ‘Well I’ve lost my life anyway.’ But I say, ‘But you’ve no, still got your wee [child] that keep well to... Maybe no in the first year, but things will soon...’ [unclear] and I’ve explained that to her, but [makes blowing noise] she’s just feels that she’s lost her life, being 10 year [minimum length of sentence] [female prisoner].

Prisoners also discussed a positive diagnosis of blood borne virus as a risk factor for injecting. One female prisoner commented on how a positive diagnosis of Hepatitis C acted as a risk factor for some women commenting that this induced the belief “that they’re done anyway”:

[I: So what some of the lasses are sharing, I mean... do they know about the sorts of health issues?] I think... oh aye, they know, they’re well aware what you can catch through injecting, but I think that problem is they’re mates do it, all of them have got Hep C and that so they think they’re done anyway, [right] cause all of them have Hepatitis C because there’s meant to be about 70 or 80% junkies have got Hep C... I think what a lot of them are gonna say ‘I’ve got Hep C anyway so it doesnae matter does it?, I cannae catch anything’ but they still get HIV and all that [female prisoner].

Deterrents

Individuals who had previously injected in the community but not in prison and those who had never injected were asked what deterred them from doing so. Deterrents were identified as the perceived health risks of injecting; having ‘something to lose;’ and (for female prisoners only) concern with body image.
I mean it’s their body they’re leaving marks on. If they want to look like, I cannae say horrible, but if they want to get all they marks on their body by injecting then that’s up to them...[female prisoner].

Having ‘Something to Lose’

A factor which appeared to differentiate most readily between those who had previously injected in the community but resisted injecting in jail and those who continued to inject was ‘having something to lose.’ These individuals saw themselves as being granted a second chance – were hopeful of the future.

Just as a positive diagnosis appeared to act as a risk factor for injecting, negative test results which provided reassurance of health appeared to act as a protective factor discouraging further injecting.

I’ve been tested right and I’m clean there, so I just don’t see the point of me risking it now, not in the jail. [right] For the sake of getting mad with it for a few hour, no way [female prisoner].

Valued family ties had a similarly protective function.

[What’s the differences then between then between folk like yourself people who are willing to inject in prison?] I’ve got family and I... got daughters and that, got a lot to lose eh? Some of these guys that’s coming into jail, for maybe nine months of every year now, they just don’t give a fuck, they’ve not much to lose really eh? Life is it’s to going out stealing to feed their habit, coming in doing their time, and in time they’ll try their best to maintain that habit [male prisoner].

Harm reduction interventions

A number of participants raised the issue of a needle exchange system as a means of reducing the health risks of injecting whilst in prison. Though these individuals believed that this could be a realistic solution to sharing in prison, concerns were also expressed that the introduction of such a system would only lead to more widespread injecting due to an increased availability of needles within the prison

If it comes right down to it, you should be giving them clean needles right? Is it no better, if they’re gonna do it anyway? I think they should get clean needles. Even if they sit in the jail and it’s not supposed to happen, they [prison staff] know it does. [Why don’t they do that then?] Because then there’d be a lot more folk injecting. Because there’d be clean needles [laughs] You know what I mean? You canny win! [male prisoner].

This participant went as far as to suggest that needle exchange could even encourage injecting in prison.
Maybe brand new tools and that but, they'll not do that, because that will be seen to be encouraging it, know what I mean? [Do you think it would encourage it or...?] Aye, suppose it would in a way, aye. When people want a jag and there’s tools in the hall, they want to get it, know what I mean? [male prisoner].

There was also some suggestion that the introduction of clean needles would lead to a decrease in safety in other ways as prisoners were provided with equipment which could be used as weapons.

What I’m saying is they could supply us with works if you really wanted them but, but their hands are tied behind their back. [Do you think that would be a good idea though, if they did?] Nah you would get guys like that say, use them as a weapon, ‘I’ve got HIV, this is full of blood, now come near me and I’m going to stick it in you.’ No officer in their right minds would approach him, or any other con for that matter. So for that reason alone, they won’t introduce clean works [male prisoner].

One addictions co-ordinator who spoke about injecting recognised that some harm reduction measures were seen as unacceptable, or even as facilitating individuals’ drug use:

We have tried to promote that as much as we can, a needle exchange and it’s totally a taboo subject because for us to do that is an admission [by the Prison Service] that there’s open injecting going on... [addictions co-ordinator].

This member of addictions staff highlighted what could be described as the ‘grey area’ between ‘acceptable’ and ‘unacceptable’ harm reduction interventions in prisons:

[A prisoner] might have a set of works... and we’d be in there amongst them giving them the safe injection guide, giving them steroids and tablets, giving them swabs, taking it as far as we can go. I shouldn’t being even giving them the swabs... [addictions staff].

However, on the grounds that restricting or removing harm reduction measures increased the pressure on injectors to share equipment, such harm reduction measures were endorsed in the interviews including in this case, making sterilisation tablets available:

[For those who do inject are there any, like, maybe harm reduction tools, like sterilisation equipment or anything?] Yes. The Prison Service introduced a few years ago sterilising tablets. It was introduced under the guise that these sterilising tablets were used for cleaning the utensils but, yeah, the truth of the matter is that they were also being used to clean the drug-taking equipment [addictions co-ordinator].

54
Summary – Drug Use

- Prisoners reported a wide variety of drugs as being available within the prison setting.
- Most prisoners suggested that heroin had increased in prevalence in recent years, whilst the availability of cannabis had decreased, linking this to the introduction of drug testing, improvements in detection and higher numbers of heroin users being convicted. Staff also perceived a rise in heroin use, but some attributed this to its decreasing cost.
- Heroin appeared to be less reliably available among young offenders. However, some adult prisoners believed experimentation with heroin was more likely as young offenders entered the adult system, where heroin use was viewed as more acceptable; and addictions staff noted that individual young offenders could still arrive with serious heroin habits.
- Cocaine and crack cocaine appeared to be less available than cannabis and heroin. Some accounts suggested that this was due to low demand, due to the belief that their pharmacological effects were more easily detected by staff.
- Residential staff and prisoners saw visits as the main route for bringing drugs in, though perhaps only for quantities for personal use. Staff also felt that prisoners could be coerced by others into bringing drugs in through visits.
- The prevalence of drugs in a hall was seen to depend on the majority attitude toward drug use. Prisoners reported cooperative cartels forming to ensure a steady supply of drugs in halls where large numbers held positive views towards drug use. This clustering was felt to be made more likely through downgrading policies.
- Locating and acquiring drugs from other prisoners was described as a perpetual activity that filled prisoners’ days; dealing in drugs can also lend an individual significant cachet.
- Prisoners felt staff members were highly aware of drug use and dealing within the prisoner population due to obvious side effects and signs; staff also felt they would be aware of drug use taking place. Though prisoners thought most staff would be likely to act on this knowledge, they also felt that staff efforts were likely to end in failure. The resignation expressed by some residential staff groups supports this claim.
- Prisoners often believed that if they kept their drug use hidden, they would avoid punishment. They claimed to have observed staff fail to act on their knowledge of drug use, and some reported direct confirmation from some of the officers themselves.
- In one prison it was felt that staff members were unlikely to act even when use was more obvious. As a result, prisoners’ reduced fear of detection or punishment appeared to increase the perceived visibility of drug use in this environment.
- Most prisoner participants did not, however, feel that staff willingly tolerated drug use. Many felt that understaffing in prisons had caused officers to fear being outnumbered in a disturbance, placing officers in an impossible position where some degree of toleration was necessary to keep the peace.
- Residential staff did not suggest that they would tolerate drug use, but several felt that they were limited in what they could do to tackle it.
• In general, prisoners felt staff would be more likely to attempt to prevent dealing in drugs than their use, again viewing them as unlikely to be successful in this.
• Residential staff and prisoners equated the drugs scene with the prevalence of conflict, and thought that some pressure was passed on to family members outside.
• Both populations viewed drugs as an ever-present facet of prison life; staff saw this as a reflection of drug use in the community. Prisoners tended to see reducing the drug problem in Scottish prisons as an impossible task, citing understaffing and their peers’ determination to foil detection, and viewed the drug supply into jail as unstoppable.

Summary – Injecting and Sharing

• A variation in prevalence of injecting between individual establishments was reported; descriptions ranged from “rife” to “never heard of”. Smoking heroin was described as considerably more prevalent than injecting the drug.
• Injecting in prisons was closely associated with sharing of injecting equipment, and the major reduction in injecting was linked to a higher awareness of the risk of infection through sharing of injecting equipment. There was some indication that awareness had been at least reinforced by prison drug programmes.
• There was evidence in most establishments of a negative attitude from staff and the majority of prisoners towards injecting, which in some reports could be described as an ‘anti-injecting culture’. Both prisoners and staff reported a surprisingly high level of collaboration between prisoners and staff in attempting find and destroy injecting equipment.
• Antagonism towards injecting was not, however, linked by prisoners to an ‘anti-drug culture’. Indeed, some prisoners were concerned that attempts by staff to find and confiscate injecting equipment could disrupt supply and dealing of drugs within prison.
• It was reported that there was some degree of difficulty in smuggling injecting equipment into prison; by contrast, there was a consensus that there was low staff awareness of the processes of injecting in prison. Injecting was typically described as highly covert, and mainly taking place within small groups – or ‘camps’ – of prisoners.
• There was a high level of awareness among staff and prisoners of risk reduction measures in relation to injecting and sharing of equipment, including recognition of the limitations of existing measures.
• A number of psychological and social risk factors for injecting in prison were identified including: previous injecting, availability of supply and ‘having nothing to lose’.
Chapter 4 - Issues Regarding the Management of Drug Use in Scottish Prisons: A Survey of Addictions Teams

In addition to the qualitative data and database information collected from establishments, a questionnaire survey was carried out to examine the attitudes and experiences addictions teams held towards drug issues in prison. This included general attitudes towards drug users in prison, perceived effectiveness of referral route, perceived effectiveness of intervention, continuity of care, health and assessment. At the end of the questionnaire, addictions teams were also given the opportunity to add any optional comments. These were content analysed in terms of emergent themes, which generally related to suggestions for improvements within addictions services.

Data Analysis

There were only a few missing values, however where there are missing values, the percentage was calculated out of the total number of responses. No gender-specific analyses were carried out due to the low ratio of female to male respondents. No response rate was calculated as addictions teams varied greatly in size and interpretation of who was member of an addictions team. The number of completed questionnaires returned varied greatly at establishment level (table 4.1), therefore no comparisons were carried out between individual prisons.

Table 4.1 Number of questionnaire responses per establishment

<table>
<thead>
<tr>
<th>Establishment ID</th>
<th>Number of completed questionnaires returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison A</td>
<td>7</td>
</tr>
<tr>
<td>Prison B</td>
<td>7</td>
</tr>
<tr>
<td>Prison C</td>
<td>10</td>
</tr>
<tr>
<td>Prison D</td>
<td>9</td>
</tr>
<tr>
<td>Prison F</td>
<td>3</td>
</tr>
<tr>
<td>Prison G</td>
<td>2</td>
</tr>
<tr>
<td>Prison H</td>
<td>5</td>
</tr>
<tr>
<td>Prison I</td>
<td>3</td>
</tr>
<tr>
<td>Prison K</td>
<td>5</td>
</tr>
<tr>
<td>Prison L</td>
<td>4</td>
</tr>
<tr>
<td>Prison M</td>
<td>1</td>
</tr>
<tr>
<td>Prison N</td>
<td>4</td>
</tr>
</tbody>
</table>

Sample Characteristics

A total of 60 members of addictions teams in 12 out of 14 (86%) establishments completed the questionnaire. Of these, 41 (68%) respondents were male, approximately twice the number of participating females. For the entire sample, ages ranged from 21 to 57 years with a mean age of 40 years (sd = 7.47). Respondents had been working for the SPS on average for 11 years (sd = 8.15) ranging from few weeks up to 34 years. Of
these, on average almost 4 years (sd = 3.30) had been spent working within the addictions team (ranging from a few weeks up to 16 years). All respondents indicated that they had received addictions training. However, 58 (97%) felt that they would benefit from further training.

While the majority of the sample were identified as core addiction staff (e.g. addictions co-ordinator or addictions officer), 6 (10%) respondents came from a variety of additional staff sources e.g. drug caseworker, team manager, social worker, health care manager, community addictions nurse, addictions team administrative manager who work in partnership with the SPS (termed ‘additional staff’ in table 4.2). Three questionnaires were not included in this analysis as the respondents stated that they were not addictions staff.

### Table 4.2 Respondents’ role within addictions teams

<table>
<thead>
<tr>
<th>Job title</th>
<th>Frequency (% in relation to total sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions co-ordinator</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Addictions officer</td>
<td>16 (27%)</td>
</tr>
<tr>
<td>Addictions caseworker</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Addictions nurse</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Cranstoun staff</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>MDT officer</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Programme officer</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Additional staff</td>
<td>6 (10%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

**Addictions Staff’s Opinion of SPS Drug Policy and Services**

In general, addictions staff seemed to approve of the current policy, strategy and services provided for drug users in prison. For instance, most respondents (N = 55, 91%) felt that they knew what their role and responsibilities were within the drug strategy, that the overall mission and values set out by SPS were clear (N = 43, 73%), and that recent changes to previous SPS drug policies were welcomed (N = 42, 71%). In line with that, the majority (N = 40, 65%) indicated that the punitive side of drug policies was not a necessity for rehabilitation to be effective. While most participants (N = 31, 60%) believed that the drug strategy was needs-led, likewise most respondents (N = 44, 73%) indicated that the drug strategy was driven by targets set by SPS or the establishment itself. There was an almost equal number of staff who reported they were satisfied (N = 24, 41%), or dissatisfied (N = 26, 44%), with how drug misuse issues had been dealt with in Scottish establishments. Also, similar numbers of addictions staff seemed to believe that their views were considered (N = 18, 30%), or not considered (N = 20, 33%), by the SPS. In reference to communication, less than half of those surveyed felt that the
dissemination of information between SPS HQ and individual establishment’s addictions teams was effective. However, a considerable number of respondents (between one third to two fifths of the sample) opted to give no opinion on the latter two statements (table 4.3).

**Table 4.3 Addictions staff’s attitudes and opinions in relation to SPS drug policy, strategy and services**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Number (valid %) strongly agreeing</th>
<th>Number (valid %) agreeing or strongly agreeing</th>
<th>Number (valid %) Indicating that they did not know</th>
<th>Number (valid %) disagreeing</th>
<th>Number (valid %) strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug strategy is led by prisoners’ needs.</td>
<td>9 (16%)</td>
<td>25 (44%)</td>
<td>6 (10%)</td>
<td>14 (25%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Drug strategy is driven by targets.</td>
<td>14 (23%)</td>
<td>30 (50%)</td>
<td>4 (7%)</td>
<td>12 (20%)</td>
<td>0</td>
</tr>
<tr>
<td>Overall mission and values within individual establishment is clear.</td>
<td>7 (12%)</td>
<td>36 (61%)</td>
<td>5 (8%)</td>
<td>7 (12%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Clear understanding of role and responsibilities within drug strategy.</td>
<td>12 (20%)</td>
<td>43 (71%)</td>
<td>4 (7%)</td>
<td>1 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Dissemination of information on drug strategy from SPS HQ is effective.</td>
<td>1 (2%)</td>
<td>24 (42%)</td>
<td>18 (31%)</td>
<td>13 (22%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Changes to SPS’s previous drug policies are welcomed.</td>
<td>6 (10%)</td>
<td>36 (61%)</td>
<td>14 (24%)</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Rehabilitation would be more effective if drug policies were more punitive.</td>
<td>3 (5%)</td>
<td>8 (14%)</td>
<td>9 (15%)</td>
<td>31 (53%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>The views of addictions teams are taken into account by SPS.</td>
<td>1 (2%)</td>
<td>17 (28%)</td>
<td>22 (37%)</td>
<td>14 (23%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Satisfied as to how SPS has dealt with drug misuse issues in establishments.</td>
<td>3 (5%)</td>
<td>21 (36%)</td>
<td>9 (15%)</td>
<td>21 (36%)</td>
<td>5 (8%)</td>
</tr>
</tbody>
</table>
General Attitudes Towards Drugs in Prison

Addictions staff were also asked about their attitudes and opinions on more general drug-related areas (table 4.4). Almost all respondents (N = 58, 97%) believed that reduction of risk factors associated with drug use was as important as drug use prevention. Addictions staff (N = 39, 65%) also indicated that visit regulations need to be stricter in order to make a difference to drug use and related problems in prisons. There were similar numbers of respondents stating that injecting was (N = 25, 42%), or was not (N = 24, 40%), a major problem in establishments. Slightly more members of addictions teams (N = 31, 52%), however, perceived sharing injecting equipment as a major problem while almost one fifth of the sample (N = 11, 18%) took a neutral stance. These findings may be due to the fact that injecting prevalence and rates are inconsistent across establishments, which would result in a wide range of attitudes and experiences reported by staff. For instance, those who strongly agreed with the statement that injecting was a major problem also indicated that sharing injecting equipment was a major problem in establishments. Addictions staffs’ beliefs about injecting and sharing are not presented at establishment level here as the number of respondents varies greatly, and in many cases is too small to be considered representative.

Table 4.4 Addictions staff’s attitudes towards general drug use in prison

<table>
<thead>
<tr>
<th>Perceived effectiveness of addictions assessment</th>
</tr>
</thead>
</table>

When taking a closer look at the CAART as an addictions assessment tool, the majority of addictions staff (N = 42, 70%) felt that the CAART was effective, and was an important part of drug users’ treatment (N = 39, 67%). Yet, most respondents (N = 44,
74%) also were of the opinion that addictions assessments, specifically the CAART could be better (table 4.5).

**Table 4.5 Addictions staff’s beliefs about the CAART as an addictions assessment tool**

<table>
<thead>
<tr>
<th></th>
<th>Number (valid %) strongly agreeing</th>
<th>Number (valid %) agreeing</th>
<th>Number (valid %) who indicated that they did not know</th>
<th>Number (valid %) disagreeing</th>
<th>Number (valid %) strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CAART is an effective assessment tool.</td>
<td>6 (10%)</td>
<td>36 (60%)</td>
<td>10 (17%)</td>
<td>7 (12%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>The CAART is an integral part of drug users’ treatment.</td>
<td>8 (14%)</td>
<td>31 (53%)</td>
<td>13 (22%)</td>
<td>6 (10%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Addictions assessments such as the CAART could be better.</td>
<td>12 (20%)</td>
<td>32 (54%)</td>
<td>12 (20%)</td>
<td>3 (5%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Addictions staff were also asked about their opinion on other more general assessments such as the STONA (Short Term Offenders Needs Assessment), or the core screening tool (table 4.6). Overall, the majority of addictions staff (N = 57, 95%) felt that drug assessments were an essential and integral part of prisoners’ sentence management, and also very helpful for prison staff to work with drug using prisoners (N = 54, 91%). The majority of participants (N = 54, 91%) seemed to believe that prisoners’ individual needs had to be taken into account for an assessment to actually be effective. At the same time though, one third of all respondents (N = 17) perceived drug assessments as ineffective in identifying drug users at admission. Albeit a minority, this is still a significant attitude implying that there is scope for improvement in prison addictions assessments.

**Table 4.6 Addictions staff’s beliefs about addictions assessments**

<table>
<thead>
<tr>
<th></th>
<th>Number ( valid %) strongly agreeing</th>
<th>Number (valid %) agreeing</th>
<th>Number (valid %) indicating that they did not know</th>
<th>Number (valid %) disagreeing</th>
<th>Number (valid %) strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care plans based on assessment make it easier for prison staff to work with drug using prisoners.</td>
<td>15 (25%)</td>
<td>39 (66%)</td>
<td>4 (7%)</td>
<td>1 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Drug assessments are</td>
<td>20 (33%)</td>
<td>37 (62%)</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>0</td>
</tr>
</tbody>
</table>
important to efficient sentence management.

Drug assessments do not effectively identify drug users at admission.

Addictions assessments need to be specific to individual needs in order to be effective.

**Perceived effectiveness of referral route**

Overall, respondents valued all referral routes except for positive MDT results as effective. Respondents seemed to view addictions assessments as predominantly effective, as well as self referral, and referrals through addictions and medical staff (table 4.7).

Although the findings seem clear cut, there was a relatively high number of addictions staff choosing the “I don’t know” option in the questionnaire survey. With the exception of MDT results, there were consistently more staff indicating that they did not know rather than indicating that a referral route was perceived to be ineffective.

**Table 4.7 Perceived effectiveness of referral route by members of addiction teams**

<table>
<thead>
<tr>
<th>Referral Route</th>
<th>Very Effective (valid %)</th>
<th>Effective (valid %)</th>
<th>Not Very Effective (valid %)</th>
<th>Not Effective at All (valid %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical referrals</td>
<td>6 (10%)</td>
<td>36 (61%)</td>
<td>11 (19%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>External agencies</td>
<td>2 (3%)</td>
<td>29 (49%)</td>
<td>15 (25%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Addictions staff</td>
<td>7 (13%)</td>
<td>39 (72%)</td>
<td>7 (13%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Addictions assessment</td>
<td>11 (19%)</td>
<td>41 (70%)</td>
<td>4 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Positive MDT result</td>
<td>9 (15%)</td>
<td>19 (32%)</td>
<td>9 (15%)</td>
<td>21 (35%)</td>
</tr>
<tr>
<td>Self referral</td>
<td>14 (24%)</td>
<td>32 (55%)</td>
<td>8 (14%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Personal Officer</td>
<td>5 (9%)</td>
<td>34 (61%)</td>
<td>12 (21%)</td>
<td>5 (9%)</td>
</tr>
</tbody>
</table>
Perceived effectiveness of treatment programmes

Across all approved, accredited and medical interventions, it was found that interventions were generally perceived to be more effective than ineffective in reducing prisoners’ drug using behaviour (table 4.8). The only exceptions to this were the activities Drug action for change, 21 hour drug awareness, and SMART, where numbers of staff believing the intervention to be effective and numbers believing the intervention to be not effective were similar. The largest number of addictions staff (N = 29, 69%) believed methadone to be effective in reducing drug seeking behaviour. These results are based on responses given by staff members who reported they had experience in running the interventions listed. Nevertheless, there are consistently high numbers of respondents choosing the “I don’t know” option (between one fifth and approximately one third of the sample). For instance, almost two thirds of the sample indicated that they had no opinion regarding the effectiveness of the activity SMART recovery.

Table 4.8 Perceived effectiveness of intervention programme by members of addiction teams

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number indicating they had experience in running intervention</th>
<th>Number (valid %) indicating intervention to be very effective</th>
<th>Number (valid %) indicating intervention to be effective</th>
<th>Number (valid %) indicating that they did not know</th>
<th>Number (valid %) indicating intervention not to be very effective</th>
<th>Number (valid %) indicating intervention not to be effective at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRPP (accredited)</td>
<td>22</td>
<td>3 (14%)</td>
<td>10 (45%)</td>
<td>6 (27%)</td>
<td>3 (14%)</td>
<td>0</td>
</tr>
<tr>
<td>Lifeline (accredited)</td>
<td>26</td>
<td>4 (15%)</td>
<td>11 (42%)</td>
<td>9 (35%)</td>
<td>2 (8%)</td>
<td>0</td>
</tr>
<tr>
<td>A guide to sensible drinking (approved)</td>
<td>29</td>
<td>1 (3%)</td>
<td>16 (55%)</td>
<td>8 (28%)</td>
<td>4 (14%)</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Awareness (approved)</td>
<td>29</td>
<td>3 (10%)</td>
<td>16 (55%)</td>
<td>8 (28%)</td>
<td>2 (7%)</td>
<td>0</td>
</tr>
<tr>
<td>Drug education and awareness (approved)</td>
<td>25</td>
<td>0</td>
<td>16 (64%)</td>
<td>5 (20%)</td>
<td>4 (16%)</td>
<td>0</td>
</tr>
<tr>
<td>Drugs action for change (approved)</td>
<td>16</td>
<td>0</td>
<td>7 (44%)</td>
<td>6 (37%)</td>
<td>3 (19%)</td>
<td>0</td>
</tr>
<tr>
<td>First step (approved)</td>
<td>20</td>
<td>2 (10%)</td>
<td>8 (40%)</td>
<td>8 (40%)</td>
<td>2 (10%)</td>
<td>0</td>
</tr>
<tr>
<td>SMART recovery (approved)</td>
<td>14</td>
<td>1 (7%)</td>
<td>3 (21%)</td>
<td>9 (65%)</td>
<td>1 (7%)</td>
<td>0</td>
</tr>
<tr>
<td>21 hour drug awareness (approved)</td>
<td>25</td>
<td>1 (4%)</td>
<td>11 (44%)</td>
<td>7 (28%)</td>
<td>5 (20%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Methadone</td>
<td>42</td>
<td>7 (17%)</td>
<td>22 (52%)</td>
<td>9 (22%)</td>
<td>3 (7%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>
While intervention programmes were thought to be mostly effective, the majority of addictions staff (N = 53, 90%) also believed that there should be more treatment programmes available to make a difference to drug use in prisons (table 4.9). It also emerged that more addictions staff (N = 52, 87%) believed that these treatment programmes should be user-specific, i.e. different drug users should receive different treatment care programmes in prison. There were similar numbers of respondents agreeing (N = 26, 43%) as disagreeing (N = 20, 34%) with the statement that most drug using prisoners were not in contact with drug interventions, while almost one fifth of the sample indicated that they did not have an opinion on this.

**Table 4.9 Addictions staff’s attitudes on intervention programmes in general**

<table>
<thead>
<tr>
<th>Perception</th>
<th>Number (valid %) strongly agreeing</th>
<th>Number (valid %) agreeing</th>
<th>Number (valid %) indicating that they did not know</th>
<th>Number (valid %) disagreeing</th>
<th>Number (valid %) strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most prisoners with drug problems are not in contact with drug interventions.</td>
<td>4 (6%)</td>
<td>22 (37%)</td>
<td>14 (23%)</td>
<td>19 (32%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>There should be different treatment programmes for different types of drug users.</td>
<td>20 (34%)</td>
<td>32 (53%)</td>
<td>2 (4%)</td>
<td>5 (9%)</td>
<td>0</td>
</tr>
<tr>
<td>More treatment programmes must be made available to make a difference to drug problems in prison.</td>
<td>21 (36%)</td>
<td>32 (54%)</td>
<td>4 (7%)</td>
<td>2 (3%)</td>
<td>0</td>
</tr>
</tbody>
</table>

*Perceived effectiveness of Drug Free Areas*

Addictions staff’s beliefs about drug free areas/addictions support areas turned out to be very mixed (table 4.10). While the majority of participants (N = 47, 80%) perceived drug free areas/drug support units as a motivator for prisoners to come off drugs, almost a third of the sample (N = 18, 31%) equally believed that drug free areas/drug support units did not decrease overall drug use in prison. Having said that, almost a quarter of the sample (N = 13, 22%) opted to have no opinion in response to the latter statement. Indeed, only 4% (N = 2) of the sample indicated that they believed there were no drugs in drug free areas/drug support units.
Table 4.10 Addictions staff’s beliefs in relation to Drug Free Areas/Drug Support Units (DFA/DSU)

<table>
<thead>
<tr>
<th></th>
<th>Number (valid %) of staff strongly agreeing</th>
<th>Number (valid %) of staff agreeing</th>
<th>Number (valid %) of staff who felt they did not know</th>
<th>Number (valid %) of staff disagreeing</th>
<th>Number (valid %) of staff strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFA/DSUs motivate prisoners to come off drugs</td>
<td>11 (19%)</td>
<td>36 (61%)</td>
<td>5 (8%)</td>
<td>6 (10%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>DFA/DSUs decrease overall drug use in prison</td>
<td>4 (7%)</td>
<td>24 (41%)</td>
<td>13 (22%)</td>
<td>17 (29%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>There are no drugs in DFA/DSUs.</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
<td>5 (8%)</td>
<td>37 (63%)</td>
<td>15 (25%)</td>
</tr>
</tbody>
</table>

These mixed results may be attributed to the fact that drug free areas and drug support units by name imply very different concepts and perhaps should not have been combined in one question. One may want to argue that a drug free area ought to be completely drug free, while a drug support unit places more emphasis on supporting drug users should relapses and/or lapses occur.

Perceived Effectiveness of Mandatory Drug Testing

The majority of the sample (N = 41, 69%) believed that MDT had not caused a decrease in the overall amount of drugs used in prison. While most addictions staff (N = 28, 49%) indicated that MDT had caused a shift in prisoners’ drug use towards opiates such as heroin, about one fifth of respondents (N = 13, 22%) chose the ‘I don’t know’ option. This noted, a slight majority (N = 33, 55%) nevertheless believed that MDT still served a purpose, while 40% (N = 24) disagreed with this statement. Just over half of the sample (N = 31, 52%) did not view MDT as a possible cause that may have increased the prevalence of injecting and sharing injecting equipment amongst prisoners. However, 40% (N = 22) of respondents chose not to give a decisive opinion on this statement. It is unknown whether the latter results are due to staff’s beliefs that there is no causal link between MDT and an increase in injecting, or whether respondents were of the opinion that there actually had not been an increase in injecting in the first place.
Table 4.11 Addictions staff’s beliefs towards Mandatory Drug Testing MDT)

<table>
<thead>
<tr>
<th></th>
<th>Number (valid %) of staff strongly agreeing</th>
<th>Number (valid %) of staff agreeing</th>
<th>Number (valid %) of staff who felt they did not know</th>
<th>Number (valid %) of staff disagreeing</th>
<th>Number (valid %) of staff strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT has caused an overall decrease in the amount of drugs used.</td>
<td>1 (2%)</td>
<td>10 (17%)</td>
<td>7 (12%)</td>
<td>29 (49%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>MDT has caused prisoners to change their drug use to opiates e.g. heroin.</td>
<td>12 (21%)</td>
<td>16 (28%)</td>
<td>13 (22%)</td>
<td>17 (29%)</td>
<td>0</td>
</tr>
<tr>
<td>Due to MDT there has been an increase in injecting drugs and sharing of injecting equipment.</td>
<td>1 (2%)</td>
<td>6 (10%)</td>
<td>22 (40%)</td>
<td>27 (45%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>I feel that MDTs no longer serve any purpose.</td>
<td>5 (8%)</td>
<td>19 (32%)</td>
<td>3 (5%)</td>
<td>23 (38%)</td>
<td>10 (17%)</td>
</tr>
</tbody>
</table>

**Health**

Addictions teams were asked to indicate to what extent they agreed or disagreed with given statements covering continuity of care within a health and addictions context. The results are presented according to the following themes:-

- general health issues (table 4.12)
- health and continuity of care (table 4.13)
- health standard of delivery (table 4.14)
- health standard for improvements (table 4.15)

**General Health Issues**

Most addictions staff (N = 34, 58%) agreed that there was an integrated approach to health care provision in establishments, and the waiting times for prisoners to get medication was perceived to be acceptable (N = 35, 59%). While the majority (N = 40, 67%) believed that prisoners’ health care needs were met, most addictions staff (N = 32, 54%) were just as much of the opinion that the medical and nursing team were not adequately staffed to deal with prisoners’ health care needs. There was further disagreement about mental health care provisions in individual establishments with an
almost equal number arguing that there was and was not a sufficiently wide range of care provision for prisoners with mental health problems (table 4.12).

Table 4.12 General health issues

<table>
<thead>
<tr>
<th></th>
<th>Number (%) strongly agreeing</th>
<th>Number (valid %) agreeing</th>
<th>Number (valid %) indicating they do not know</th>
<th>Number (valid %) disagreeing</th>
<th>Number (valid %) strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners’ health care needs are met.</td>
<td>7 (12%)</td>
<td>33 (55%)</td>
<td>4 (7%)</td>
<td>15 (25%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>The medical and nursing team is adequately staffed to deal with prisoners’ health needs.</td>
<td>4 (7%)</td>
<td>17 (28%)</td>
<td>7 (12%)</td>
<td>22 (37%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>There is a co-ordinated and integrated approach to health care provision in prison.</td>
<td>3 (5%)</td>
<td>31 (53%)</td>
<td>8 (14%)</td>
<td>13 (22%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>The waiting time for prisoner to medication is acceptable.</td>
<td>6 (10%)</td>
<td>29 (49%)</td>
<td>11 (19%)</td>
<td>13 (22%)</td>
<td>0</td>
</tr>
<tr>
<td>There is a sufficiently wide range of health care provision for prisoner identified with mental health problems.</td>
<td>3 (5%)</td>
<td>20 (33%)</td>
<td>13 (22%)</td>
<td>18 (30%)</td>
<td>6 (10%)</td>
</tr>
</tbody>
</table>

Health and Continuity of Care From the Community into Prison

An almost equal number agreed and disagreed with the statement that prison health care was adequately continued from community into prison (table 4.13). However, the majority (N = 38, 80%) indicated that there should be better links between the community and in-prison health care. Most respondents believed that the communication between the health care team and the addictions team was satisfactory. Half of the respondents (N = 29) implied that drug issues were dealt with in a broad health care context. However, one third of the sample (N = 20, 33%) felt that this was not the case while 16% (N = 9) of respondents indicated that they did not know. Mental health was
found to be an issue that needed to be addressed as the majority of the sample (N = 48, 80%) were of the opinion that prisoners’ mental health problems were often not recognised by mental health services in prison as well as the addictions team.

Table 4.13 Health and continuity of care

<table>
<thead>
<tr>
<th></th>
<th>Number (valid %) strongly agreeing</th>
<th>Number (valid %) agreeing</th>
<th>Number (valid %) indicating they do not know</th>
<th>Number (valid %) disagreeing</th>
<th>Number (valid %) strongly disagreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care services in prison adequately continue prisoners' health care needs from the community.</td>
<td>5 (9%)</td>
<td>18 (31%)</td>
<td>14 (24%)</td>
<td>19 (33%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Communication between health care and addictions team is satisfactory.</td>
<td>4 (7%)</td>
<td>38 (63%)</td>
<td>4 (7%)</td>
<td>10 (17%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Drug issues in prison are addressed within a broad health care context.</td>
<td>2 (3%)</td>
<td>27 (47%)</td>
<td>9 (16%)</td>
<td>18 (31%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Prisoners’ mental health problems often go unrecognised by mental health and addictions team.</td>
<td>16 (27%)</td>
<td>32 (53%)</td>
<td>6 (10%)</td>
<td>3 (5%)</td>
<td>0</td>
</tr>
<tr>
<td>There should be better links between community and in-prison health care.</td>
<td>16 (27%)</td>
<td>32 (53%)</td>
<td>9 (15%)</td>
<td>3 (5%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Health Care Standard of Delivery

Overall, addictions staff suggested that the standard of health care delivery was good to acceptable. In detail, primary and dental care were predominantly rated as good to acceptable with responses being skewed towards the positive end of the scale. Ratings of the delivery of substance misuse, mental health and health promotion were more spread out albeit responses tended to focus on ratings of good to acceptable (table 4.14).
Table 4.14 Health – standard of delivery

<table>
<thead>
<tr>
<th></th>
<th>Number (valid %) indicating very good</th>
<th>Number (valid %) indicating good</th>
<th>Number (valid %) indicating acceptable</th>
<th>Number (valid %) indicating bad</th>
<th>Number (valid %) indicating very bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>11 (19%)</td>
<td>20 (35%)</td>
<td>21 (37%)</td>
<td>5 (9%)</td>
<td>0</td>
</tr>
<tr>
<td>Dental Care</td>
<td>7 (13%)</td>
<td>15 (27%)</td>
<td>22 (40%)</td>
<td>7 (13%)</td>
<td>0</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>5 (9%)</td>
<td>18 (31%)</td>
<td>20 (34%)</td>
<td>11 (19%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6 (10%)</td>
<td>18 (31%)</td>
<td>16 (28%)</td>
<td>10 (17%)</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>3 (5%)</td>
<td>17 (30%)</td>
<td>22 (39%)</td>
<td>14 (25%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Perceived Need for Improvements in Health Care

While addictions staff seemed to be fairly satisfied with the standard of health care delivery, respondents likewise argued that overall there was room for improvement in every single health service (table 4.15). The majority of the sample (N = 40, 73%) rated the need for improvements within substance misuse services as most important, followed by a need to better mental health care services. The need for improvement within primary care services was perceived to be neither important nor unimportant. The necessity for improvements in dental care were rated as least important while the need for meliorations in health promotion were considered to be not as important as betterments in primary care, substance misuse and mental health.

Table 4.15 Health – need for improvements

<table>
<thead>
<tr>
<th></th>
<th>Number (valid %) rating most important</th>
<th>Number (valid %) rating important</th>
<th>Number (valid %) rating neither</th>
<th>Number (valid %) rating not as important</th>
<th>Number (valid %) rating least important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>9 (18%)</td>
<td>8 (16%)</td>
<td>18 (37%)</td>
<td>7 (14%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>Dental Care</td>
<td>4 (8%)</td>
<td>3 (6%)</td>
<td>9 (18%)</td>
<td>15 (30%)</td>
<td>19 (38%)</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>28 (51%)</td>
<td>12 (22%)</td>
<td>10 (18%)</td>
<td>4 (7%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>15 (28%)</td>
<td>24 (45%)</td>
<td>8 (15%)</td>
<td>4 (7%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>4 (8%)</td>
<td>9 (18%)</td>
<td>11 (22%)</td>
<td>17 (33%)</td>
<td>10 (19%)</td>
</tr>
</tbody>
</table>

Suggestions for Improvements in Addiction Services

About one third (N = 21, 35%) of all participants chose to make a brief statement on what they believed could be improved in addictions services in prison and in the community. Data were content-analysed by identifying recurrent themes.

Lack of training: Survey respondents frequently pointed out that there was a general lack of training for addictions teams, as well as nursing and clinical staff. It was suggested that nursing staff and GPs should attend joint training sessions in substance misuse along
with health staff from the community. This was considered to improve continuity of care as it would encourage effective communication and the sharing of best practice between different drug service providers in prison and in the community.

**Better care of drug users:** It was generally felt that there should be increased efforts at providing more intense drug and alcohol programmes. It was further suggested that methadone procedures such as dispensing and monitoring could be improved. For instance, one participant felt that prisoners on methadone should receive more support once they are on their script. One respondent indicated that there should be more recognition for the work addictions teams deliver. This was linked to the idea that addictions staff should be more integrated into community services in order to continue addictions support for their clients.

**Staff shortage:** Addictions teams frequently pointed out that staff shortage, in particular amongst addictions and health staff, had a detrimental impact on the delivery of programmes. This was felt to leave vulnerable prisoners without any treatment.

**More resources:** It was frequently voiced that there should be more resources for addictions services. This would ensure effective intervention and also introduce holistic care and complementary therapies. Some respondents believed that the KPI standard and cost cutting exercise had caused a focus on quantity rather than quality. This was thought to have a detrimental impact on addictions work.

**SPS Seventh Prisoner Survey**

This section aims to describe the findings of the seventh prisoner survey involving all prisoners and all establishments in Scotland. A summary of certain items of relevance to the data obtained from the survey of addictions staff is provided in order to compare the views collected in each study. Between June and July 2004, a total of 4792 (77%) of all prisoners in Scotland completed a self-reported questionnaire that was designed to cover all core aspects of prison life. Amongst other things, prisoners were invited to give their opinion on treatment services, assessment, mandatory drug testing and drug free areas in prison.

The majority of respondents were male (N = 3789, 79%) while one in five prisoners failed to specify their gender (N = 751, 16%). Ages ranged from 14 years to 96 years with a mean age of 31.55 years (s.d. = 11.24) based on 3843 out of 4792 (80%) respondents. At the time of data collection, about one fifth of the sample (N = 764, 19%) were on remand, while 3583 prisoners indicated that their sentence length varied between 1 year to 6 years with a mean sentence length of 3.31 years (s.d. = 1.27).

**Continuity of Care - Treatment**

While most addictions staff believed that the continuation of health care between community and prison was adequate, the majority of respondents also purported that
nevertheless there was a need for better links between community and prison health care services to ensure effective continuity of care in respect to health and treatments. The prisoner survey, however, showed that only a quarter (N = 912, 23%) of prisoners who indicated previous illicit drug use in the community reported that they had received drug treatment in the community, and only about two in five of this group of prisoners (N = 1005, 38%) further stated that they had received the chance of treatment in prison. Similarly, one third of prisoners (N = 1029, 34%) who claimed to have used illegal drugs in prison four weeks prior to data collection stated they had received a chance of treatment.

Assessment

While two thirds of addictions staff thought that drug assessments were effective in identifying drug users at admission, less than half of prisoners asked (N = 2226, 46%) indicated they had been assessed for drug use at admission. Indeed, about three quarters of this group of prisoners (N = 1630, 73%) reported that they themselves had told staff voluntarily about their drug use at admission.

Mandatory Drug Testing

About a quarter of the prisoner sample (N = 834, 24%) claimed that MDT had affected their drug use in some way. However, in contrast to addictions staff’s opinion, the majority of these prisoners (N = 567, 68%) indicated that as a result of MDTs their drug use had decreased or even stopped. While less than half of the addictions staff were of the view that MDT had caused a shift in type of drug used, namely to opiates, a quarter of the prisoner sample (N = 212, 25%) reported that they had changed their type of drug due as a result of MDT being in place. However, there is no detailed information available on what other factors may have constituted this change in type of drug, and also it is unknown whether this change was largely directed towards opiates.

Drug Free Areas

The majority of all prisoners (N = 3444, 84%) perceived drug free areas as important, however, of these only 1633 (43%) indicated that they had ever served in a drug free area. Statistically, those respondents who had served time in drug free areas were more likely to rate these as important (\( \chi^2 = 21.593, \text{ df} = 1, p = 0.000 \)). While the majority of addictions staff thought that drug free areas may motivate prisoners to come off drugs, only about one third of prisoners (N = 508, 34%) indicated that they stopped using drugs and one in five prisoners (N = 306, 19%) stated a decrease in his drug use. Indeed, the majority of prisoner respondents (N = 489, 38%) rated drug free areas as ‘ok’ in being helpful in coming off drugs. This may be linked to addictions staff’s belief that there are drugs in drug free areas and hence prisoners may be tempted to use again. This noted, the majority of prisoners (N = 1241, 81%) reported that they had been drug free at some point while being in a drug free area. However, the extent to which individual and
situational factors facilitated the processes and support in drug free areas, and how these could be improved to offer further support is unknown from these data.

Summary - Issues Regarding the Management of Drug Use in Scottish Prisons: A Survey of Addictions Teams

- The majority of addiction staff were broadly supportive of current addictions policy, strategy and services provided for drug users in prison. The mission and values set up by SPS were considered clear and concise. Communication between SPS HQ and individual establishments, and between health and addictions teams were viewed as effective.
- The reduction of risk factors was seen as being as important as prevention of drug use. While there was an equally split attitude towards the assertion that injecting and sharing of injecting equipment were major problems in prison.
- To actually reduce the level of drug use and drug-related risk in prison, it was suggested that more treatments should be made available. It was felt these should be tailored as far as possible to individual needs.
- Addictions assessments were found to be helpful and integral to prisoners’ substance treatment. However, one third of respondents felt that these assessments were ineffective in identifying drug users at admission.
- The CAART as an assessment tool was viewed as effective and an important part of drug users’ treatment. Yet, addictions staff also pointed out that assessment procedures could be improved.
- Referral routes were largely reported to be effective. Self referral and referrals through addictions assessments and addictions staff were seen to be most effective.
- Addictions teams felt that all interventions (including accredited, approved and medical) were more effective than ineffective bar Drug Action for Change, 21 hour drug awareness and SMART. Methadone was reported as the most effective intervention. These results are based on responses only by staff members who have run these interventions.
- While drug free areas/addictions support areas were viewed as a good motivator for prisoners to become drug free, they were not seen as having a major impact on overall drug use in prison.
- Although MDTs were not perceived to have caused a decrease in the amount of drugs used in prison, and instead may have been associated with an increase in illicit use of opiates, MDTs were nevertheless considered to have a purpose by a slight majority of respondents.
- Addictions staff indicated that care provisions for addictions services required more support and resources.
- The majority of the sample considered the overall approach to dealing with prisoners’ health issues as integrative and co-ordinated. The current standard of delivery of health care services was rated positively.
- Mental health was considered a pressing issue that required to be addressed including the need to recognise mental health problems in prisoners as well as to expand support services and care provisions within mental health services.
• Staffing levels emerged as another issue indicating that nursing and medical teams felt they were not sufficiently staffed to deal with prisoners’ health problems adequately. However, it was also stated that in general prisoners’ health care needs were met. This noted, it is not known to what extent addictions staff believed prisoners’ health care needs were met. For instance, health care needs could have been interpreted as having broken an arm or a leg, but also as having a cold or a sore back.

• Although addictions teams suggested that there was a need for better links between community and prison, there were inconclusive opinions on the quality of current continuation of health care services between community and prison.

• Survey respondents reported that training for addictions and health staff could be improved. It was also felt that staff shortage had a detrimental impact on addictions services. Respondents indicated that there should be more resources to offer a wider range of treatments for drug users, in particular complementary interventions. Finally, some staff commented that the KPI targets changed the focus of addictions work from quality to quantity.

• When comparing some of the results of the addictions teams survey with the seventh prisoner survey, it emerged that addictions staff’s opinions and prisoners’ statements seemed to correspond in respect to continuity of care, mandatory drug testing and drug free areas. In relation to addictions assessments, however, addictions teams and prisoners’ views were not in concordance with each other. While the majority of addictions staff suggested that assessments were effective in identifying drug users at admission, the prison survey showed that only half of drug using prisoners had been assessed for drug use at admission. Of these, almost three quarters opted to tell staff voluntarily that they used drugs.
Chapter 5 – Current SPS Database for Assessment, Referral and Intervention

This chapter aims to provide a quantitative perspective on the procedures and processes inherent to addictions services in Scottish establishments. In particular, the number of prisoners completing as well as dropping out of the addictions process are analysed and discussed. This process includes initial addictions assessment, subsequent referral to appropriate interventions, and finally the commencement and completion of these interventions.

All establishments involved in this research were contacted on numerous occasions in order to collect all data necessary to provide a comprehensive picture representative of Scottish prisons. However, in many establishments, as well as for many interventions, data were mostly not available because it had not been recorded. Therefore, the analysis presented in this chapter will only focus on datasets where information was complete (e.g. number of prisoners entering and completing intervention), and numbers ‘made sense’, i.e. the number of prisoners entering was higher or equal to the number of prisoners completing intervention or assessment.

Assessment

Assessments are an important part of prisoners’ progression through their sentence. Various aspects of prisoners’ needs require assessment in areas such as health; addictions; sentence management; suitability for interventions (programmes and activities), medical interventions including methadone and detoxification; as well as risk management (e.g. suicide risk management). The Common Addictions Assessment Recording Tool (CAART) is the assessment scale used across all Scottish establishments to record prisoners’ substance misuse. The CAART in its current version concentrates on prisoners’ prescribed and illicit drug use in the community and/or in prison. Thereby the nature, the frequency, the quantity and the method of substances used is examined and recorded. Prisoners are also asked about injecting and sharing injecting equipment in and/or outwith prison.

The scope of this section is to establish the consistency with which the CAART is applied across establishments. According to the addictions services contract, all prisoners allocated to an addictions caseworker are required to have an addictions assessment (CAART) offered within three working days of allocation (SPS Addictions contract, 2001 Contract No. 017/02).

Data Analysis

The analysis is based on monthly return responses Cranstoun drug services provide to SPS Headquarters. The number of assessments offered, number of assessments refused and completed, and number of assessments not offered within three working days are recorded on a monthly basis by individual establishments. These data cover year 2002/3 and 2003/4 (table 5.1).