Home Office
BUILDING A SAFE, JUST AND TOLERANT SOCIETY

Tackling prison drug markets: an exploratory qualitative study

Clarissa Penfold
Paul J. Turnbull
Russell Webster

Home Office Online Report 39/05

The views expressed in this report are those of the authors, not necessarily those of the Home Office (nor do they reflect Government policy).

Tackling prison drug markets: an exploratory qualitative study

Clarissa Penfold
Paul J. Turnbull
Russell Webster

Institute for Criminal Policy Research
King's College London

Online Report 39/05

Acknowledgements

We are grateful to the Home Office for funding this study. At the Home Office we would specifically like to thank Andy Bell, Sandra Bell, Lesley Franklin, Kypros Ioannou, Malcolm Ramsay and Jacqueline Townley for their assistance.

We are also grateful to prison staff who helped organise interviews in each of the six establishments involved in the research.

We would also like to thank Probation Service and community drug agency staff for their invaluable help in recruiting recently released prisoner interviewees.

Special thanks go to Abigail Robin for her help with fieldwork, and Mike Hough for his editorial input.

Finally, we would especially like to thank the 121 prisoners and ex-prisoners and 37 prison staff interviewees who participated in the research.

Clarissa Penfold
Paul J. Turnbull
Russell Webster

Contents

Acknowledgements ii

Lists of tables and figures iv

Summary v

1. Introduction and methodology 1
- Previous research on drugs in prison 1
- Aims and objectives of the research 5
- Methodology 5
- Structure of the report 7

2. Drug use in six local prisons 8
- 'Lifetime' drug use in prison 8
- Drug use during current or most recent period in custody 10
- Prevalence of drug use as estimated by prisoners in six prisons 11
- Positive random Mandatory Drug Testing (rMDT) rates at six local prisons 12
- Discussion 13

3. How drugs get into local prisons and what is done about it 15
- How drugs get into prison 15
- Discussion 20

4. Buying, selling and the marketplace 21
- Three levels of drug dealing in prison 21
- Completing a drug transaction in prison 24
- The drug market and violence in prison 26
- Discussion 27

5. Drug treatment in local prisons 29
- Detoxification 29
- Treatment programmes 30
- Drug-free wings 31
- CARAT service 31
- Discussion 32

6. Conclusions and recommendations 34
- Recommendations 36

References 38

Annex: Brief summaries of three other research studies commissioned by Drug Strategy Unit 40

List of tables

1 Principal types of illicit drugs and relative frequency of use during current or most recent period of imprisonment (n=96) vi
2 Drug supply routes identified by prisoners/ex-prisoners and staff vii
3 How prisoners/ex-prisoners obtained their first and subsequent supply of drugs in prison (n=93) vii
4 Summary of security and treatment and implications for drug supply and demand at six local prisons xi
1.1 Breakdown of interviews conducted at six local prisons 6
2.1 Prisoners'/ex-prisoners' drug use during current/most recent period of custody 11
2.2 Average estimates of prisoners/ex-prisoners of the percentage using cannabis, heroin, crack and non-prescribed medication at each establishment 12
3.1 How drugs get into six local prisons: number of prisoner/ex-prisoner (n=121) and staff (n=37) respondents mentioning each route 15
4.1 Prisoners/ex-prisoners stating drug sellers/dealers were present on wing 21
4.2 How prisoners/ex-prisoners obtained their first and subsequent supply of drugs in prison 24
5.1 Types of detoxification programme at six local prisons 29

List of figures

1.1 Obtaining and maintaining a drug supply 4
2.1 Lifetime drug use in the community compared to in prison (n=118) 9
2.2 Annual percentage positive rMDTs for six local prisons (2001-2 to 2003-4) 13

Summary

This summary presents the main, essentially qualitative, findings from this exploratory study of drug supply and demand in six local prisons (five male and one female) in England. As with any small-scale qualitative research, findings should be interpreted with appropriate caution. The research was undertaken as one element of the Supply Reduction Programme launched by the Prison Service Drug Strategy Unit in February 2003. The study forms part of a co-ordinated programme of work that aims to support establishments in their ongoing efforts to reduce the supply of drugs in prisons. Interviews were conducted with 121 serving and recently released prisoners (purposefully selected to be knowledgeable about prison drug markets) and 37 staff from the six establishments between June 2003 and March 2004. Data from mandatory drug testing (MDT) and drug-related security information reports (SIRs) were also collated and analysed.

Key points

- Interviews with prisoners and ex-prisoners indicated that illicit drug use was occurring in all six prisons and, although the amounts involved were often small, some prisoners were able to use on a semi-regular basis and sustain a low-level drug dependency.
- Four main illicit drugs (heroin, cannabis, non-prescribed medication and crack cocaine) were reported to be in circulation and were supplied through six different routes (social visits, mail, newly arrived prisoners, staff, over the perimeter and after court appearances).
- Interviews with prisoners and ex-prisoners indicated that the drug market operated at different levels; there was evidence of more organised dealing in some of the prisons.
- Drug treatment (detoxification) programmes varied across the prisons, and the differences had implications both for prisoners' reported experiences of treatment and their decisions on whether to use in prison, and indeed whether to bring drugs into prison.
- Security measures and detoxification programmes appeared to have a dual impact on drug supply and demand, particularly in terms of supply route displacement and the demand for non-prescribed medication (this finding is based on triangulation of interview data and other sources from across the six prisons).

Drug use

Prisoners and ex-prisoners (n=121) were selected for interview on the basis of their knowledge of drug use in prison, which helps to explain why nearly eight out of ten respondents (79%) reported using illicit drugs during their current/most recent period of imprisonment. As shown in Table 1, the two most popular drugs used were heroin and cannabis followed by non-prescribed medication and crack cocaine. Over half those reporting heroin, cannabis and non-prescribed medication use described their pattern of use as frequent (defined as using the drug on two or more days per week). Crack cocaine was the only stimulant drug reported as being used in prison, and its use was more likely to be infrequent and opportunistic.

Table 1: Principal types of illicit drugs and relative frequency of use during current or most recent period of imprisonment (n=96)

Drug	Number reporting use	Number reporting frequent use[1]
Heroin	67	34
Cannabis	65	33
Non-prescribed medication	28	16
Crack cocaine	14	5

1. Frequent use is defined as using the drug on two or more days per week during the last month of use.

Non-prescribed medication used by respondents included:

- *benzodiazepines* (minor tranquillisers), diazepam being the most frequently reported;
- *anti-depressants* prescribed for depression with associated sleep disturbance, restlessness and anxiety (amitriptyline was commonly mentioned); and
- *opioid analgesics* (opiate-based painkillers) such as codeine phosphate, morphine sulphate, tramadol, methadone, dihydrocodeine and buprenorphine (the latter three are prescribed in detoxification programmes).

Many respondents said that certain types of non-prescribed medication (particularly diazepam, amitriptyline and buprenorphine) were becoming increasingly popular in prison. Such drugs are often less expensive and more easily obtainable than heroin or cannabis, and when tolerance to these drugs is low only small quantities are required. Such drugs are also used in combination with heroin and cannabis to enhance their effects. Seven respondents from three establishments reported using non-prescribed buprenorphine. Although an opioid analgesic, the detection of illicit buprenorphine use requires a separate test as it does not show up in the current test for opiates. Not all prisons routinely test for buprenorphine at present.

Eighty-eight interviewees answered a question asking why they used drugs in prison. Six main themes emerged, listed below in order of popularity:

- To relieve boredom and pass the time (n=45)
- Escapism (n=28)
- To relax and relieve stress (n=27)
- To help sleep better (n=14)
- Because drugs are/were available (n=9)
- To manage withdrawal and relieve withdrawal symptoms (n=7)

Drug supply routes

There was a broad consensus between prisoners, ex-prisoners and staff on the routes of drug supply into prison. Six main routes were identified (see Table 2) and are discussed below. Other less frequently identified routes included via reception after home leave, through legal visits, concealed in new clothes brought by visitors, and via contractors (for example, delivery drivers and construction workers) working in the prison.

Table 2: Drug supply routes identified by prisoners/ex-prisoners and staff

Route of supply	Prisoners/ex-prisoners identifying route	Prison staff identifying route	Total identifying route
Social visits	117	34	151
Mail	88	22	110
New receptions	73	23	96
Prison staff	56	20	76
Over perimeter wall/fence	37	27	64
Reception after court visits	21	6	27
Total no. of interviewees	**121**	**37**	**158**

Social visits

Both prisoners/ex-prisoners and staff interviewees cited social visits as the main route of drug supply into local prisons. Of 96 prisoners/ex-prisoners who had used drugs during their current/most recent period of imprisonment, 93 respondents explained how they had obtained their first and subsequent supplies of drugs. Five respondents had obtained their first supply of drugs through social visits, and 17 had obtained subsequent supplies via this route (see Table 3). Some prisoners and ex-prisoners who admitted selling drugs had imported them through social visits. Three factors were reported as helping prisoners and their visitors to avoid detection.

- Visitors concealed drugs in their mouths or other bodily orifices when arriving, as did prisoners when returning to the wing; this internal concealment is hard to detect.
- Contact visits mean that drugs can be passed from visitor to prisoner.
- Security measures are inconsistently enforced, often because of staff shortages or unavailability of drug dogs.

Table 3: How prisoners/ex-prisoners obtained their first and subsequent supply of drugs in prison (n=93)

Method of obtaining drugs	First drugs used	Subsequent drugs used
Purchased on wing	40	45
‘Given’ drugs by friends/cellmate	26	21
Imported drugs through reception	22	1
Received drugs through social visits	5	17
Mail	-	3

Mail

Although drugs sealed in items of incoming mail were mentioned by the majority of respondents, only three prisoners reported receiving drugs in this way. The majority of interviewees acknowledged that security measures imposed to tackle this route of supply had been successful, in particular the restriction of items allowed for personal possession, the requirement to have goods delivered direct from the retailer, and the use of x-ray machines and drug dogs to screen all post.

New receptions

Bringing in drugs on reception into prison represents the second most important reported route for drug supply into local prisons. It is worth bearing in mind that large numbers of new prisoners enter the gates on a daily basis. New prisoners were reported as commonly concealing drugs internally in the anus (‘plugging’ or ‘bottling’) or vagina (‘crutching’). Reported motives included ensuring a personal supply (to cope with or manage opiate withdrawal) and sometimes to trade the drugs for canteen items (tobacco, food and toiletries).

Twenty-two prisoner/ex-prisoner respondents stated they had brought a supply of drugs into prison with them.

Prison staff

The fourth most commonly mentioned route of drug supply was via uniformed or civilian prison staff. Many staff who were interviewed acknowledged that such trafficking goes on, and could substantially increase the amount of illegal drugs available in an establishment.

Perimeter wall/fence

The importance of the perimeter wall or fence as a potential supply route varied considerably from prison to prison, depending on the location and architectural design of the establishment. Those prisons located in cities with perimeters that border exercise yards and other areas used by inmates were most vulnerable. Use of the perimeter wall or fence as a drug supply route was relatively well organised, with staff at some prisons reporting that large amounts of drugs (particularly cannabis) were entering prison in this way, possibly for distribution among a group of dealers. Mobile phones, which staff interviewees indicated were invaluable for prisoners in arranging perimeter drops or for drugs to be brought in on visits, were also thrown over the perimeter wall or fence, along with packages of drugs. Prison staff tended to mention the perimeter route more frequently than prisoner/ex-prisoner interviewees, and its importance at certain establishments was underlined by its regular appearance in security information reports (SIRs).

Reception after court appearances

Finally, court appearances were also reported as being a potentially important route for drug supply. Local prisons hold relatively large numbers of remand prisoners, some of them making multiple visits to courts. Contact with family, solicitors and court security staff provides an opportunity for drugs to be passed to prisoners, who can internally conceal them before returning to prison (and was mentioned by 21 prisoners and six staff).

Drug markets

The most common means of obtaining drugs in prison, as reported by prisoner and ex-prisoner interviewees was simply by purchasing them on the wing, either from somebody already known from outside prison, or from a new seller (see Table 3). The six main methods of payment, in descending order of frequency, were: with canteen items (tobacco, food and toiletries); via outside payments (either made from prison to outside or vice versa, or arranged entirely outside the prison); with personal property; by swapping for other drugs; by providing services (usually acting as a runner); and with cash.

Three different levels of drug dealing in prison were found.

- At the least sophisticated end of the scale there was low-level opportunistic, altruistic or reciprocal supply involving sharing and/or swapping drugs with cellmates and friends. Of 96 prisoners and ex-prisoners who had used drugs during their current or most recent period of imprisonment, over a quarter (n=26) had been 'given' their first supply of drugs by cellmates/friends, usually in exchange for canteen items (tobacco, food and toiletries) or other drugs (including medication prescribed through prison healthcare). Twenty-one prisoner/ex-prisoner respondents had obtained subsequent supplies of drugs in this way. Low-level drug supply often involves family members or drug-using friends who bring in small quantities of drugs on social visits.

- Middle-level dealing involved drugs being used as a form of currency to make prison life more comfortable (simultaneously enhancing the dealer's status) and/or to maintain the prisoner's own drug supply. This intermediate level of dealing requires a semi-regular supply route (usually through social visits).

- At the upper end of the scale there were signs of higher-level, more organised dealing involving co-operation with outside contacts with greater resources to import regular supplies of drugs. Higher-level dealers may use multiple visitors and multiple prisoners to take visits on their behalf in order to import drugs. Where perimeter security is easier to breach, higher-level dealers may arrange for drugs to be imported 'over the wall'. They use other prisoners to act as runners and do not hold drugs themselves. Usually the only acceptable method of purchasing drugs from a higher-level dealer is via a payment made entirely outside the prison establishment.

There were indications of bullying and violence associated with local prison drug markets. The majority of prisoner/ex-prisoner interviewees agreed with the statement that the trade in drugs is the major cause of violence between prisoners. Respondents attributed tensions in prison to the paucity of drugs in circulation in prison. Access to regular supplies was limited, and drugs that were available were expensive (consistently costing approximately four times their street value). Frequent use often entailed debt, whether for the drugs themselves or canteen items (tobacco, food and toiletries) borrowed to pay for drugs. Prisoners and ex-prisoners interviewed also explained that prisoners suspected of importing and stashing drugs were robbed for their supplies. Bullying and intimidation were frequently mentioned in relation to prescription medication, with reports of prisoners in receipt of medication being forced to hand over their prescribed drugs.

Drug treatment

Four different opiate-detoxification regimes were operating at the five male establishments, reflecting the lack of consistency in treatment across the male local prison estate. Two of the male prisons used buprenorphine, one used methadone, one used dihydrocodeine and one used lofexidine. The female prison used methadone. The programmes using buprenorphine or methadone had replaced dihydrocodeine programmes and were felt by staff, prisoners and ex-prisoners to be far superior in terms of alleviating withdrawal symptoms. All four male detoxification programmes had problems associated with them.

- Two particular problems were associated with the buprenorphine detoxification regime. Firstly, it emerged that some prisoners were pretending to take their buprenorphine and retaining the dose for illicit use (crushing and snorting buprenorphine provides an intoxicating effect) or to trade/sell. Secondly, other prisoners/ex-prisoners said they had been bullied or intimidated into retaining and giving up their medication. Prisoners and ex-prisoners interviewed explained a number of techniques used to avoid taking their detoxification drugs whilst under supervision.
- A further problem relates to dispensing practices for diazepam, prescribed alongside methadone to alleviate withdrawal symptoms. Prisoners and ex-prisoners interviewed complained that diazepam was dispensed too early in the day, meaning they were drowsy during the day and unable to sleep at night.
- The dihydrocodeine and lofexidine detoxification regimes were considered by both staff and prisoners/ex-prisoners who were interviewed to be inadequate in terms of effectively managing withdrawal symptoms.

Only one prison offered any treatment programme beyond pharmaceutical detoxification and associated harm minimisation and group work. All prisons were operating a voluntary testing programme (VTP), although staff reported that a lack of resources often meant that voluntary testing was not a priority and prisoners reported that it was easy to 'cheat' such tests (for example by carrying a 'strap' containing a clean urine sample). Thirty-eight prisoners/ex-prisoners were or had been in contact with a Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team. Half held a positive view of the service they had received, but

over a quarter of those using the service felt that, whilst it was valuable, it was inadequately resourced. A further quarter held very negative views on the service due mainly to the limited number of appointments available.

Dual impact of security and treatment on supply and demand

The high proportion of new receptions to the prison system with an established drug or poly-drug dependency results in an environment where drugs are valuable as both currency and commodity (Bullock, 2003; Singleton *et al.*, 2005). Overcrowding and lack of sufficient activity in local prisons, where many prisoners spend lengthy periods of time locked up (Annual Report HM Chief Inspector of Prisons 2003-4), may further exacerbate this situation.

Findings from this exploratory study of local prison drug markets indicated that levels of drug use in different establishments are a function largely of the interaction between anti-drug supply security and detoxification provision. Table 4 provides a summary of security and treatment and the implications of the relationship between these for drug supply and demand at the six study prisons. This table demonstrates how security measures and drug treatment have a dual impact on supply and demand, particularly in terms of supply route displacement and the demand for non-prescribed medication. For example, at Prison B where security was tight on all external supply routes, but detoxification poor, there was a corresponding increase in bullying for medication. In contrast, external supply route displacement was occurring at Prison D, where prisoners and staff interviewed stated that the relative ease with which it was possible to throw and retrieve drugs over the perimeter wall and internal fences had made this an increasingly attractive route above social visits, where the risk of being caught and drugs intercepted was higher.

Table 4: Summary of security and treatment and implications for drug supply and demand at six local prisons

Prison	Security	Treatment (Detoxification)	Proportion positive rMDTs 2003-4[1]	Implications for supply and demand
A	Perimeter supply route precluded by architectural design and location of establishment. However, searching of visitors and prisoners after visits felt to be lacking in rigour. Recent convictions of staff for drug supply into establishment.	Buprenorphine	14% (+)	Positive rMDT rate below national local prison average, although on the increase. Improved security for social visits could reduce upward trend.
B	Only study prison with dedicated Drug Supply Reduction Team (DSRT). All aspects of anti-drug security overseen by DSRT. Use of drug dogs, an x-ray machine (for visitors' outer clothing/property and new clothes brought in for prisoners), closed circuit television (CCTV), and searching on social visits felt to be consistent and rigorous. Closure of a vulnerable exercise yard and regular perimeter searches by the DSRT had effectively stopped the perimeter supply route.	Lofexidine	10% (-)	Clear success in terms of security, although inadequate drug treatment was cause of bullying and misuse of medication, leading to increased need for bed-watches, and consequent staff shortages and regime disruption.
C	Passive drug dogs in short supply, and searching of visitors felt to be lax. Recent convictions of staff for drug supply into establishment.	Buprenorphine	19% (+)	Rate of positive rMDTs above national average. Performance could be improved with increased security on social visits. Although detoxification considered good, there is a need to monitor illicit use and trade of buprenorphine.
D	Increased security on visits had led to displacement of the main supply route to the perimeter. Breaches of perimeter security compounded by: irregular deployment of Dedicated Search Teams (DSTs) due to both staff and active drug dog shortages; unsupervised yard cleaners able to retrieve packages of drugs; diversionary tactics employed by both prisoners and those throwing drugs over the wall to avoid interception of drugs.	Dihydrocodeine	19% (-)	Positive rMDT rate above national local prison average. Poor performance reflects combination of limited perimeter security and inadequate detoxification treatment.
E	CCTV system in the visits room non-operational for over six months. Searching of prisoners after visits considered lax. Active perimeter supply route.	Methadone	15% (+)	Increase in positive rMDTs from 2002-3 to 2003-4 reflects need for improved security.
F Female	Relatively strong anti-drug security measures have effectively tackled supply routes. Prison may also benefit from its rural location. There may be important differences between male and female establishments, which would merit further exploration.	Methadone	6% (-)	Low incidence of positive rMDTs. Good security coupled with effective detoxification treatment considered important factors in improving rMDT performance.

1. Proportion of positive random mandatory drug tests (rMDT) recorded in 2003-4 (positive or negative sign indicates whether this represents an increase or decrease compared to 2002-3). The proportion of positive rMDTs for all male local prisons in 2003-4 was 17.5% and 14.2% for all female local prisons.

Conclusions

This exploratory study found that supply and demand relating to drugs in six local prisons were driven by two main factors: firstly, the impact of security on the availability of drugs; and secondly, the efficacy of detoxification programmes in managing withdrawal. An examination of drug use, drug supply routes, drug markets and drug treatment in six local prisons has revealed that it is the combined effects of enforcement measures and detoxification programmes which have an impact on prisoners' decisions to use drugs in prison and how to obtain them. With the possible exception of the female establishment (Prison F), the six study prisons did not appear to have a comprehensive strategy that tackled the problem of drug supply and demand from all angles and acknowledged the dual importance of security and treatment. Tight or uneven security coupled with inadequate drug treatment was leading to problematic displacement effects and ultimately failing to reduce demand. If supply reduction measures are to have a positive impact they must be revised and implemented with a view to balancing enhanced security with effective treatment. A set of recommendations is outlined below, although the caveat, that these are derived from mainly qualitative research carried out in six local prisons, should be borne in mind.

Recommendations

- All local prisons should employ a Drug Strategy Co-ordinator whose key role is to give equal weight to drug treatment and supply reduction measures within the establishment.

- All local prisons should set up dedicated Drug Supply Reduction Teams (DSRTs).

- Security for social visits must be enforced consistently given that this is perceived to be the main route of drug supply into prison. Passive drug dogs, x-ray machines, CCTV and good staff cover are vital and should be deployed on all visits sessions without exception.

- It is important that prisons 'talk up' their security where this is credible in order that the perception among the local prisoner population of the ease of a particular route of supply is eroded. This should include the publicising to prison visitors of the penalties for possession with intent to supply, and education among prisoners' families regarding the nature and effects of drug use and supply in prison.

- Improved liaison with local police is important for tackling all routes of external supply and should be included as an aim of all local prison drug strategies.

- Trafficking by uniformed or civilian prison staff and contractors should be addressed through security measures and identification of vulnerable staff members.

- All local prisons should have a good clinical detoxification regime in place and offer a choice of detoxification drugs. However, the prescribing of buprenorphine in prisons must be accompanied by recognition of the potential for its misdirection and misuse. Establishments should routinely test for buprenorphine and this facility is available on request.

- Follow-up and aftercare is as important as pharmaceutical detoxification and this component of drug treatment in local prisons must be given a far higher priority than at present. CARAT services must be able to offer more than simply assessment and the recent £10 million investment into CARAT services by the Prison Service should contribute to an increase in numbers of staff and the effectiveness of work undertaken.

- Voluntary testing programmes have an important role in helping prisoners maintain a drug-free status, but at present they are under-staffed and under-funded. This should be rectified so that prisoners wishing to stay 'clean' have appropriate support and incentives to do so.

- Healthcare prescribing protocols need an urgent review in order to combat the trend of the misuse and diversion of prescribed medication in prisons.

1. Introduction and methodology

The Prison Service Drug Strategy aims to reduce both the supply of, and demand for, drugs in prison and has four over-arching objectives:

- to restrict the availability of drugs in establishments;
- to identify prisoners who have been misusing drugs;
- to provide these prisoners with advice, treatment and support of appropriate intensity; and
- to prevent harm to the well-being of these prisoners and others.

These objectives are pursued through the following combination of measures focusing on treatment, enforcement, and security:

- detoxification (clinical management of withdrawal);
- provision of CARATs (Counselling, Assessment, Referral, Advice and Throughcare services);
- mandatory drug testing (MDT) to deter prisoners from misusing drugs, and supply better information on patterns of drugs misuse, as well as identifying prisoners in need of treatment;
- voluntary testing programmes (VTPs); and
- effective security measures aimed at supply reduction, including:
  - searching to find drugs and related paraphernalia within the establishment;
  - monitoring and control of prisoners' communications and visits;
  - police liaison to prevent drug trafficking and prosecute offenders;
  - the collation, evaluation and dissemination of intelligence to be acted upon in relation to drugs; and
  - security surrounding social visits including CCTV, passive drug detection dogs and the use of closed visits and visitor bans where appropriate.

The Prison Service Drug Strategy was first published in 1998 and updated in line with the National Strategy in 2002. Since then, a specific Supply Reduction Programme (SRP) has been launched (in February 2003) by the Drug Strategy Unit (DSU) of the Prison Service. This is intended to be a co-ordinated programme of work that aims to support establishments in their ongoing efforts to reduce the supply of drugs in prisons. The SRP comprises three main elements and it is the last of these to which this study is intended to contribute.

- Review supply reduction best practice and issue a Good Practice Guide (issued in November 2003).
- Conduct research into improved methods of drug detection at points of entry.
- *Conduct further research to gain a better understanding of drug supply routes into, and within, prisons*.

Previous research on drugs in prison

To date there has been limited research on the distribution of illicit drugs in prisons. Most of the literature focuses on prevalence of drug use, injecting risk behaviour and the effectiveness of drug treatment. These studies tell us little about drug supply, buying or marketing in prison. This is partly to do with the difficulty in collecting such information.

Although the feasibility of carrying out such a research project has not been previously tested in the UK, a number of obstacles to conducting research on prison drug markets have been suggested. Most studies of drug markets rely on information about the market from key players within the market, including users, runners and dealers. Some individuals are sceptical that serving prisoners who use, trade or sell drugs will disclose their sources of supply and methods of distribution even to independent researchers. Prisoners may fear the consequences of disclosure, which could include reduced access to drugs, further restrictions on prisoner activities, and reprisals either against the prisoner or family and friends outside of prison. Other individuals have suggested that there are likely

to be marked differences between prisons in the prevalence of drug use, the extent of any internal markets, the degree to which they are structured and organised, and the supply routes into prison. Researchers would therefore find it difficult to synthesise such a wide range of activities to develop a comprehensive view of prison markets and how they could be tackled.

Other sources, however, can produce useful information on prison markets, in particular ex-prisoners and serving prisoners who are undergoing drug treatment. Those working in prisons may also have useful information that can contribute to the overall picture of prison drug markets. Previous research (Bullock, 2003; Singleton *et al*., 2005) has shown that:

- many drug users continue to use drugs whilst serving their sentences, albeit at lower levels than in the community;
- some prisoners start – or at least develop – drug careers whilst in prison; and
- drugs get smuggled into prisons in numerous ways, for example:
  - by new inmates;
  - by relatives, friends and associates during prison visits;
  - through breaches of perimeter security; and
  - by staff.

Once smuggled in, drugs may be used by the recipient, shared, or traded. The costs of drugs in prison vary greatly (as discussed later), but, compared to the community, prices generally appear to be higher for smaller quantities. Prison drug use, despite being less frequent than outside, can intensify the dangers associated with drug use in the community, in particular danger relating to debt and the possibility of violence and bullying (Swann and James, 1998). Some studies provide information on patterns of drug use and give some indication of supply and distribution, dealing indirectly with drug supply and distribution patterns in prison (e.g. Dillon, 2001). Described below are findings from a selection of studies containing some directly relevant information or insights, which may be useful in furthering our understanding of drug-using patterns, supply and distribution in prison, and the impact of enforcement activity.

An important starting point within the literature is that there should be little surprise that prison inmates use drugs or indeed that they take risks in order to smuggle drugs into prison. Risk taking is as much a part of prison life as it is outside of prisons. However, Cohen and Taylor (1972) argue that prisons may actually enhance such behaviour. Controls within prisons have unintended consequences which can lead to risk behaviour:

> *"The gross power imbalance in the prison, coupled with the sheer monotony of a long sentence, encourages an ideology of risk which matches the criminal value system."*

Swann and James (1998) conclude that: "for most respondents the prison environment (reduced availability apart) only encouraged drug use" (Swann and James, 1998: 264).

Patterns of use

Previous research has shown that not only do a high number of prisoners enter custody dependent on drugs, but that many of them continue to use drugs in prison (Turnbull *et al*., 1994; Singleton *et al*., 1999; Boys *et al*., 2002; Bullock, 2003). However, most of the studies of UK prisons indicate that for many drug users imprisonment is a time when they use less drugs. Problematic users, likely to be using drugs on a daily basis in the community before entering prison, usually report using a reduced range of substances on fewer occasions when in prison (Turnbull *et al*., 1991, 1994; Shewan *et al*., 1994; Edgar and O'Donnell, 1998; Swann and James, 1998; Dillon, 2001), although some prisoners will be able to sustain high levels of drug consumption. Heroin initiation in prison is of particular concern, and there are studies that indicate prison is a setting in which a proportion of offenders are introduced for the first time to specific drugs (Gore *et al*., 1995; Swann and James, 1998; Dillon, 2001; Boys *et al*., 2002).

Patterns of drug use in prison are affected by a number of factors. Some prisoners attempt to use their time in prison as an opportunity to become drug free, stopping or reducing consumption dramatically; for others, reduction in their use of drugs is purely related to their inability to access the resources in

order to purchase them (Bullock, 2003). This group tends not to be able to draw on much financial support from outside prison. The availability of drugs is another important factor; smaller quantities of drugs are available, less frequently and often at a higher price (Swann and James, 1998). There is obviously likely to be an important interaction between availability, price and access to resources for payment.

Motivation to use drugs appears to change during the period of imprisonment. In the early stages of imprisonment reasons for using drugs are often related to withdrawal and the need to self-medicate (Turnbull, 2000). Further into a sentence motivation to use drugs often revolves around the need to relieve boredom and the monotony of prison life, as well as getting uninterrupted sleep; drug-using prisoners rarely report wanting to get 'high' as a motivating factor for using drugs in prison (Turnbull, 2000; Dillon, 2001).

Supply and distribution

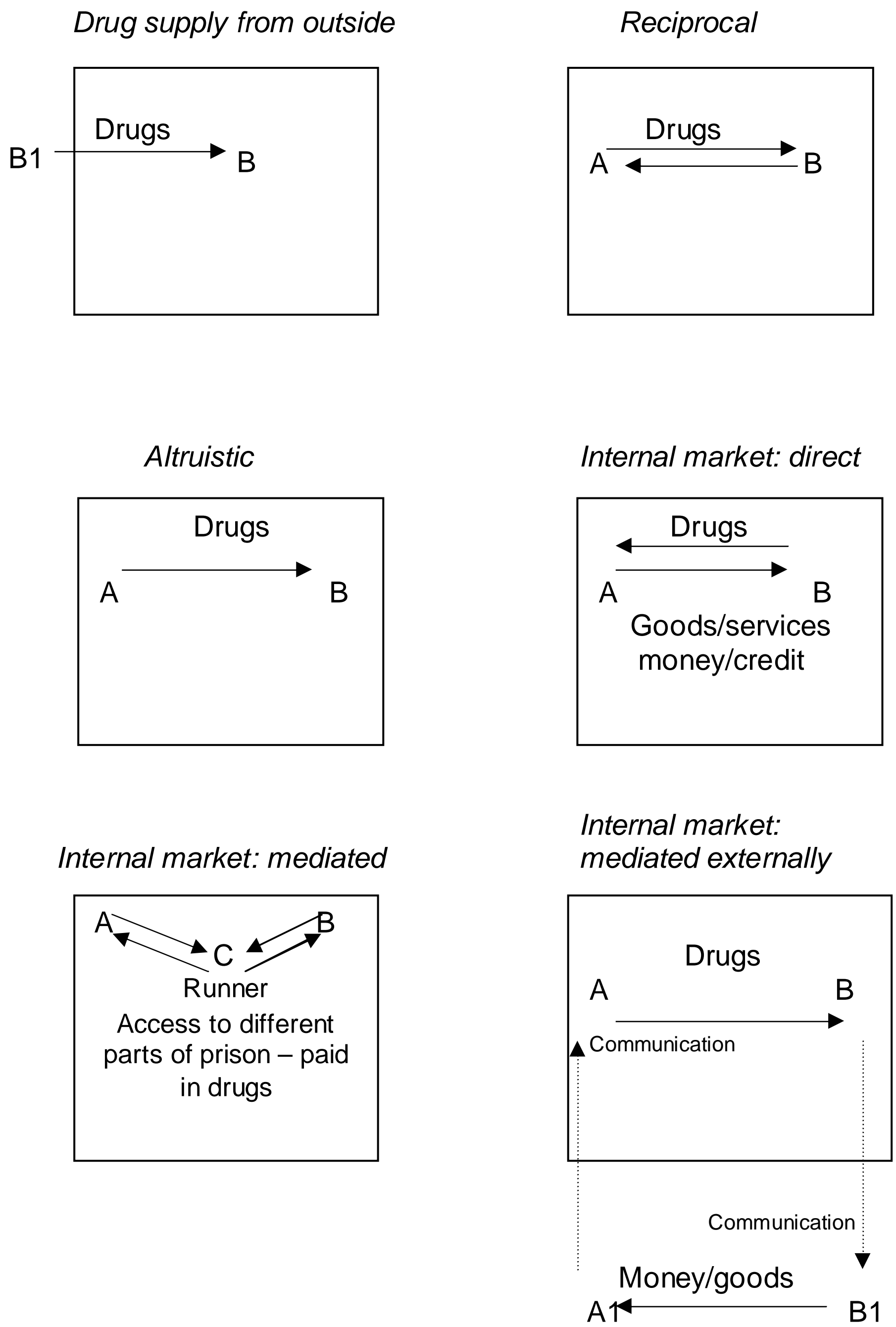
In her study of Mountjoy Prison in Ireland, Dillon (2001) states that prisoners identified two stages involved in accessing drugs in prison – getting drugs into prison and then distributing them. Supply routes into prison were not a focus of this study and Dillon states that given the sensitivity of the subject, it would have been difficult to question inmates about this. However, prisoner interviewees did comment that prison staff were not involved and that getting drugs in during visits had become more difficult due to increased security measures. Family members, partners and associates were reported as being the principal suppliers of drugs. Interestingly, she comments that payment was not expected for drugs brought into prison in this manner. A custom was reported whereby prison drug users were 'looked after' by other drug users in the community during their prison term.

Visits were the most frequently mentioned route by which drugs were brought into prison in a UK study of recently released prisoners (Turnbull *et al*., 1994). This study also identified another important route for bringing drugs into prisons: on entry into prison. Drugs were often concealed anally, a practice known as 'bottling' or 'plugging'. Drugs brought in by a new prisoner were often shared or partially sold in order to maintain a future supply of drugs.

The distribution of drugs within prison is affected by the actors (those supplying, selling, distributing and buying drugs), the prison structure, regime and physical environment. Studies indicate drug distribution is a dynamic process that can often change in response to these influencing factors (Dillon, 2001). Dillon (2001) found at the time she was conducting her research the principal means of distribution were networks set up between prisoners. Networks were generally established between prisoners who had known each other in the community. Drugs were shared in reciprocal arrangements whereby one prisoner would be supplied with drugs through a visit and then the drugs were distributed among his or her network. When other members of the network received a supply, they would in turn distribute drugs to other members of the network. No payments were exchanged, though interviewees reported that while serving previous sentences they had paid for drugs. Also they reported that different distribution systems operated in different prison establishments.

Having friends and acquaintances in prison was also identified as essential to gaining access to drugs by Turnbull *et al*. (1994). Although 'who you know' appears to be essential to securing a supply in prison, most interviewees reported having multiple supply routes. Figure 1.1 shows a number of ways prisoners obtained and maintained supplies. The figure also illustrates the number of ways drugs can be paid for including with goods, services, money and credit, both in and outside of prison. Money is rarely exchanged for drugs although cash is used occasionally in open prisons, or when cash transactions can be facilitated on the outside. Many alternatives to cash are used including telephone cards, confectionery, food, tobacco and other drugs. Swann and James (1998) found in their study of one prison that a culture of 'debt' rather than credit exists, which can lead to threats of violence and actual bodily harm.

Figure 1.1: Obtaining and maintaining a drug supply



Reducing the supply and distribution of drugs

Much previous research is mainly concerned with harm minimisation and little has been written on enforcement activities aimed at reducing the supply and distribution of drugs in prison. One exception is the study by Stevens (1997), of two US prisons, which comments that the type of prison regime affects drug trafficking. His research combined interviews with inmates and drug smugglers, an assessment of inmate and custodian relations, and an analysis of disciplinary reports. He found that when a regime has relaxed rules but, more importantly, its enforcers help inmates solve problems, there is less illegal drug trafficking than in a more restrictive environment with formal inmate-staff

relations. When asked who was most likely to bring drugs into prison without getting caught, most interviewees nominated prison staff. Convicted drug traffickers also believed that prison staff were the 'best choice' amongst those who could get drugs in safely. Unlike the present study, the findings are based on respondents' opinions rather than their actual experience.

In the UK context similar concerns about the effects of drug control in prisons have been presented. In a survey of heads of prison security, Seddon (1996) identified a tension between the need to maintain a balance between drug control and broader control. Within these complex institutions the introduction of measures to further a particular goal often has an impact on other areas. Possible consequences of increased security included prisoners switching from less harmful to more harmful drugs, an increase in outbreaks of disorder, and an inflationary effect on price leading to problems of debt, violence and intimidation. Keene (1997) echoes this point when she argues there is an inherent conflict between the need for control and the rehabilitative philosophy of maintaining family links. Further, policy initiatives resulting in tightened security do not automatically of themselves lead to a more stable environment. They can upset the status quo leading to confrontation between staff and inmates.

Aims and objectives of the research

The overall aim of the research described in this report was to provide a more detailed and nuanced understanding of prison markets than has been available to date. This information is intended to help the Prison Service meet its key objectives of supply and demand reduction. The study set out to:

- describe and compare drug use, supply, markets and drug treatment in six local establishments;
- assess what is likely to be the most effective response to drug markets in local prisons; and
- assess the likely displacement effects of those responses.

Methodology

The authors' approach was to use multiple sites and multiple methods in order to build up a picture of prison markets from several different sources. The Prison Service selected the prison establishments in which the research was to be conducted. The rationale for selection was to include a geographically diverse group of local prisons, with varying degrees of drug use based on mandatory drug testing (MDT) data. Local prisons have specific characteristics that distinguish them from other prisons. All offenders sentenced to a period of imprisonment or remanded in custody by a court are received by the court's local prison. Thus local prisons are characterised by a large number of prisoner movements and a transient population. A high proportion of prisoners enter the gates dependent on drugs (Bullock, 2003; Singleton *et al.*, 2005). Overcrowding results in insufficient purposeful activity, especially for remand prisoners. Numbers of social visitors are greater at local prisons, since remand prisoners can receive a higher number of visits than convicted prisoners. There is also a strong likelihood that established networks of drug users and dealers are imprisoned at the same time.

The selection of six local prisons comprises one female establishment and two prisons in the high security estate. The prisons represent both those located in city and rural sites, and are of differing architectural design.

This study involved the collation and analysis of routine statistics relating to drugs in prison, and interviews with prison staff and prisoners.

Analysis of statistics

There are many existing sources of information regarding detected drug supply and drug use in prison. However, these are not routinely analysed in reference to each other. The authors attempted to synthesise a range of potential indicators of drug supply and prison drug market activity. The types of centrally held routine data collated included those relating to mandatory drug testing (MDT), security information reports (SIRs) relating to drugs, drug adjudications and visitor bans.

Interviews

The main methodological approach relied on interviews with those who have knowledge of this aspect of prison life. The strategy was to gather a range of different experiences focusing on individual establishments. There were two main groups of interviewees:

- those working in prisons; and
- those who have bought from, or have otherwise participated in, the market.

A total of 158 interviews were conducted with 37 staff and 121 serving or recently released prisoners from the six establishments.[1] A breakdown is provided in Table 1.1.

Table 1.1: Breakdown of interviews conducted at six local prisons

Prison	**Number of interviewees**			
	Staff	**Serving prisoners**	**Recent prisoners**	**All prisoners/ex-prisoners**
A	8	10	16	26
B	6	8	11	19
C	7	8	21	29
D	7	8	13	21
E	4	7	5	12
F (Female)	5	8	6	14
Total	**37**	**49**	**72**	**121**

Interviews with a range of prison staff were conducted in each establishment, including:

- CARAT staff (8)
- Staff involved in detoxification treatment (5)
- Security staff (12)
- Landing Officers (3)
- Drug Strategy Co-ordinators/Workers (6)
- Resettlement Manager (1)
- Outreach Worker (1)
- Foreign Nationals Co-ordinator (1)

Staff were asked a range of questions including their views on the availability of different types of drugs, the effect of drug markets on their establishment and individual prisoners, information on larger-scale dealers, and the limitations of current methods of detection.

Given concerns about the willingness of serving prisoners to participate in the research and the reliability of the information they provide, the authors' strategy was to interview both current and ex-prisoners. In total they aimed to interview 120 prisoners or recently released prisoners from the six study sites. Their definition of 'recently released' was any prisoner (remand or sentenced) who had been released within the previous 12 months and had been remanded or served part of his or her sentence in one of the six selected prisons.

Respondents were purposefully selected to be knowledgeable about prison drug markets. Serving prisoners were located primarily through CARAT teams, who sought volunteers on behalf of the researchers. Several strategies were adopted to recruit suitable ex-prisoners. The most successful one was approaching a number of helping agencies (primarily drug services, those running Drug Treatment and Testing Orders (DTTOs) and CARATs) who were able to assist in contacting suitable potential respondents. Recruiting female respondents proved more difficult due to their geographical dispersal and therefore six women released on home detention curfew (HDC) licence were interviewed. All community-based respondents received a voucher to the value of £20 in return for their participation. Data from interviews were analysed using the Statistical Package for the Social Sciences (SPSS).

[1] Interviews with staff and serving prisoners were conducted at the six establishments between June and November 2003, and interviews with recently released prisoners were conducted in the community between August 2003 and March 2004.

Interviews with serving and ex-prisoners covered the following areas:

- history of imprisonment;
- history of drug use;
- experience of drug use in prison;
- perception of demand for drugs;
- knowledge of drug supply routes and direct experience of drug supply patterns;
- information about and experience of drug distribution and trade;
- drug costs and currencies used to purchase drugs in prison;
- drug use and punishment; and
- experience of drug treatment.

Profile of prisoner/ex-prisoner interviewees

As can be seen from Table 1.1, a total of 121 serving or recently released prisoners were recruited. Fourteen women were interviewed who had been or were in Prison F. The rest of the interviewees were male. At the time of interview their average age was 30 years, with a range from 18 to 46 years. The majority (n=104) described their ethnicity as white, and the remainder (n=17) were black or Asian. The average age interviewees reported first using a drug was 14 and over two-thirds (n=85) had injected drugs at some point. Most (n=116) had used drugs in the month before entering prison with 94 interviewees reporting using heroin on a daily basis and 70 reporting using crack on a daily basis. The average amount spent on drugs in a week prior to imprisonment was estimated to be £957. This is considerably higher than community-recruited samples of drug users. The most common ways of raising cash for drugs were shoplifting, theft and burglary.

The average length of time interviewees had spent in prison on this occasion was four months, with a range from one to 18 months. Sentences ranged from one month to 11 years. The majority believed the offences they had committed were related to their use of drugs (n=112). For only eight interviewees was this their first time in prison. The mean age that interviewees had started their prison careers was 18, with an average of ten previous periods of imprisonment.

Structure of the report

Chapters 2 to 5 of the report present analyses of the main themes arising from the research. Chapter 2 looks at drug use in six local prisons, and Chapter 3 explains how drugs get into these prisons and what is done about it. Chapter 4 examines buying, selling and the marketplace for drugs in the prisons under investigation. Chapter 5 assesses the provision of drug treatment in each establishment. Finally, Chapter 6 presents the conclusions and recommendations arising from the research.

2. Drug use in six local prisons

This chapter first compares 'lifetime' drug use in prison with use in the community among this study's sample of prisoners and ex-prisoners. The authors then look in more detail at reported drug use among their interviewees in the month prior to interview, or in the last month that they were using in prison, as well as views about levels of drug use amongst inmates. Finally, rates of positive random mandatory drug tests (rMDTs) are compared across the six study sites.

'Lifetime' drug use in prison

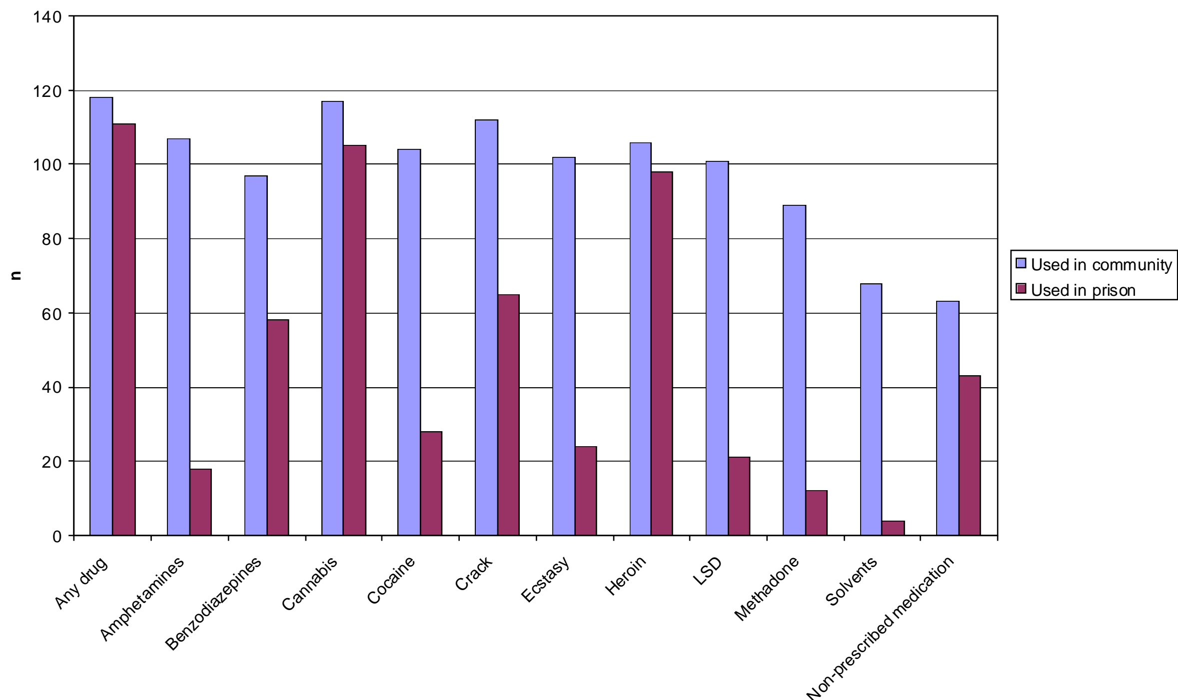
> *"Drugs is what everyone's thinking about [in prison] – not a day goes past when you don't hear the word 'drugs'."* [Prisoner, Prison D]

Of 121 prisoners and ex-prisoners interviewed for this study, 118 had used drugs in the community, and of these, 111 had used drugs in prison at some stage in their lives. The high proportion of respondents reporting drug use in prison is unsurprising given that the sample was purposefully selected (and therefore unrepresentative) to include those who would be knowledgeable about prison drug markets. The five most frequently reported drugs ever used in prison were, in order of popularity:

- Cannabis (n=105)
- Heroin (n=98)
- Crack cocaine (n=65)
- Benzodiazepines (n=58)
- Other non-prescribed medication (n=43)

Aside from the use of crack cocaine, Figure 2.1 (which compares prison and community use) shows the clear tendency towards using depressant as opposed to stimulant drugs in prison, echoing findings from other research (Swann and James, 1998; Dillon, 2001; Bullock, 2003). The prevalence of crack use in prison is a new phenomenon and, whilst its use is said to be infrequent, it nevertheless was a feature of prison drug use for the interviewees, and probably reflects the high level of crack use for the sample before custody. It tended to be smoked on an infrequent basis, and often with cannabis (referred to as a 'crack spliff') in order to reduce the intensity of the 'high'. Injecting drug use in prison was very low among the sample, despite the high levels of injecting prior to imprisonment. The main reasons given for not injecting inside were the lack of clean injecting equipment, along with the lowered tolerance to heroin and consequent reduced need to inject.

Figure 2.1: Lifetime drug use in the community compared to in prison (n=118)



Fifty respondents of the 111 prisoners and ex-prisoners who had ever used drugs in prison) had tried one or more drugs for the first time in prison. Most of these 'first-time' users (33/50) reported that they had first used heroin in prison. The reasons given for first using heroin in prison ranged from trying the drug because they were sharing a cell with a heroin user (n=5), switching to heroin from cannabis because of mandatory drug testing (n=3), using heroin to pass the time and relieve boredom (n=3), or to ease depression after a relationship had ended (n=2). Nine respondents had tried crack for the first time in prison, five had initiated cannabis use in prison, and three interviewees had used non-prescribed buprenorphine for the first time in jail. These findings are similar to those of Boys *et al.* (2002) among a sample of 3,142 prisoners.

Eighty-eight respondents (of the 111 who had ever used drugs in prison) answered an open-ended question asking them why they used drugs in prison. Six main themes emerged, listed below in order of popularity:

- To relieve boredom and pass the time (n=45)
- Escapism (n=28)
- To relax and relieve stress (n=27)
- To help sleep better (n=14)
- Because drugs are/were available (n=9)
- To manage withdrawal and relieve withdrawal symptoms (n=7)

The following quotes from prisoners and ex-prisoners demonstrate the range of reasons given by interviewees for using drugs in prison:

> *"It melts the bad away, you forget you're in prison, you're buzzing about. Heroin is preferable to cannabis for the effects and only stays in [your] system for three days. Cannabis can make you go into yourself, makes you paranoid."* [Prisoner, Prison D]
>
> *"When you do a sentence you're thinking of outside – a good way of escaping is a few downers or a little toot on the foil to get a nice sleep in."* [Ex-prisoner, Prison B]
>
> *"Boredom is a big problem in jail, heroin makes you comfy, you can handle things better."* [Prisoner, Prison F]

"Drugs pass the time, make the time go quicker, you feel more relaxed and at ease, and more secure." [Prisoner, Prison A]

"You'll have as much drugs as you can get so you get so fucked up you'll go to sleep and the day goes." [Ex-prisoner, Prison C]

"When you feel trapped, which is basically all the time, when you smoke [drugs] it makes you feel free, makes the bars disappear, makes you relax and not too bothered about being there." [Prisoner, Prison B]

"[The] main priority in that place is to make sure you've got some drugs before you get banged up. You got it [heroin] on a Monday and saved it for yourself to make it stretch. It passes the time." [Ex-prisoner, Prison E]

The overwhelming majority of prisoners and ex-prisoners who had ever used drugs in prison (n=108) stated that the threat of punishment from a positive rMDT did not deter them from using drugs. There was a general consensus that the deterrent effect of mandatory drug testing (MDT) had been reduced for two main reasons. First, a European Court of Human Rights ruling in 2002 led to the transfer of power to impose additional days as a punishment from prison governors to independent adjudicators. Second, prisoners have learnt a number of procedural and legal ways in which a positive test can be avoided or challenged, including refusing to do the test (which attracts a lesser punishment), or ensuring they are being prescribed opiate-based medication through healthcare (to cover illicit opiate use). Prisoners may also be released before the appeal process has been exhausted and a punishment can be imposed.

The change in prison rules regarding the imposition of additional days has greatly reduced prisoners' fear of punishment for positive drug tests and appears to be resulting in an increase in the popularity of cannabis, previously avoided by some because it is detectable in the system for much longer than opiates. Several prisoners told the interviewers that they used prison as a rest from 'hard' drug use and preferred to use cannabis rather than heroin to help them relax and sleep. Using cannabis rather than heroin also means that prisoners do not experience withdrawal symptoms as a result of 'jail habits' and can avoid the hassle and expense associated with a low-level dependency on heroin. Against this trend is the increasing popularity of the heroin-substitute buprenorphine, and the possible increase in the prevalence of crack use in prison.

Drug use during current or most recent period in custody

Ninety-six prisoner and ex-prisoner interviewees had used drugs during their current or most recent period in custody. Four main drugs were mentioned by the sample, as shown in Table 2.1. The majority of those using drugs in prison prior to interview reported using heroin (n=67) or cannabis (n=65). Lesser numbers reported using non-prescribed medication (n=28), and crack (n=14).

Non-prescribed medication used by respondents included:

- *benzodiazepines* (minor tranquillisers), diazepam being the most frequently reported;
- *anti-depressants* prescribed for depression with associated sleep disturbance, restlessness and anxiety (amitriptyline was commonly mentioned); and
- *opioid analgesics* (opiate-based painkillers) such as codeine phosphate, morphine sulphate, tramadol, methadone, dihydrocodeine and buprenorphine (the latter three are prescribed in prison detoxification programmes).

Table 2.1: Prisoners'/ex-prisoners' drug use during current/most recent period of custody

Drug	Prison						Total
	A	B	C	D	E	F (Female)	
Heroin	15 (8)[1]	7 (3)	19 (10)	16 (8)	1 (1)	9 (4)	67 (34)
Cannabis	15 (10)	10 (7)	18 (11)	11 (2)	6 (3)	5 (-)	65 (33)
Non-prescribed medication	4 (3)	6 (4)	11 (6)	2 (1)	-	5 (2)	28 (16)
Crack	2 (1)	1 (-)	5 (2)	1 (-)	1 (1)	4 (1)	14 (5)
Total no. respondents	**21**	**14**	**24**	**9**	**8**	**10**	**96**

1. Figures in brackets represent the number of respondents reporting they used the drug more frequently than one day per week.

More than half of those using heroin, cannabis and non-prescribed medication reported frequent use, defined here as using the drug on two or more days per week. Many respondents said that buprenorphine, along with diazepam and amitriptyline were becoming increasingly popular in prison, and when tolerance to these drugs was low only small quantities were required, making them desirable – as well as less expensive and more easily obtainable – alternatives to heroin.

> "*Subutex [buprenorphine] is a problem in there now, people would rather buy Subutex than heroin, everyone was being pressured for it, also amitriptyline and Valium [diazepam], anything to get your head down."* [Ex-prisoner, Prison C]
>
> *"People wanted amitriptyline, they'd trade heroin for it, anything that helps you sleep or knocks you out in prison is considered to be a godsend, heroin and amitriptyline work well together because the tolerance for amitriptyline is not as high as for heroin."* [Ex-prisoner, Prison C]

Seven respondents from three prisons (including the two prisons which offer a buprenorphine detoxification programme) reported using non-prescribed buprenorphine.

Prevalence of drug use as estimated by prisoners in six prisons

Prisoners and ex-prisoners from each establishment were asked to estimate the proportion of inmates at the prison who were using cannabis, heroin, crack or non-prescribed medication. The interviewees gave a considerable range of estimates. Most respondents were only able to talk about their own wing, and it should be noted that levels of use were reported to vary substantially between wings, with use being higher on induction, remand and voluntary testing wings, and lower on vulnerable prisoner units.

Whilst in no way a precise guide to actual levels of use, and with the above caveats in mind, interviewees' prevalence estimates are interesting, particularly when considered alongside the positive rMDT rates (discussed below). Overall, levels of cannabis use were estimated to be higher than heroin use at four male prisons (see Table 2.2), but lower at Prison E and Prison F (Female). The average[2] estimates for cannabis and heroin use were lowest at Prison B and Prison F (these two establishments recorded the lowest average proportion of positive rMDTs in 2003). Prison D interviewees gave the highest average estimates for cannabis (70%) and heroin use (57%). Interestingly, Prison D recorded the highest average proportion of positive rMDTs in 2003 of all six prisons.

[2] Given the wide range of estimates, medians have been used rather than means, to ensure that outliers did not skew results excessively.

Table 2.2: Average estimates of prisoners/ex-prisoners of the percentage using cannabis, heroin, crack and non-prescribed medication at each establishment

Drug	Prison					
	A	B	C	D	E	F (Female)
Cannabis	50	40	50	70	55	20
Heroin	30	30	50	56.5	60	50
Crack	4	2.5	2	2.5	5	0
Non-prescribed medication	12	55	58	15	50	80
Total no. respondents	22	14	28	18	9	7

Average estimates for crack use were low at all prisons, although slightly higher for two establishments (Prison A and Prison E). The use of non-prescribed medication was estimated to be highest at the female prison (Prison F), followed by Prisons C, B and E. Prisoners at Prisons A and D made the lowest estimates of the proportion using non-prescribed medication.

Positive random Mandatory Drug Testing (rMDT) rates at six local prisons

The average proportion of positive rMDTs rose from 2002-3 to 2003-4 across the local prison estate to 17.5 per cent for male local prisons and 14.2 per cent for female local prisons. The overall picture masks different trends for individual establishments, and the percentages of positive rMDTs from 2001-2 to 2003-4 for the six study prisons are shown in Figure 2.2.

The average proportion of positive rMDTs fell over the three-year period for two of the male local prisons. The fall was most dramatic at Prison B, with a fall of around 12 percentage points, from 22 per cent in 2001-2 to only ten per cent in 2003-4. Prison C also recorded a fall of over 12 percentage points from the highest recorded average rate among the prisons studied (32% in 2001-2) to 19 per cent in 2003-4, which is slightly above the national average (17.5%) for all male locals. However, whilst this represents an overall fall, the rate increased by five per cent from 2002-3 to 2003-4.

Prisons A, D and E recorded an overall increase in the rate of positive rMDTs from 2001-2 to 2003-4. At Prison D the rMDT rate rose by around five percentage points from 14 per cent in 2001-2 to 19 per cent in 2003. Prisons A and E consistently recorded positive rMDT rates below the national average, but the rate at Prison E has risen steadily over the three-year period from around nine per cent in 2001-2 to around 15 per cent in 2003, and Prison A also had a rise in its average positive rMDT rate in the last two years from 11 per cent to 14 per cent. Prison F, the female local prison in the study, performed consistently below the average for all female local prisons, and overall had improved to just six per cent positive rMDTs in 2003.

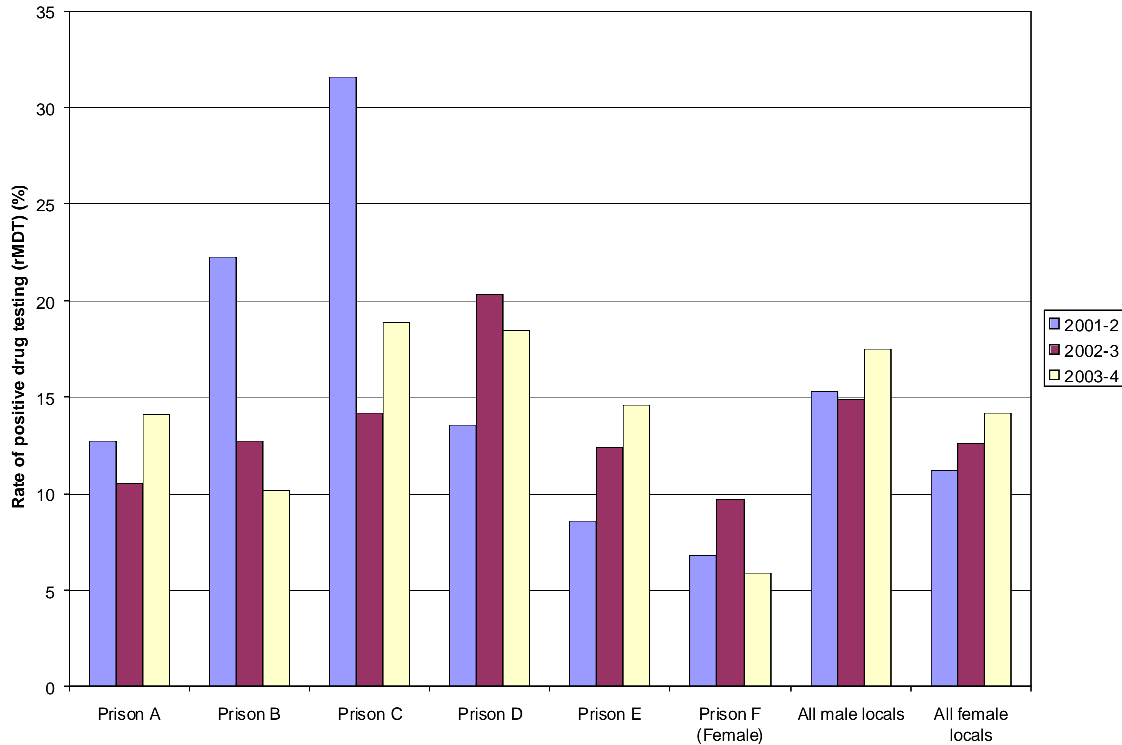
Recorded rates of positive random mandatory drug tests (rMDTs) provide an indication of the overall prevalence of illicit drug use in prison. There are, however, a number of problems associated with using positive rMDT rates as a reliable measure of drug use.

- Random Mandatory Drug Testing (rMDT) inevitably under-reports opiate use, due to the short length of time that opiates stay in the body.
- Buprenorphine (Subutex) is not tested for at all establishments.
- Drugs prescribed by prison healthcare can result in medical mitigations for positive tests.
- rMDT is constrained by resources. Lower proportions of tests are performed at the weekend and prisoners perceive they can minimise the risk of testing positive for opiate use by timing their use accordingly.
- An rMDT test must contain more than a trace of drugs in order that a positive indication is beyond reasonable doubt. This helps exclude contaminated samples and accidental positives, especially for longer-lasting drugs which may have been taken prior to imprisonment (such as

cannabis and benzodiazepines). However, this standard of proof may result in under-reporting since some 'false' positives may in fact reflect custodial use.

- Refusals may also lead to an under-reporting of drug use, since although these are low (representing 1.1% of rMDT tests across the prison estate in the calendar year 2003), there is the possibility that some of these would have been positives.

Figure 2.2: Annual percentage positive rMDTs for six local prisons (2001-2 to 2003-4)



Discussion

Qualitative research conducted in six local prisons found that heroin, cannabis, non-prescribed medication and crack cocaine were being used by varying proportions of prisoners. Levels of heroin and cannabis use in prison were similar for all respondents, although they reported that cannabis use was more prevalent overall at four establishments, and heroin use was more prevalent at two establishments. The use of non-prescribed medication was lower and crack use was lower still, and tended to be infrequent. Buprenorphine (Subutex) was identified as emerging as a relatively popular drug in prison and its illicit use needs to be closely monitored. The main reason given by prisoners for using drugs was boredom and the need to pass the time. Escapism, relaxation and stress relief were also commonly mentioned.

Drug use in prison was reported as being driven in part by availability (nine prisoners told the interviewers they had used drugs simply because they were available), but where routes of supply are under less intense scrutiny, availability may also be driven by demand. Drug use is also exacerbated by the need to control withdrawal symptoms, both upon first entering prison (mentioned by seven respondents answering a question about why they used drugs in prison), and after having used drugs in prison (mentioned by 21 respondents answering a question about what is bad about using drugs in prison).

As discussed in subsequent chapters, interviews with prisoners and ex-prisoners indicated that drugs are supplied to these local prisons through six main external routes, and also re-routed internally through prison healthcare or detoxification. The differing levels of drug use in prisons can in part be explained by the efficacy of anti-drug supply security and drug treatment (particularly detoxification regimes). Where individual establishments have improved their performance in terms of lowering the positive rMDT rate, contributing factors need to be illuminated so that models of good practice can be established for use across the estate. The next chapter examines how drugs get into prison and what is done about it.

3. How drugs get into local prisons and what is done about it

Whilst community-based drug markets have now been researched in some detail (e.g. Edmunds *et al.*, 1996; May *et al.*, 2000; Lupton *et al.*, 2002), this study is the first to address prison markets. Nevertheless, the general principles governing the operation of the market seemed broadly similar to those of community-based markets. The market in each prison was shaped by the complex interactions between demand, supply, security, enforcement strategies and treatment strategies. As will be seen, new communications technology, in the shape of mobile phones, is having an impact on prison markets no less than on community-based ones.

How drugs get into prison

All the interviewees were asked how they thought drugs got into their local prison and they told of ten ways in which drugs entered the establishments. Different routes were identified more frequently at different prisons by the 158 prisoner, ex-prisoner and staff interviewees (see Table 3.1 below). The six main methods are discussed below in more detail.

Table 3.1: How drugs get into six local prisons: number of prisoner/ex-prisoner (n=121) and staff (n=37) respondents mentioning each route

Route of drug supply	**Prison**												*Total*
	A		**B**		**C**		**D**		**E**		**F (Female)**		
	P	*S*	*P*	*S*	*P*	*S*	*P*	*S*	*P*	*S*	*P*	*S*	
Visits	25	8	19	5	29	6	21	7	10	4	13	4	151
Mail	17	3	8	4	26	6	19	5	8	1	10	3	110
New receptions	15	3	15	6	12	5	15	2	6	2	10	5	96
Prison staff	15	6	8	2	14	3	11	4	8	3	1	1	76
Perimeter	1	-	10	3	10	1	15	7	4	3	8	2	64
Court visits	10	2	3	2	5	-	1	-	1	-	1	2	27
Home leaves	1	-	-	-	2	-	2	1	3	-	3	3	15
Legal visits	2	1	-	-	4	-	2	1	1	-	-	-	11
New clothes	2	-	-	-	1	-	2	2	1	-	1	-	9
Contractors	1	-	3	1	-	-	1	-	-	-	-	-	6
Total interviewees	**26**	**8**	**19**	**6**	**29**	**7**	**21**	**7**	**12**	**4**	**14**	**5**	**158**

Bringing drugs in through social visits

There was a consensus across the six study establishments that bringing drugs in through social visits was the most common way of trying to get drugs into prison. It is not possible to estimate what proportions of drugs enter prisons in this way, but this would seem the most common route. Almost one in five (17/96) of these prisoner interviewees who had used drugs in the month prior to interview had got these drugs from a social visitor.

In order to smuggle drugs into prison by this route successfully, both visitor and prisoner must survive a number of surveillance and prevention strategies. An experienced and well-organised smuggler will wrap the drugs in as small a package as possible, sealing them in clingfilm. They may spray the package with perfume to make detection by the drug dog difficult. They will then conceal the package, usually either in underwear or internally in the vagina, rectum or back of the throat. On occasions, drugs will be concealed in babies' clothes or nappies. The visitor must hold their nerve past the drug dogs and the signs detailing the punishment for bringing drugs or other prohibited materials into Her

Majesty's Prisons. There may also be copies of local press cuttings giving the length of custodial sentence received by a visitor apprehended at the prison.

The visitor must then keep the drugs concealed when being searched on arrival at the visit. After passing through the search and going into the visits area, the visitor must retrieve the package and pass it to the prisoner without being observed by CCTV or prison officers supervising the visits hall. The retrieval is easier if there are toilets within the visits area. Drugs are normally passed either mouth to mouth by kissing, or in food and drink purchased in the visits hall. The prisoner must then conceal the drugs, usually internally, to avoid them being detected on a post-visit search. Once again, prison staff may be monitoring the visits holding area.

Many visitors find this process an extremely frightening and exhausting ordeal. For instance, they may have got involved as a result of intense emotional pressure or even physical intimidation.[3] Others, sometimes drug-using friends of the prisoner, may have developed a tried and tested approach which gives them little cause for concern.

Visitors suspected of bringing in drugs may be turned away, and any who are caught in possession of drugs will be arrested and prosecuted. Prisoners are sometimes caught receiving drugs. Nonetheless, there may be a relatively low level of detection. In the six prisons, two visitors per prison per month were banned because of suspicion of bringing in drugs, and less than one prisoner per prison per month was found guilty at adjudication of receiving drugs on a visit.[4]

There may be three main reasons for the relative success of getting drugs into prison via a social visit.

- Internal concealment of drugs is very hard to tackle, given the legal and moral constraints on intimate searches.
- Contact visits make the passing of contraband relatively easy to achieve.
- Many of the security measures are inconsistently enforced.

In addressing this third point, the interviewees gave different views about the level of security on visits, depending on the prison concerned. Only at Prisons B and F (which had the lowest proportions of positive rMDTs in 2003 among the six study prisons) did the respondents consider visits security to be a significant challenge to be overcome. At these two establishments both staff and prisoners felt that searching was rigorous and consistent. At Prison B, a Drug Supply Reduction Team used drug dogs and CCTV systems in an intelligence-led manner. All visitors' outer clothing and clothes brought in for prisoners were put through the x-ray machine. Prisoners at Prison B regarded these security measures as successful and visits security was considered to be greatly improved:

> *"There's less drugs because the drugs officers keep catching them on visits bringing it in."*
> [Prisoner, Prison B]

However, numerous failings were brought to the authors' attention at the time of the research in all the study prisons (with the notable exception of Prison B), in most cases by both staff and prisoners.

- Passive drug dogs were often not deployed on visit sessions at every prison.
- Searching of visitors at Prison C was lax.
- Searching of prisoners after visits at Prison E was lax.
- Searching procedures at Prison A were considered not to be undertaken as rigorously as needed.
- The visits room CCTV system had been out of action for over six months at Prison E.
- Although Prison F owned an x-ray machine it was not used on visitors' property or clothing exchange.

---

[3] It should be noted that videos, posters and supportive literature are available to visitors detailing who to contact, in confidence, if under duress to bring drugs into the establishment.
[4] In the 12-month period April 2003 to March 2004 a total of 146 visitors were banned and 42 prisoners were found guilty at adjudication of offences involving drug smuggling through visits across the six study sites.

In many cases, a lack of resources was blamed for poor security. Individual prison dog teams had been removed and were being shared within local clusters. Dedicated search teams and visits teams had been disbanded.

Sending drugs into prison through the mail

This was the second most frequently mentioned way of getting drugs into prison. The interviewees detailed a large number of possible ways of concealing drugs in prison post. These included drugs concealed:

- under stamps and envelope flaps;
- in the barrels of felt tip pens;
- between the pages of magazines;
- in the tongues or soles of trainers; and
- in electrical goods and clothing sent in by post.

In most cases, the amount of drugs that can be concealed is limited and heroin is more likely to be sent in the post than cannabis because of its smaller bulk. A prisoner expecting a parcel containing drugs would often badger a wing officer for the parcel, causing maximum disruption in the hope that the officer would hand over the package after only a cursory inspection.

Sending drugs into prison by post was a practice well known to the prison staff interviewed and some prisoners acknowledged that it was no longer worth trying to send in small amounts of heroin under stamps, for example, since:

> *"Everyone knows about that now."* [Prisoner, Prison C]

Indeed, this was an area where there was a broad consensus that the Prison Service had made substantial gains in preventing drug smuggling. At all the study prisons, with the exception of Prison C, prisoner and ex-prisoner interviewees felt it was much harder to get drugs in by post than it used to be. The reasons given for this were:

- the restriction of items allowed for personal possession;
- the requirement to have magazines and electrical goods delivered direct from the retailer; and
- the use of x-ray machines and drug dogs.

However, it should be mentioned that two of the study prisons (Prison C and Prison F) had, but were not using, x-ray machines to vet incoming post at the time of the research.

New prisoners bringing drugs into prison

All the prisons studied were local prisons serving the courts in their area; as such they had large numbers of new prisoners entering the penal system through their gates.

Almost one in four of the interviewees[5] brought drugs into prison with them during their latest stay in custody. The process of concealing drugs internally (for men usually in the rectum, known as 'plugging' or 'bottling', and for women usually in the vagina, known as 'crutching') is very hard to detect. Interviewees explained that this practice is usually undertaken by drug-using offenders who wish to have a supply of drugs for their first few days inside, either to cope with withdrawal or to trade for other items to make prison life more bearable. Defendants on bail who know they are at a risk of custody will often conceal drugs before going to court. Some ex-drug users or non-drug users also bring in drugs in this way as an important source of prison income.

Again, the constraints on intimate searching make this a very difficult practice to tackle, and a sizeable amount of drugs can be brought in this way.

---

[5] 22 out of 93 who answered this question.

"I knew I was going down so I concealed six bags [of heroin]. I knew I was going to withdraw, they don't give you enough on detox." [Prisoner, Prison D]

"A girl came in on Friday with an ounce each of heroin and crack (she was a dealer outside). My pad mate knew her, she got the foil out and it was right in my face. There were 80 on the wing and we all used that weekend, we were all smashed." [Prisoner, Prison F]

Prison staff bringing drugs in

A considerable number of prison staff and prisoner interviewees at all the study prisons, with the exception of Prison F[6], stated that prison staff were involved in bringing drugs and mobile phones into prison.

At two of the study prisons, officers had been apprehended. There were two known instances of uniformed prison staff bringing drugs into Prison A in the two years prior to the fieldwork; one member of staff had been convicted of supplying drugs into Prison C in 2001 and had been sentenced to seven years' imprisonment.

The Drug Strategy Co-ordinator at Prison D estimated that three or four members of staff could be either actively bringing drugs into the establishment or allowing them to be brought in. A package of drugs found in the staff search area in early 2003, combined with drug dog and other intelligence had increased his suspicions regarding drug supply through officers.

In another location (Prison E) three prisoners commented on the relatively large number of mobile phones that had been smuggled into the prison and one stated that he knew of seven incidents involving three different prison officers in which either drugs or mobile phones had been brought in over a three-month period.

An interviewee at Prison B told the research team about persuading an officer to bring in a pack of tobacco containing drugs:

"I asked her to get tobacco from my missus, she said she'd get me some herself but I convinced her to pick it up from my wife. She met my wife in a pub, and my wife left the stuff in the toilet. The officer collected it and brought it in for me. It had cannabis in it, the officer must have known." [Ex-prisoner, Prison B]

When asked how a member of staff might get involved, both prison staff and prisoners stated that this may happen when an inmate knows an officer in the community. Once an officer has been persuaded to bring in any contraband once, he or she is vulnerable to blackmail and may find it very difficult to stop doing so.

Prison staff were increasingly aware of this practice and spoke of it much more openly than in past research the authors have conducted into drug use in prison. At Prison A several members of staff felt that security measures directed against staff were not sufficiently stringent and that staff should be encouraged to confide in managers or a confidential service if they were being pressured into smuggling drugs or felt they had made an error of judgement. The Security Department at Prison D was engaged in identifying vulnerable members of staff at the time of fieldwork, and it was hoped that the introduction of the Professional Standards Unit would help in this task.

Drugs being thrown over perimeter walls and fences

The incidence of drugs coming over the perimeter walls and fences varied considerably between the six prisons. All interviewees agreed that no drugs came into Prison A by this route, mainly because the modern design and location of the prison essentially made it impossible to throw packages into exercise yards and other areas frequented by inmates.

At Prison B, the Drug Supply Reduction Team had succeeded in closing off this route by relocating the exercise yard and instituting daily checks of target areas. Although drugs being thrown over the walls

[6] Only one member of staff and one prisoner mentioned this route, neither giving any details.

was mentioned by a considerable number of prisoners at Prisons C and F, on further exploration it was found that such events were talked about much more than they actually occurred.

At Prison E, however, staff and inmates were aware that this was a route of supply for two wings whose exercise yard was close enough to the perimeter wall. Large quantities, including slabs of cannabis, were known to have been smuggled in by this route and one had been intercepted just prior to the authors' fieldwork. One prisoner provided details:

> *"Bars of cannabis on two wings who use a particular exercise yard are thrown over at the same time as exercise. The yard is only supervised by one camera and two officers, one prisoner distracts the camera and over it comes. It's picked up in seconds."* [Prisoner, Prison E]

At Prison D, this supply route had become very significant, due in part to increased security on visits. Drugs were being concealed in the same brand of food or toiletry packaging sold in the prison canteen and discarded by prisoners out of their cell windows. Drugs thrown over at night were being collected by unsupervised yard cleaners. There were a number of mobile phones in the prison which were being used to organise drug drops to certain exercise yards:

> *"My pad mate was arranging drops on a mobile [phone] in the cell when I arrived. The drugs were thrown over during exercise but the parcel had only made the inner fence and my pad mate called on his mobile for them to send another one over because it hadn't made it!"* [Ex-prisoner, Prison D]

Prison staff were of the view that incidents where drugs come in over the wall are well organised with both prisoners and people outside the perimeter using diversionary tactics in order to breach perimeter security. One prisoner told the interviewers that a large amount of drugs is usually thrown over for distribution among a group of dealers:

> *"Obviously you take a chance over the wall because they catch 90 per cent of it, but once one package is through it will make up for what you've lost. A £10 [street] bag [of heroin] can make four bags inside. It's worth taking that risk, that's why there's never a drought in prison."* [Prisoner, Prison D]

The prison had been relatively slow to respond to this problem. Although there was an intelligence-led operation being conducted at the time the authors conducted their fieldwork, they were told that discussions had been going on for 18 months regarding the employment of unsupervised prisoners to pick up the rubbish (and drugs) in outside areas.

Prisoners bringing drugs back from court appearances

Twenty-seven respondents reported that a route of entry for drugs into prison was reception after court appearance. At Prisons A, B and C in particular, 18 prisoner interviewees specifically stated that it was possible to get drugs when appearing in court and to bring them back into prison concealed internally.

Ten prisoners at Prison A stated that they were able to get drugs via contact with family members, solicitors or court security staff. One prisoner at Prison B described how escort service contractors would hand prisoners cigarettes from family or friends present in court which were filled with drugs. There are, to the knowledge of the authors, no searches of legal or security staff, nor are drug dogs present. The internal concealment of drugs by prisoners makes detection unlikely.

It is worth noting that, despite the installation in some establishments of live video links with Magistrates' Courts used for seven-day and 14-day remand hearings, no prison officers mentioned this as a positive step in tackling court appearances as a route of supply. If used comprehensively, video link suites could cut off an avenue of drug supply into prisons.

Other routes

A small number of interviewees mentioned other ways of getting drugs into prison. Prisoners reported bringing in drugs concealed internally on return from home leave. Contractors, including delivery drivers, were mentioned at two prisons as being suspected of bringing in drugs. Solicitors and others coming in on legal visits were cited as bringing in drugs by 11 interviewees (nine prisoners and two staff) at four different prisons and the practice of concealing drugs in clothes sent in to prisoners was mentioned by nine interviewees at five different prisons.

Discussion

Although the same basic routes of drug supply were were reported as being used by interviewees in all six prisons, it is clear from this qualitative research that local enforcement makes a significant impact on prisoners' decisions on how to get drugs in.

The demand for drugs amongst prisoners and the sources of supply are such that unless enforcement is brought to bear effectively against a number of trafficking routes, the main effect of increased security is merely to change the routes used. So, in Prison D, the success of enhanced security in the visits hall has led to reliance on the most basic 'throwing drugs over the wall' approach. This technique has proved surprisingly successful owing to the prison's limited success in tackling the 'pick-up' part of the operation and to prisoners' capacity to control closely when and where drug packages come in by the use of mobile phones (mobile phones also enter prison via the same supply routes as drugs).

The prison service has had considerable success in greatly reducing the amount of drugs that come in by mail, but continues to struggle in preventing drugs being brought in by social visitors. The degree of co-ordinated preventative measures employed in tackling visits varied considerably. Prison B has an intelligence-led operation with passive dogs, x-ray machines and closely scrutinised CCTV. In contrast, at Prison E, the CCTV system had not been used for more than six months and at Prison C, dogs are a rarity and searching erratic. Staff at several prisons lamented the worsening of security owing to staff shortages and tightening resources which had resulted in the disbanding of dedicated search and visits teams and the less frequent deployment of drug dogs.

It is clear that a dedicated drug supply reduction strategy can make a difference if properly resourced. For example, prisoner interviewees expressed the view that drugs were in shorter supply at Prison B (which was attributed directly to the work of the Drug Supply Reduction Team), whereas they were considered easier to come by at Prison E (which at the time of the research had no operational CCTV in its visits room and lax searching of prisoners after visits).

4. Buying, selling and the marketplace

Prisoners and ex-prisoners interviewed from all six establishments said that there were drug sellers or dealers on their wing (see Table 4.1). Indeed, over two-thirds of the interviewees (n=84) stated that drug dealing went on in their local prison, and a smaller number (n=33) said that there were large-scale dealers at the prison, selling to five or more people. The majority of respondents explained, however, that no single dealer exercised overall control of the drug trade due to the transient nature of the local prison population.

Table 4.1: Prisoners/ex-prisoners stating drug sellers/dealers were present on wing

Prison	Number stating there were sellers/dealers on their wing	Total no. of respondents
A	20	26
B	11	19
C	25	29
D	14	21
E	9	12
F (Female)	4	14
Total	**83**	**121**

In this chapter prisoners' views on the motivation of drug sellers are discussed, and three levels of drug dealing identified. Next, the drug transaction in prison (including arranging purchases, methods of payment, drugs prices and the mechanics of the exchange) is examined. Finally, the connection between the drug market and violence in prison is discussed.

Three levels of drug dealing in prison

Based on findings from interviews with staff, prisoners and ex-prisoners, as well as analysis of SIRs, three levels of drug dealing in prison were identified.

- Low-level opportunistic and mutual supply among drug users, involving swapping and sharing drugs with friends.
- Middle-level dealing in order to make prison life more comfortable as well as maintaining the prisoner's own drug use if he or she is a drug user.
- Higher-level dealing, implying a greater degree of organisation, contacts and resources, which extend outside prison, in order to make a profit from selling drugs in prison.

Opportunistic and mutual supply of drugs

Much dealing that goes on in prison is low level and opportunistic, often involving 'sorting friends out' in exchange for canteen items (especially tobacco) or a share of other drugs. The trade in drugs at the female prison (Prison F) tended to be confined to swapping or sharing with friends:

> *"No organised trade, just trading with mates when people haven't got tobacco, normally just sort mates out. It's more opportunistic, if a visit falls right or someone comes in off the street [with drugs]."* [Prisoner, Prison F]

> *"No selling or dealing, just a case of if they managed to get any in on visits they shared it between whoever they were friends with."* [Ex-prisoner, Prison F]

This level of dealing also went on in the five male local prisons studied, and indeed formed the bulk of drug supply and trade.

"My padmate was getting visits. Some weeks he got no visits but if he went out one week we'd smoke for four days and he'd sell some to get canteen. I got Subutex [buprenorphine] and shared with him in exchange." [Ex-prisoner, Prison C]

It is important also to mention the mutual supply and trade in medication prescribed through prison healthcare. This was said to be very common in all establishments. The misuse of medication was important as an alternative to heroin and cannabis, which were less available, or for use in combination with those drugs to enhance their effects (especially sedative effects). The most commonly mentioned non-prescribed drugs were benzodiazepines, anti-depressants (particularly amitriptyline) and opiate-based painkillers including those prescribed for heroin detoxification (methadone, dihydrocodeine and buprenorphine).

"If they gave you proper meds in here you wouldn't use. All you do is trade [tobacco] for tablets. I've been in for four and half months and I haven't slept properly yet." [Prisoner, Prison F]

"A lot are selling meds for tobacco, it's a hard thing on the detox wing, it's hard to let your family know where you are, so you've got no money for tobacco, so you go down [to the dispensary], keep the meds in your mouth, and then sell them." [Prisoner, Prison D]

Interviews with prisoners and ex-prisoners indicated that drugs prescribed in liquid form could be kept in the mouth and spat back into a container when not being observed. Drugs prescribed in tablet form and required to be taken under supervision can be stuck under the tongue, by the gum or on the roof of the mouth, to be scraped off later in the cell, or spat down prisoners' jumpers or tracksuit bottoms for later retrieval. Prisoners agreed that the length of the medication queue meant that it was easy to avoid being caught. Prescription drugs dispensed for self-administration (referred to as 'in-possession medication') were considered easy to obtain and trade.

Using drugs as a form of currency to make prison life more comfortable and maintain own drug use if a drug user

Prisoners and ex-prisoners interviewed from all establishments explained how drugs are often used as a form of currency to purchase canteen items including tobacco, tea, coffee, sugar, food and toiletries to make prison life more comfortable. Local prisons contain an easily identifiable population that prisoners in possession of drugs can target: those coming off the detoxification wing or unit, and those receiving chemical detoxification on normal location. These prisoners are likely to be experiencing withdrawal symptoms, particularly sleeplessness, and may even have continued using drugs taken in with them on reception. As such they are likely to agree to purchase drugs in exchange for canteen items. Any prisoners operating as dealers might also buy drugs from those wishing to 'set themselves up'.

"Girls that come in and out regularly and know the runnings of the place, they can come in with drugs and can trade straight away with girls on [X] wing, because when girls get off detox [onto X wing] and they're rattling, they're that poorly, they want to buy drugs. When you first come in it might take a couple of weeks before you get any money or canteen, no job allocation, no spending money, so by bringing drugs in to trade they can get everything they need for their room, canteen, tobacco, toiletries, plus they big up their jail cred." [Prisoner, Prison F]

"*You use drugs to get yourself kitted out for what you need, to buy decent canteen instead of use the crap they give you. It's handy to have drugs to get yourself started – to buy cereals, bread, shower gel, decent razors – these would take months to accumulate. It's a choice of buying with drugs or using the prison razors which shred your face to ribbons, buying decent shampoo, or using the crap they give you."* [Prisoner, Prison C]

"*I went in with drugs stashed which I had to wait to pass my system. I contacted a dealer and told him I had some stuff stashed and I asked to be sorted out in return for some of my stash.*

Once the stash came out I paid the dealer back and had enough to keep me going and to trade." [Prisoner, Prison A]

Prescribed medication is also an important form of currency for some:

"*People sell meds to get tobacco and toiletries. People on [landing X] don't work because there's not enough jobs so they haven't got an income coming in. They sell meds to support a basic lifestyle."* [Prisoner, Prison B]

"*I traded my tramadol – half an ounce of [tobacco] for three pills. I had everyone on my case. I used to have 28 tablets a week in possession. I had about 20 people coming to my door."* [Ex-prisoner, Prison C]

Some prisoners said they were managing to obtain drugs on a regular basis, usually through social visits, and sold these in exchange for tobacco, phone credit, canteen items and other drugs. One ex-prisoner at Prison C had received cannabis through visits on a regular basis.

"I had cannabis brought in by my girlfriend through visits and used it to trade for heroin on the wing. At first I got a visit every other day, quarters and half ounces in at a time, and then I thought it was less risky to bring in an ounce at a time. I sold regularly, everyone was mad for it, escaping for a few hours or getting a good night's sleep. I used to bail a bit out for phone credit, or cash sent in to my account." [Ex-prisoner, Prison C]

An ex-prisoner from Prison A told the interviewers:

"*I was a dealer, you have others running drugs for you. I'd write what canteen items I wanted (tobacco, biscuits etc.) on a list, then the runners would have to get people to pay for the drugs with those items. I stored my excess canteen in other people's cells so as not to arouse too much suspicion."* [Ex-prisoner, Prison A]

Organised dealing for profit

At all the male establishments prisoners and ex-prisoners who were interviewed said that there were a small number of dealers who were selling drugs for profit. Often dealers in the community, these prisoners have the contacts and resources to ensure a continuous supply of larger quantities of drugs into the establishment, either through social visits or another route (commonly over the wall at Prison D). This level of dealing often involves the use of mobile telephones smuggled into prison via reception or visits, or thrown over perimeter wall or fence. Organised dealers usually employ a number of different prisoners to receive drugs on visits, hold drugs in their cells or elsewhere, make deliveries and collections (runners), provide protection, and 'collect' debts. Runners are commonly paid in drugs.

"*Some dealers only accept outside payments – they ain't in it for canteen, they're in it for money – and they won't part with the drugs until the payment lands."* [Prisoner, Prison C]

Security staff at Prison D explained that:

"It's organised dealing. The main players stand aloof while holding no drugs, cash or property, while other people are running around and holding drugs in return for their own personal supply. A lot of people see it as petty dealing because of the amounts involved, but it's an extension of what's on the street where there's a lot of money and organisation. Inside it's a captive audience, a ready-made market, and with dealer networks a lot of them are obliged to carry on dealing once inside." [Security Manager, Prison D]

"It's a local prison so if police do a clean-up of dealers, if they're all inside they'll all want to try to get drugs in from remaining gang members outside. The ones on the outside will help the ones on the inside, it's a well-organised operation, you can tell a lot from the amount of drugs intercepted on visits and over the wall." [Security Staff, Prison D]

A prisoner also explained that:

> *"I think it's easier to get drugs on the wing than it would be if I went outside now, because they're always there. You'll get drug dealers who are locked up and getting drugs brought in and they're getting three-times-fold the money. People will try and get drugs to someone in jail because more money can be made and money comes back out."* [Prisoner, Prison D]

Completing a drug transaction in prison

Of 96 prisoners and ex-prisoners who had used drugs during their current or most recent period of imprisonment, 93 respondents explained how they had obtained their first and subsequent supply of drugs (see Table 4.2). The most common means of obtaining the first supply of drugs was by purchasing them on the wing, either from someone already known from outside prison (n=19), or from a new seller (n=21). Purchasing drugs on the wing was also the most common method of obtaining subsequent supplies of drugs.

Table 4.2: How prisoners/ex-prisoners obtained their first and subsequent supply of drugs in prison

Method of obtaining drugs	First drugs used	Subsequent drugs used
Imported drugs through reception	22	1
'Given' drugs by friends/cellmate	22	15
Purchased on wing from new seller(s)	21	16
Purchased on wing from somebody already known from outside prison	19	29
Received drugs through visits	5	17
Swapped drugs with friends	4	6
Mail	-	3
Total	**93**	**NA**[1]

1. No total given since some prisoners got no further supplies of drugs, and some prisoners used more than one method to obtain subsequent supplies.

Arranging to buy drugs in prison

Interviewees explained that arranging to purchase drugs in prison worked in a similar way to purchasing drugs in the community: it required either knowing the seller or dealer already, or getting an introduction through someone else. This was particularly the case when buying heroin.

> *"If you're new you've got to know who to go to, you have to know the people to get it from, but cannabis you get all the time."* [Prisoner, Prison B]
>
> *"It depends who you know, and how you hustle to get it. There could be five people you know from the street who are dealers, it's easy for me because I know certain people, but there could be people in there that you don't know who've got drugs and you won't get nothing."* [Ex-prisoner, Prison E]

Methods of payment

Prisoners and ex-prisoners who had used drugs during their current or most recent period of custody (n=96) had paid for them in six main ways:

- Canteen (n=74)
- Outside payments (n=31)
- Personal property (n=18)

- Swapped for other drugs (n=17)
- Services (n=8)
- Cash (n=7)

The principal method of payment was with canteen items (mentioned by 77% of respondents). The second most frequently used method of payment was outside payments. Prisoners used the term 'outside payment' to refer to three different ways of paying for drugs.

- Sending money from the prisoner's private account to an outside address as specified by the dealer.
- Arranging for somebody on the outside (usually a family member) to send money to an outside address.
- Arranging for somebody on the outside (usually a family member) to send money to a prisoner's private account.

Items of personal property, including jewellery, trainers, clothes and electrical items such as stereos were also used to pay for drugs. These items were either sent in from outside, or ordered through the prison catalogue system. Drugs were also often 'paid' for through swapping for other drugs or prescribed medication. A minority of respondents told the interviewers they had paid for drugs via services rendered, usually acting as a runner for the dealer.

> *"I got drugs in jail by grafting – X wants to buy a bag [of heroin], so I go and get it [fetch it] and get to keep some for myself."* [Ex-prisoner, Prison D]
>
> *"I work at weekends [as a kitchen worker] when everyone's locked up – I get asked to take drugs from one cell to another – I get [tobacco], a bag [of heroin] or a [cannabis] spliff in return, the [cannabis] I'll keep, heroin I'll sell on."* [Prisoner, Prison C]

Finally, some prisoners had smuggled cash into prison via reception or social visits in order to purchase drugs. The interviewers were also told that prisoners sometimes asked other inmates who were not receiving 'privates' (private income) if they could have private cash sent in to that account as well as their own, in order to increase the amount of money they could use to buy drugs. The prisoners allowing their account to be used in this way could keep one-third of the money.

Drug prices

The most common method of payment for drugs was with canteen items and it is therefore unsurprising that drug prices are commonly expressed in terms of 'items'. One item is equivalent to half an ounce of tobacco (worth £2.40) or other canteen products (such as shower gel) valued at approximately £2.00 per item. Prisoners told the interviewers that there was a mark-up when using canteen items, rather than tobacco, as payment for drugs. A cannabis joint cost one item, and a small amount of heroin, referred to as a £10.00 prison bag or 'joey', consistently cost four items across all six establishments. The street value of a prison bag was most frequently given as a quarter of its cost inside. In other words, a £10.00 bag in prison is worth only £2.50 on the street. Buprenorphine commonly cost one item per 2ml. Crack commanded an inflated price, as two prisoners explained:

> *"The crack I was getting in, because that's so rare, for a tiny little pipe you couldn't believe what I could get – tablets, anything I wanted, even a quilt once, for crack, they'd go mad for it."* [Prisoner, Prison F]
>
> *"The reason why I don't smoke crack in prison is because I haven't got the time and people think you're a target, it makes you vulnerable, they know you'll take any rubbish for canteen items, you'll have people walking all over you. They'll come in your cell and take all your canteen for crumbs."* [Prisoner, Prison E]

The exchange and movement of drugs around the prison

The exchange of drugs and payment and the movement of drugs around the prisons were considered to be relatively easy by all interviewees. Drugs could be swapped for other drugs or canteen items in a variety of settings:

- Church;
- gym;
- workshops;
- education;
- association;
- visits; and
- dinner queue.

Prisoners talked about being able to attend both Church of England and Roman Catholic services in order to exchange drugs, or book non-existent visits in order to meet up with another prisoner. Particular significance was attached to the role played by cleaners, kitchen, hot plate or servery workers, laundry workers and listeners. These prisoners were able to move freely around the establishment and act as runners, conducting transactions at cell doors during lock-up periods, as well as enabling the movement of drugs between wings.

The drug market and violence in prison

Of those who answered an open-ended question (n=78) asking what is bad about using drugs in prison, around a third (n=25) stated that the expense of buying drugs in prison resulted in debt or being short of things (particularly tobacco, canteen and toiletries). Debt might lead to prisoners putting pressure on family members to bring in drugs or make outside payments as well as threats of violence from creditors. Due to the fluctuations in availability of drugs in prison, withdrawal from a "jail habit" was also commonly mentioned (n=21) as a negative aspect of using drugs in prison.

> *"Using is a wind-up to other people, you get people growling at you cos they ain't got none, it can cause you a lot of grief. And you have to go through a rattle, it sets you right back to square one. You get bad mood swings, and you don't enjoy it because everyone's looking at you."* [Prisoner, Prison F]

> *"The bad things are getting in debt, leaving yourself short for things you need (toiletries and food), it can get to that, the temptation is to have too much and the deals were crap."* [Ex-prisoner, Prison D]

The combination of the need for drugs (to avoid withdrawal), and being in debt for drugs or simply unable to afford them inevitably leads to tensions in prison. A majority (72/121) of prisoner and ex-prisoner interviewees agreed with the statement that the trade in drugs is the major cause of violence between prisoners. Reasons for drug-related violence given by prisoners included:

- unhappiness with the size of the deal, being 'ripped off';
- dealers refusing to 'give out' (supply drugs when they have them);
- prisoners not sharing drugs when they have them;
- scarcity of drugs;
- debt and inability to pay for drugs;
- robbery of others for their stash of drugs; and
- withdrawal from 'jail habit'.

The following quotes from prisoner interviewees are typical:

> "*If someone's holding back and you're ill, especially if you've been a customer of that person."* [Prisoner, Prison D]

"*Definitely, the frustration involved with obtaining [drugs], especially waiting for outside payments to land."* [Prisoner, Prison C]

"*Well it happened to me – a lass were getting a visit and said she'd sort me out, but she didn't. I could tell she had some and I ended up hitting her."* [Prisoner, Prison F]

When asked whether violence was ever perpetrated on those believed to have drugs in order to steal their supplies, many of the interviewees who answered the relevant question (n=96) said that such violence did occur, either occasionally (n=49) or frequently (n=33):

"*Certain people get visits and are weak; it's survival of the fittest. People who get drugs and let people know they've got them, they're setting themselves up to be robbed."* [Prisoner, Prison C]

One prisoner told how he was involved in taking other people's drugs to sell on:

"*Me and my mates would find out who was bringing it in and go and take it off them. There were five of us, all the most well known in the prison, the top people. If someone gave us something out of the kindness of their heart then there was no need to take it off them."* [Ex-prisoner, Prison B]

Prisoners at Prisons B and C in particular spoke of the negative effects resulting from increased security around the main routes of prison drugs supply. As an ex-prisoner from Prison C explained:

"Compared to when I was in [Prison C] two years ago it was a lot more hectic, a lot more hyper – the pursuit of anything to get off your face. People would sniff just about anything. While I was there, there was a riot, someone got his throat cut, I saw a kid come out of his cell all bashed up. I've read because they've clamped down on drugs coming into [Prison C], what's there is at a premium. You're paying a lot more for less and prescription drugs play a big part". [Ex-prisoner, Prison C]

A reduction in drug supply has led to increased bullying for medication, either by those who need it to avoid withdrawal symptoms, or those who wish to benefit from its sale. Again, prisoners and staff interviewed at Prisons B and C in particular mentioned the high incidence of bullying for medication.

"*People on Subutex [buprenorphine] and Valium [diazepam], other inmates find out they're on them and basically threaten them before they get that day's supply and they come back with that day's dose for them. It's a big problem at [Prison C], people getting all their medication taken off them."* [Ex-prisoner, Prison C]

"The system of prescribing medication is wide open to abuse. The problem is that prisoners are getting issued too much medication in possession at a time. It becomes a security issue with bed watches which result in staff shortages and regime disruption." [Security Manager, Prison B]

Discussion

This mainly qualitative research carried out in six local prisons shows that the high proportion of new receptions to the prison system with an established drug or poly-drug dependency results in an environment where drugs are in demand and are valuable as both currency and commodity. As such, a prison drug market, albeit operating at differing levels, is set to thrive. The successful disruption of this market can only be achieved through a combination of a reduction in drug supply through improved security and adequate drug treatment. Interviewees also reported negative consequences associated with an increase in security, namely bullying, violence and withdrawal, which likewise need to be tackled.

It is essential that prisons provide adequate detoxification to reduce prisoners' withdrawal symptoms and alleviate their need to import or purchase illegal drugs or other prisoners' medication. Prisons must increase their efforts to reduce supply. This will reduce opportunistic use, and with it the risk of

prisoners developing ‘jail habits’ in custody. Finally, it is essential to recognise that increased security can have perverse effects. It can displace supply routes, rather than eliminate them. It may result in increased pressure on new inmates, including intimidation and robbing of those believed to have imported drugs into prison, and a higher incidence of bullying of prisoners for their prescribed medication or detoxification drugs.

5. Drug treatment in local prisons

The quality and capacity of drug treatment provided in prisons has increased considerably since the early 1990s, the pace of change accelerated by the Prison Service Drug Strategy (1998) formulated as a response to the first National Drug Strategy (Home Office, 1995). In the early days of improved treatment, many prisoners were reluctant to take up the services offered. Wary of the quality of treatment provided, they often preferred to try to secure their own supply of drugs to avoid withdrawal symptoms. This has gradually changed and in 2003 45,695 prisoners underwent detoxification from drugs, 30,771 were on drug-free wings, and 46,261 underwent an initial assessment by Counselling, Assessment, Referral, Advice and Throughcare services (CARATs).

Nevertheless, there remain strong connections between prisoner take-up of treatment services and the availability of drugs inside. In this chapter, the four main categories of drug treatment provided in prison are examined:

- detoxification;
- treatment programmes;
- drug-free wings – also known as voluntary testing units (VTUs); and
- CARAT services.

Detoxification

The six prisons studied offered a range of detoxification programmes which are summarised in Table 5.1. The detoxification regimes most valued by staff and prisoners who were interviewed were those offering buprenorphine. At Prisons A and C, most of the prisoners interviewed who had undergone detoxification with buprenorphine preferred the process to previous detoxifications they had experienced. A minority of prisoners reported a less favourable experience and it appears important to offer a range of detoxification regimes. Nonetheless, several of those who had been prescribed buprenorphine were very positive indeed, stating that it made the whole withdrawal process something no longer to be feared.

Table 5.1: Types of detoxification programme at six local prisons

Prison	Buprenorphine	Dihydrocodeine	Lofexidine	Methadone
A	✓			✓
B			✓	
C	✓			✓
D		✓		
E				✓
F (Female)				✓

As reported by prisoner and staff interviewees, the main problem with buprenorphine detoxification was that some prisoners were pretending to take their buprenorphine, and later selling or giving it to other prisoners who crushed and snorted it in order to get an intoxicating effect. In Prison C in particular, this meant that some prisoners who wanted to be drug free were put under pressure to hand over their medication:

> *"People shouldn't be pressured to give their Subutex [buprenorphine] out because it messes up their detox. I saw some people had knives to their throats. I was intimidated, really I just wanted to do my detox but was pressured to get Subutex out of healthcare, Subutex was holding me properly, you don't feel ill, so I wish I had done the programme."* [Ex-prisoner, Prison C]

The detoxification nurse at Prison C explained his technique for trying to stop this practice:

> *"When I give it to them, I watch them closely, they are not allowed to put their hands near their mouth. Then I check their mouth, ask them to swill with water and then re-inspect. I also give them a mint, this is nice for them because Subutex [buprenorphine] has a bitter taste, but it's good for us, because the mint contaminates the Subutex."* [Detox nurse, Prison C]

Prisons E and F both offer methadone-based detoxification. Prison E has a 14-bed unit, although detoxification is offered throughout the prison. Two automated dispensing machines enabled Prison E to detoxify 40 prisoners per week in the financial year 2002/2003. Prison F (Female) has a dedicated 44-bed detoxification wing. Women are offered a ten-day methadone detoxification for opiate dependency, beginning with three days of stabilisation followed by seven days on a decreasing dose. Women on methadone scripts in the community are offered an extended detoxification lasting 21 days. There is also a 12-week benzodiazepine detoxification (liquid-form diazepam).

Opinions on the methadone detoxification amongst the prisoners interviewed were split, with some prisoners finding it a good service and others less so. The main complaint was of too short a detoxification programme, leaving prisoners still experiencing withdrawal symptoms at the end of it. Prisoners at Prisons A and E complained that diazepam was prescribed too early in the day, making them tired in the day and unable to sleep at night.

The detoxification manager at Prison E stated that applications for detox had reduced recently – she felt in response to the greater availability of drugs within the prison. However, both prisoners and staff at Prison F favourably compared the methadone detoxification regime with the previous dihydrocodeine programme.

Dihydrocodeine forms the basis of the detoxification regime provided at Prison D on its dedicated 62-bed detoxification wing. The ten-day programme is followed by a ten-day group work programme. The majority of the 16 interviewees who had undergone the detoxification complained about the length and dosage structure of the detoxification regime saying that it prolonged their withdrawal. CARAT staff also said that smuggled heroin was available on the detoxification wing. The most recent Inspectorate report suggested that some prisoners abandoned the detoxification programme, seeking relocation to the main wings where they could buy drugs, because the programme was not effectively managing their withdrawal symptoms.

The lofexidine detoxification programme provided at Prison B was considered inadequate by all the interviewees who had experienced it (n=19). One prisoner, with experience of detoxification in other prisons, expressed shock at the poor quality of service offered at Prison B:

> *"I've lost weight since I've come to prison and I find that really fucking hard to believe, I came in here and it's been terrible. If they prescribed Subutex [buprenorphine] I'd be quite well, I would have slept. I've been in 15 days, I'm still aching, still sore, I'm hurting. [Prison B's] detox programme at the moment is terrible, they use lofexidine and give you far too much of the bloody stuff. They give you blister packs for three days; some lads are saving them up and taking about 15 to 20 tablets at a time. It lowers your blood pressure, you basically collapse, they're doing it simply to get their heads down at night. I think that's why you get a lot of bullying."* [Prisoner, Prison B]

Treatment programmes

Only one establishment studied (Prison E) ran a drug treatment programme since most of these are not located in local prisons. Staff and prisoners interviewed at Prison E had a high opinion of the Rehabilitation for Addicted Prisoners Trust (RAPt) drug treatment programme which is a rehabilitation model based on a 12-step philosophy. It was described as being a well-designed programme with good working relationships between drug workers and prison officers. It was felt appropriate for those prisoners who were motivated to make significant changes in their drug use. The programme had limited capacity; one of the interviewees complained that he could not get on the course before his release in 11 weeks' time. However, at the time of the Inspectors' visit, there were vacancies on the initial phase, related to the lack of marketing of the programme. One of the interviewees had direct experience of the programme:

"RAPt were good, they're friendly, approachable, very helpful, quite understanding of the situation." [Ex-prisoner, Prison E]

Drug-free wings

Drug-free wings, more commonly known as voluntary testing units (VTUs) are now established in most prisons – as noted above, over 30,000 prisoners were on such units in 2003. The basic premise of a VTU is that prisoners commit themselves not to use drugs and in return receive enhanced privileges. Prisoners are tested regularly for drugs to ensure they are complying with the programme. Signing up to a voluntary testing compact is often a condition of having a job or being placed on an enhanced landing, thus making voluntary testing programmes (VTPs) more about compliance than being therapeutic in their primary aim.

This study found that some prisoners who were interviewed preferred not to use drugs in prison, but found it very hard to be abstinent because of the constant presence of drugs on their wing, landing and sometimes in their cell. However, on VTUs the concentration of drug users in one place, sometimes with the opportunistic presence of non-user drug dealers using the VTU as a cover for dealing activity, can mean that drugs are more available on drug-free wings than anywhere else in the prison. This latter phenomenon was apparent at some of the establishments in this study. According to both prisoners and staff interviewed, there was more drug use on the VTUs at Prisons A and E than anywhere else in those prisons. Prison D had suspended its VTU for the same reason.

At the time of the fieldwork, there was no dedicated drug-free wing in Prison C, although many prisoners did sign a testing compact. At Prison F, few prisoners commented on the VTU; the three who did were split between those who thought it was a good idea in principle (2) and one who thought it was impossible to have a drug-free wing.

At Prison B, staff viewed their voluntary testing programme (VTP) as successful, a view underpinned by the proportion of positive drug tests on the unit, reducing from nearly 14 per cent in April/May 2002 to just three per cent in April/May 2003. However, some prisoner interviewees felt testing was not rigorous enough. Five prisoners specifically mentioned the practice of "strapping up" or "wearing a strap" to avoid positive test results on the VTP. A "strap" is a makeshift holder such as a toothpaste tube or tablet bottle containing a clean urine sample and carried next to the body:

"It is very easy to cheat on a VTP. With voluntary tests you can pretty much work out when they're due – if you suspect you're due you hold fire. There is a reasonable length of time before the next one, they do three over every two-month period so you've got plenty of scope in that. I personally think, now being an ex-user and seeing what drugs do, the officers should check that you've got no little bottles with piss samples – they should pay more attention and do more MDTs. I completely agree with voluntary drug testing – if it were more rigorous." [Prisoner, Prison B]

CARAT services

Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) were introduced into every prison in England and Wales in 1999. CARATs were intended to provide prisoners with a one-stop intervention for drug treatment within a new national network. Basic information and advice is made available to all prisoners, and assessment leads to onward referral or ongoing counselling within the CARAT service. The CARAT service provides a foundation for more intensive specialist drug treatment when sentence length and prisoner motivation make this viable. It provides referrals into treatment, and post-treatment support to try to ensure that the gains made in treatment are not lost.

Thirty-eight of the interviewees had been in contact with CARAT services in the six study prisons. They held a broad range of views, representing three main perspectives. Some (n=17) held broadly positive views about CARATs:

"The CARAT team were very valuable, a big asset. They are very busy but they have been very efficient in helping me organise rehab." [Prisoner, Prison E]
"CARATs was good - as long as you get to see them, the way they help you, they talk, they listen, it's better if you can make an appointment though, it's hard in a local jail because it's busy." [Prisoner, Prison E]

Fewer (n=11) felt that the CARAT team could be useful but they did not have enough staff to be effective:

"The CARAT service is under-funded, their hands are tied, they want to do more but they're not allowed, it's under-staffed and there's no actual programme." [Prisoner, Prison A]

"CARATs - they were good. A really nice, positive, helpful CARAT worker helped me get on a DTTO, put a word in with probation. But they're very stretched for time and resources, and not always reliable at keeping appointments, but it's not their fault." [Ex-prisoner, Prison C]

Finally, the remainder (n=10) held very negative views:

"CARATs are a waste of time - you had to tell them what was going on, I had to contact them, fill in a form for the VTP, I tried doing all this and it was ignored at court, no information was at court when I got there." [Prisoner, Prison D]

"The CARAT team is useless - I only saw them once in six months and that was as much help as you got off them." [Ex-prisoner, Prison C]

The problem of under-resourcing is compounded by difficulties in recruiting staff. At the time of the fieldwork, Prison A had four vacancies in its CARAT team and when the authors re-visited eight months later, there were still two vacancies – in this case, workers had been appointed some months previously but were still awaiting security clearance. There were also vacancies at Prison E. Various CARAT staff interviewed reported that these difficulties are made worse by the contractual obligation to meet key performance targets which are concerned mainly with the number of initial assessments. This leads to a prioritisation of initial assessments with insufficient time to provide follow-up work.

CARAT teams are, however, also tasked with delivering on the throughcare component of the service, by organising continuity of treatment with community-based drug services and in this research there were two positive examples of work aiming to support drug-using prisoners on release. At Prison C, an outreach worker attached to the CARAT team, although funded from a charitable trust, was providing a valuable aftercare service of up to eight weeks for those drug-using prisoners returning to the local area. Prison F had recently established a naltrexone clinic, available to sentenced women due for release from prison within two months. The clinic releases women on the opiate-blocker naltrexone, with a prescription that will last them until their first appointment at a community drug agency. The process begins two months prior to release, when the CARAT team assesses the motivation of prospective prisoners. If considered suitable, and subject to passing a liver function test, women begin a course of naltrexone, under the supervision of a detoxification nurse, five days before their release. The CARAT team organises an appointment for the released prisoner at her local drug treatment agency or with a GP, where the prescription can be continued. The detoxification nurse manager felt this was an important development since it would support women in the early days of their release and contribute to maintaining their drug-free status. At the time of this research, no monitoring of this initiative was yet underway.

Discussion

This mainly qualitative research conducted in six local prisons has shown that, despite the considerable increase in funding for drug treatment in prison, there remains a very long way to go before drug-using prisoners have routine access to good quality detoxification, treatment and aftercare. Although there has been some improvement in detoxification services, this is far from universal (although this research was not specifically designed to test this). In this study, drug-free wings did not live up to their name and CARAT services were under-staffed. The recent provision of

specific funding aimed at aftercare services for released drug-using prisoners may improve the throughcare component of this work.

6. Conclusions and recommendations

> *"Devising a policy for tackling drugs in prison is important. As well as reducing tensions and criminal behaviour within prison, it has a major contribution to make to reducing offending outside prison. The prize at stake for success is high. But there are very real difficulties which have to be addressed; these include the need to strike a balance between cracking down on the supply of drugs and providing humane treatment of prisoners, and a balance between a disciplinary and a therapeutic response to drug use in prison."*
>
> Home Affairs Select Committee Report on Drugs and Prisons, 1999

> *"The establishments that were most successful in reducing drug use integrated [supply reduction strategies] with demand reduction, by establishing a good detoxification service."*
>
> Annual Report of HM Chief Inspector of Prisons for England and Wales 2002/2003

This qualitative research has described drug use and drug markets in six local prisons. It is clear that drug use is commonplace within prisons, and that there are various routes by which drugs reach prisoners. The existence of drug markets in prisons brings with it a range of problems.

- Prisoners keep on using drugs whilst in prison, increasing the chances that they will resume dependent drug use on release.
- Some prisoners start drug careers when in prison, or broaden their existing patterns of use, for example starting to use heroin.
- Drug markets are associated with systematic violence and bullying, and represent a threat to the stability of prison regimes.

Levels of drug distribution – and thus levels of drug use – in these different establishments are a function largely of the interaction between the opportunities for bringing drugs in, the responses taken by the prison to limit these opportunities, and the facilities for drug treatment. Below, two sets of recommendations for containing prison drug markets are offered, relating on the one hand to drug treatment and on the other to anti-drug supply security.

The authors are conscious of the two main limiting factors on effective action. Firstly, prison budgets are stretched and have failed to keep pace with the growth in the prison population. Individual establishments have to spread resources too thinly across both security measures and treatment services. For example, as previously discussed, prisons were able to afford differing intensities of security checks during visits, with some being unable to deploy quite basic – but effective – surveillance techniques. Others were unable to provide adequate detoxification facilities and other treatment.

The second limiting factor presents problems that are in some ways thornier. Prison visits are probably the main route by which drugs come into these prisons. It is clear that visits could be controlled much more tightly, effectively closing this route. However, this would be at excessive cost, in terms of the added inhumanity that would be inflicted on all prisoners and their visitors - and indeed there is recent research indicating that prisoners could benefit in terms of their resettlement from the fostering of family ties (Niven and Stewart, 2004). Prisoners and visitors could be denied face-to-face contact; visitors could be screened more tightly and searched more thoroughly. However, such procedures could be highly degrading; and they might offer a greater threat to the legitimacy of prison regimes than a degree of drug use within prison.

This research has shown that supply of drugs in these prisons and demand for them, as reported by interviewees, are driven by two main sets of factors: firstly, the impact of security on the availability of drugs; and secondly, the efficacy of detoxification programmes and other drug treatment. There is a symbiotic relationship between treatment and supply which needs to be acknowledged. Prisoners' fear of experiencing withdrawal symptoms can compel them to take drugs into prison through reception, and their actual experience of detoxification, which is often short and lacking in a follow-up or aftercare

component, leaves them vulnerable to the temptation to use illicit drugs. As indicated by this qualitative research conducted in six establishments, the regime of local prisons, which often involves long periods of lock-up for remand prisoners, tends to encourage drug use as a means of coping with the reality of prison life.

Triangulation of findings from interviews and other sources, across the different locations, indicates that the improvement in MDT performance demonstrated by three establishments can be explained, at least in part, by either improved security measures or drug treatment.

Enhanced anti-drug supply security at Prison B

Prison B established a Drug Supply Reduction Team (DSRT) in 2001. The team has eight full-time officers, two dog handlers, four dogs and an x-ray machine at its disposal. The team is responsible for gathering intelligence, conducting area searches, acting as a presence on visits in addition to visits staff, searching the mail, administering the voluntary testing programme, and proposing improved security measures to tackle supply. One such measure was the closure and relocation of the main exercise yard in order to stem the supply of drugs over the perimeter wall. Prison B had the lowest proportion of positive rMDTs in 2003 among the study's five male local prisons.

Enhanced drug treatment and security of drug dispensing at Prison F (Female)

Prison F replaced its dihydrocodeine detoxification regime with a reducing methadone programme, extended for those on methadone prescriptions in the community. The new methadone programme, introduced in 2002, is considered by both nursing staff and prison staff to be a great improvement in terms of successfully managing opiate withdrawal symptoms. In 2002 there was an increase in positive MDTs for benzodiazepines, and this has been tackled through the dispensing of diazepam for benzodiazepine detoxification in liquid form from November 2002, thereby reducing the potential amount of diazepam tablets in circulation. Prison F had the lowest proportion of positive rMDTs among the six prisons, and performed considerably better than the national average in 2003 for all female locals.

Enhanced drug treatment at Prison C

Prison C now offers a buprenorphine detoxification programme, which prisoner and ex-prisoner respondents said had improved their experience of detoxification markedly in comparison to previous regimes. However, whilst Prison C had improved its MDT performance, it still recorded the second highest (behind Prison D) proportion of positive random tests in 2003 among the study prisons.

The authors only looked at one female establishment, Prison F, which had a low incidence of positive rMDTs, and a market which involved mainly low-level opportunistic and mutual supply. The low levels of use and any organised dealing at Prison F could simply reflect the prison's rural location and relatively good anti-drug supply security, but there may also be important differences between male and female establishments which would merit further exploration.

In contrast, all of the male study sites had particular problem areas. Prisons D and E were experiencing problems with perimeter security and drug supply via this route. Prison D was facing major difficulties in this area due to the scale of the problem, the lack of staff to form regular dedicated search teams, and a shortage of drug dogs. The success of Prison B in tackling drug supply through its dedicated Drug Supply Reduction Team masks clear shortfalls in its drug treatment. An isolated detoxification wing has only recently been established, and it is still only able to offer a non-clinical lofexidine regime, which by general consensus is acknowledged to be inadequate. Prisons A and C especially were experiencing difficulties in relation to dispensing buprenorphine and ensuring that prisoners did not retain it for redistribution. The misdirection and use of prescribed medication was reported as high by prisoners at Prisons B, C and E. Staff at Prison E expressed concern that their annual positive rMDT proportion had been rising steadily and that there had been a decrease in requests for detoxification, possibly reflecting increased availability of drugs.

The perverse effects of an imbalanced combination of security and treatment can be detrimental to success in supply reduction. The displacement of supply routes and trade which can be caused by

tight security coupled with inadequate treatment is of particular concern. Local enforcement currently has an impact on prisoners' decisions on how best to import drugs into prison, and/or obtain supplies internally, rerouted through prison healthcare or detoxification. For example, prisoner interviewees explained that the relative ease with which it was possible to throw and retrieve drugs over the perimeter wall and internal fences at Prison D had made this an increasingly attractive route above social visits, where the risk of being caught and the drugs intercepted was perceived to be higher. Where security was tight on all external supply routes (as at Prison B), and detoxification poor, there was a corresponding increase in bullying for medication. These displacement effects must be taken into consideration in the co-ordination of an effective drug supply reduction strategy.

What the research clearly demonstrates is that these prisons faced constraints in implementing a comprehensive strategy which tackled the problem of drug supply and demand from all angles, giving equal weight to security and treatment. The different approaches to supply and demand reduction at the six establishments varied in emphasis and had corresponding degrees of success. These approaches were dependent on the pressure on resources for the provision of both security and treatment.

It is unlikely that the supply of drugs into local prisons will ever be cut off completely, especially given the internal concealment of drugs by both prisoners and visitors on reception and social visits, as well as the importance of maintaining open contact visits for all prisoners. However, this realism should not be confused with pessimism; there is much that can be achieved in terms of security and treatment in order to continue to gain ground in the reduction of drug supply and demand in prison. The authors' findings lead them to a number of recommendations, outlined below.

Recommendations

The authors offer recommendations firstly relating to drug treatment and secondly relating to anti-drug supply security. They begin their recommendations with the caveat that MDT statistics and the perceptions of security staff are not necessarily reliable indicators of levels of supply and use and the success of deterrent measures in individual prisons. They would advocate regular local audits of drug use amongst prisoners, drawing on information provided by both treatment staff and current and ex-prisoners. Both Prison B and Prison F had carried out such audits, but there needs to be an annual commitment to the task. Only then can supply and use be tackled in a strategic and intelligence-led manner. The authors also note that all their study prisons knew what they should be doing to reduce supply but were not able to do it because of an overall lack of resources. A shortage of drug dogs, staff for dedicated search teams, and staff time to carry out dedicated searches, operate voluntary testing programmes (VTPs) appropriately, use mail scanners etc. meant that anti-drug supply security was often inadequate. Most of the study prisons reported struggling with inadequate resources, particularly in terms of staff time, but at some, drug supply and/or treatment were not accorded a high enough priority.

These recommendations are based on careful assessment of evidence from interviews and other sources from research carried out in six local prisons. While this qualitative research would not necessarily be representative of all prisons, it is the first systematic piece of research into prison drug markets to have been carried out in England.

Recommendations relating to drug treatment

- A good clinical detoxification regime is of paramount importance in tackling both supply and demand. The best detoxification regimes offer a choice between buprenorphine and methadone, and this should be standard practice across the local prison estate. The continuation of methadone maintenance prescriptions, particularly for short-term prisoners receiving prescribed methadone in the community, should be urgently considered.

- The growth in popularity of buprenorphine as an illegal drug means it is imperative that the dispensing of buprenorphine is organised in such a way that prisoners cannot keep their dose for illicit use or sale, and are not vulnerable to bullying from other prisoners to give up their dose. This requires close supervision of prisoners, as well as discretion in dispensing practices to reduce the visibility of those in receipt of buprenorphine.

- The lack of follow-up or aftercare for prisoners receiving detoxification must be reviewed. The vulnerability of prisoners once detoxification has been completed should not be underestimated, and if more support was in place some prisoners might not return to illegal drug use at this point.

- CARAT teams in local prisons have been struggling with staff shortages and a lack of resources, and an overwhelming pressure to reach key performance targets relating to the number of assessments carried out. This leads to difficulties in undertaking constructive work with prisoners. Further funding has been made available which should improve this situation. Whilst the authors recognise that the CARAT service in local prisons represents the beginning of a process, there is little value in performing many hundreds of initial assessments if prisoners are provided with no follow-up work. A change of emphasis from output to outcome monitoring might also result in the provision of a more effective service.

- The reported ease of 'cheating' on some VTPs, due to inadequate resources for regular testing and security to ensure that urine is not substituted, means that many VTPs have a poor reputation and lack incentive for prisoners to remain 'clean'. Further funding should be made available so that VTPs can become more rigorous and respected. Isolated and secure voluntary testing units, with strict entry procedures and testing protocols, should be operational at all local prisons. In addition to rigorous testing, VTPs should provide good quality drug treatment rather than merely being a wing where an enhanced regime is offered.

- There is a clear need to address the misuse and diversion of prescribed medication in prison, which can be achieved through prescribing protocols to control the amounts of drugs prescribed and the times at which drugs are dispensed. For example, it is obviously inappropriate to dispense diazepam in the morning, so that prisoners have nothing to help them sleep at night, yet this was the practice at one of the study sites. At another site, healthcare had been unable to provide security staff with details of which prisoners should be in possession of which medication. This is clearly problematic in terms of being able to tackle and prevent the illicit trade in prescribed drugs, and associated bullying and violence.

Recommendations relating to anti-drug supply security

- All local prisons should employ a Drug Strategy Co-ordinator whose key role is to give equal weight to drug treatment and supply reduction measures within the establishment.

- Security for social visits must be enforced consistently and should always include the use of passive drug dogs, x-ray machines, CCTV (especially in conjunction with intelligence), adequate staff cover for observational purposes, and protocols for re-searching visitors who go to the toilet during the course of a visit.

- The Drug Supply Reduction Team (DSRT) at Prison B is unique among the study prisons, and the establishment of a similar team at every local prison is recommended as an effective means of gathering and acting on drug supply-related intelligence in a strategic and co-ordinated way. Funding should be made available.

- It is important that prisons 'talk up' their security where this is credible in order that the perception among the local prisoner population of the ease of a particular route of supply is eroded. This should include the publicising to prison visitors of the penalties for possession with intent to supply, and education among prisoners' families regarding the nature and effects of drug use and supply in prison.

- There needs to be improved liaison with local police in terms of sharing intelligence. This is important for tackling all routes of external supply from social visits, to mail, to over the perimeter.

- Suspicion continues to fall on uniformed and civilian prison staff and contractors for supplying drugs into prisons. Regular staff searches must be implemented along with the identification and support of vulnerable staff members.

References

Annual Report of HM Chief Inspector of Prisons for England and Wales 2002/2003. London: The Stationery Office.

Annual Report of HM Chief Inspector of Prisons for England and Wales 2003/2004. London: The Stationery Office.

Boys, A., Farrell, M., Bebbington, P., Brugha, T., Coid, J., Jenkins, R., Lewis, G., Marsden, J., Meltzer, H., Singleton, N. and Taylor, C. (2002) 'Drug use and initiation in prison: results from a national prison survey in England and Wales'. *Addiction*, 97, 1551-1560.

Bullock, T. (2003) 'Changing levels of drug use before, during and after imprisonment' in Ramsay, M. (Ed.) *Prisoners' drug use and treatment: seven research studies.* Home Office Research Study 267. London: Home Office.

Cohen, S. and Taylor, L. (1972) *Psychological Survival*. Harmondsworth: Penguin.

Dillon, L. (2001) *Drug use among prisoners: An exploratory study*. Dublin: Health Research Board.

Edgar, K. and O'Donnell, I. (1998) *Mandatory Drug Testing in Prisons: The relationship between MDT and the level and nature of drug misuse*. Home Office Research Study 189. London: Home Office.

Edmunds, M., Hough, M. and Urquia, N. (1996) *Tackling Local Drug Markets*. Crime Prevention Initiative Paper 80. London: Home Office.

Gore, S. M., Bird, A. G. and Ross, A. (1995) 'Prison Rites: starting to inject inside'. *British Medical Journal*, 311, 1135-1136.

HM Prison Service (1998) *Tackling Drugs in Prison: the Prison Service Drug Strategy*. London: HM Prison Service.

Home Affairs Select Committee (1999) *Drugs and Prisons*. London: The Stationery Office.

Home Office (1995) *Tackling Drugs Together*. London: The Stationery Office.

Keene, J. (1997) 'Drug Misuse in Prison: Views from Inside: A qualitative study of prison staff and inmates'. *The Howard Journal*, 36 (1), 27-41.

Lupton, R., Wilson, A., May, T., Warburton, H. and Turnbull, P. J. (2002) *A rock and a hard place: drug markets in deprived neighbourhoods*. Home Office Research Study 240. London: Home Office.

May, T., Harocopos, A., Turnbull, P. J. and Hough, M. (2000) *Serving up: The impact of low-level police enforcement on drug markets*. Police Research Series Paper 133. London: Home Office.

Niven, S. and Stewart, D. (2005) *Resettlement outcomes on release from prison in 2003*. Research Findings 248. London: Home Office.

Seddon, T. (1996) 'Drug Control in Prisons'. *The Howard Journal*, 35 (4), 327-335.

Shewan, D., Gemmell, M. and Davies, J. B. (1994) *Drug use and Scottish prisons: Summary Report*. Scottish Prison Service Occasional Paper 5. Edinburgh: Scottish Prison Service.

Singleton, N., Farrell, M. and Meltzer, H. (1999) *Substance Misuse Among Prisoners in England and Wales*. London: Office for National Statistics.

Singleton, N., Pendry, E., Simpson, T., Goddard, E., Farrell, M., Marsden, J. and Taylor, C. (2005) *The Impact and Effectiveness of Mandatory Drug Testing in Prisons*. Research Findings 223. London: Home Office.

Stevens, D. J. (1997) 'Prison Regime and Drugs'. *The Howard Journal*, 36 (1), 14-27.

Swann, R. and James, P. (1998) 'The effect of the prison environment upon inmate drug taking behaviour'. *The Howard Journal*, 37 (3), 252-265.

Turnbull, P. J., Dolan, K. A. and Stimson, G. V. (1991) *Prison, HIV and AIDS: risks and experiences in custodial care*. Horsham: AVERT.

Turnbull, P. J., Stimson, G. V. and Stillwell, G. (1994) *Drug Use in Prison*. Horsham: AVERT.

Turnbull, P. J. (2000) 'The effect of prison on drug use' in Muscat, R. (Ed.) *Drug Use in Prison*. Strasbourg: Council of Europe Publishing.

Annex
Brief summaries of three other research studies commissioned by Drug Strategy Unit

'Tackling Prison Drug Markets: an exploratory study' was commissioned by DSU (Drug Strategy Unit, previously in the Prison Service and now part of NOMS/National Offender Management Service) in collaboration with the relevant part of RDS/Research Development and Statistics (now RDS NOMS). This coordinated programme was intended to support prisons in their efforts to curtail drug supply to prisoners. The largest item is the report already presented here, by Clarissa Penfold and her colleagues. Three additional items of research are briefly summarised here, by RDS staff, who have also carried out a limited amount of fresh analysis in some cases. The three items are:

- a study of visits as a supply route;
- a survey of the views of PLOs (police liaison officers) and drug workers about supply routes in prison; and
- a survey of the views of prisoners and staff about various aspects of drug supply and drug use in prisons.

Collectively, these three studies tend to confirm and perhaps enlarge the picture presented in 'Tackling Prison Drug Markets'.

Brief summary of 'Effective Practice: the Reduction of Drugs Entering Prisons via Visits' by Christine Morgan with Rob Hornsby and Dick Hobbs (University of Durham, 2004)

Introduction

This summary presents the main findings from a study on the supply of drugs into prisons by visitors. The key questions underlying this qualitative research were first why there were variations in Mandatory Drug Testing (MDT) rates between prisons and secondly whether these variations could be explained by the differences in security arrangements in relation to controls on social visits (by prisoners' family and friends) and other security procedures.

Nine prisons of different security categories were involved in the study. The research methods were qualitative; they included observation and semi-structured interviews with visitors (n=92) and staff. Background data from MDT and other relevant local security actions were also scrutinised.

Key Points

- Most visitors believed that bringing drugs into prisons caused a range of problems for prisoners (including debts and bullying as well as drug use and possible heroin dependency), and were opposed to the practice.
- Visitors and staff reported broadly similar routes of entry. But routes other than social visits were considered more likely.
- Visitors were generally less critical of stringent security measures than of measures that were perceived to be lax or cursory. Robust measures consistently and fairly applied were viewed benignly.
- Visitors were aware of the potential consequences of drug smuggling but there was a greater variation in their views on the likelihood of detection. The tight application and enforcement of a combination of security measures provided the greatest support in terms of providing vulnerable visitors a reason not to supply drugs.

- Visitors viewed the use of passive drug dogs as an effective deterrent. However, they also felt that dogs need to be handled sensitively, as they can be off-putting to visitors (especially Muslims). Also, there was a concern that they are not 100% reliable.
- Whilst staff viewed search procedures as limited in their effectiveness in detecting drugs, the thoroughness of a search had a strong effect on a visitors' perception of security. Both staff and some visitors pointed to the value of a consistent approach across similar categories of prisons and on the part of different members of staff.
- Both staff and visitors preferred low-level furniture in visit halls. Proactive supervision by staff in the visit hall was welcome not only as a deterrent but to maintain an air of decency; many visitors found that the level of intimate physical contact sometimes allowed was embarrassing.
- Staff identified the need for effective intelligence gathering to identify suppliers.

Discussion

The report emphasises that curtailing the importation of drugs into prisons by visitors is not straightforward and there are no simple answers or standard 'toolkits'. One complicating factor is that levels of positive MDT tests in different prisons do not absolutely reflect different levels of drug use and availability.

The report highlights the finding that visitors tended to have a vested interest in prisons being drug-free places and were particularly likely to be opposed to heroin being smuggled in. They were likely to be critical of lax or inconsistent security. They were sometimes prepared to share information about smuggling if they were treated with tact and sensitivity. A related finding was that visitors with the best information were those most likely to be those seen as 'risks' or 'targets'; but any unduly tough response tended to reduce their willingness to share any information, so it is important that even "suspicious" visitors should be treated with tact and sensitivity.

In summary, visitors can be viewed as potential allies in a prison's attempts to reduce drug supply rather than simply as security risks.

With regard to staff, the report finds that the key ingredient in reducing drug supply in general and via visits in particular is to ensure that all staff and volunteers in Visitors Centres should be involved and understand their role in the establishment's drug strategy.

Finally, drawing both on this qualitative work in the nine prisons and on other research, the report acknowledges that no single supply reduction measure is likely to be effective in isolation. A dynamic interactive range of supply reduction measures is most likely to have a positive outcome. Where a management lead on drug supply reduction is proactive; where systems and procedures are clearly defined and conveyed to staff; and where accountability is rigorously maintained, then the overall security system is more robust.

Recommendations

These recommendations come with the caveat that they are based on qualitative research and based on a sample of nine prisons – although the nine prisons did span a range of different security levels.

- Consideration should be given to the implications of exploiting visitors' potential hostility to drugs.
- Good intelligence analysis demands specialist training.
- Visitor Centre staff should contribute to the implementation of the drug strategy.
- Ensure that high visibility and consistently applied measures are in place in visits. Low-level tables are also recommended to facilitate CCTV and other surveillance and to help discourage excessive physical contact between prisoners and their visitors.
- All staff need a good general understanding of the drug strategy in operation in their prison.
- Active involvement of local police is vital both in providing intelligence and in helping to deter the smuggling of drugs into prisons.
- Visitors may be more willing to pass on information and constructive comments than is sometimes assumed by staff. A 'listening ear' on the part of staff or volunteers can be useful. So can a consultative committee of staff, volunteers and visitors.

- Visitors can benefit from press cuttings about the punishment of visitors caught importing drugs into prisons.
- Visitors can also benefit from other notices or advice – but it is important not to overload them with information.

Brief summary of results of a survey about drug supply routes into prisons

This survey, which took place in 2002, was completed by 62 prison-based Police Liaison Officers (PLOs) and 90 CARAT workers (CARAT is the counselling, assessment, referral, advice and throughcare service delivered by drug workers in prisons). It is probably best seen as qualitative research, rather than as a fully representative, quantitative survey. Initial analysis was carried out by the Police Foundation (Malcolm Hibberd). Further work was done by RDS.

In this survey, both PLOs and CARAT workers were asked similar questions about the nature of drug supply into prisons and about possible counter-measures.

Key results (and the caveats above about qualitative research should be recalled) were as follows:

- Both PLOs and CARAT workers in the sample identified similar supply routes into prisons for drugs. In particular, the majority of each group identified visitors as the most common supply route.
- Other routes strongly highlighted by both groups were: drugs being brought in by prisoners on reception, or hidden in mail for prisoners or thrown over perimeter walls/fences.
- Both staff groups felt all these routes could be successfully disrupted, mainly by making better use of existing methods. Some staff also suggested new approaches, such as intimate searches of prisoners by medical staff.
- Similar proportions (a third) of both staff groups felt that supply routes into prisons were 'organised' rather simply the result of individualised activity.
- PLOs suggested that there was a need for more resources and training, and also for enhanced use of intelligence.

Brief summary of further results of a survey of prisoners and staff in Leicestershire

This survey about drugs issues in prisons, involving 237 prisoners and 153 prison officers, was carried out in 1996-7. The survey can be viewed as a small-scale quantitative project, as carried out in three Leicestershire prisons (the prisoners were a reasonably representative sample of those in the three prisons, and so included both drug users and a smaller set of non-users). Results relating to drug treatment have already been published in Home Office Research Study 267, in the chapter by Wilkinson et al. (2003). While this is not a new survey, it does postdate the introduction of Mandatory Drug Testing (MDT), an important policy change alongside the expansion of drug treatment in prisons. The survey not only confirms aspects of other studies (particularly in terms of prisoner attitudes) but also offers fresh insights into the views of uniformed custodial staff. While the survey was originally done by the Scarman Centre (University of Leicester), this summary is based on additional analysis by RDS.

Prisoner attitudes

Percentages are based on the responses of 237 prisoners, unless otherwise stated.

- The majority of interested prisoners in the sample did not find it difficult to obtain drugs in prison (in line with the main study presented in this report).
- The main drug of choice was cannabis, followed by heroin (there was less interest in other drugs than in the ICPR study, perhaps reflecting the limited geographical focus of the survey as well as the difference in dates of the two studies).
- The main reasons for using for using drugs were escapism, boredom, or simply to pass the time (broadly in line with the ICPR study).

- Very few prisoners (12%) thought a drug-free prison would be possible, though a larger minority (38%) thought a drug-free wing would be possible (as is now commonplace in prisons).
- More than nine out of ten prisoners mentioned visits as a supply route, a far higher proportion than that mentioning any other route (the ICPR study and other research summarised in this annex also tends to highlight visits).
- Over half of the prisoners (55%) stated that drug trading had side-effects: the main effects mentioned were debts (49% of the 131 prisoners who cited effects) and threats/violence (44% of those citing effects). However, a smaller group (21% of those citing effects) stated that drugs calmed people down and lessened violence.
- Some prisoners also mentioned other effects, including problems being caused for prisoners' families and friends, through being asked/pressured to help finance prisoners' drug use or bring drugs into prison on visits.
- Most of the prisoners (71%) believed drugs were far more likely to be smuggled into prisons than money. Almost as many (61%) stated that it was more useful to bring in drugs than money; among this group, the commonest reason, mentioned by 42% of the 142 prisoners stating this, was that drugs 'make more money'.
- Over a quarter of the prisoners admitted asking visitors to bring in drugs or money.

Officers' attitudes

Percentages are based on the responses of 153 officers, unless otherwise stated.

- Like the prisoners, officers most commonly mentioned visits as a supply route (cited by 97%). They also mentioned the range of other possible sources documented by other research, including 'over the fence' (cited by 41%) and staff (cited by 29%).
- Again like the prisoners, the officers mentioned side effects. High proportions of the officers mentioned debts (69%) and violence (65%).
- Some officers (23%) stated that drugs made life difficult for them. However, almost as many (22%) stated that drugs were just 'part of the day's work' for them. Only 12% believed staff were themselves in danger of violence.
- Officers were divided as to the effectiveness of security measures. Some (32%) saw current measures as effective, or very effective. Rather more (48%) felt they did not go far enough, or were lacking in effectiveness.
- The counter-measures most commonly cited by officers were closed visits (mentioned by 60% of the 131 officers offering suggestions) and more intimate searches of prisoners and visitors (mentioned by 19%). However, only 12% thought that measures of this kind would be acceptable to prisoners.
- Roughly a third of the officers (35%) thought that drug-free wings were possible: much the same as the equivalent figure for prisoners (38%).
- Only a relatively small minority (18%) of officers thought a drug-free prison was possible. Again, this was not far out of line with the equivalent figure for prisoners (12%).

Reference

Wilkinson, C., Hucklesby, A., Pearson, Y., Butler, E., Hill, A. and Hodgkinson, S. (2003) 'Management of drug-using prisoners in Leicestershire' in Ramsay, M. (Ed.) *Prisoners' Drug Use and Treatment: Seven Research Studies*. Home Office Research Study 267. London: Home Office.

Produced by the Research Development and Statistics Directorate, Home Office

This document is available only in Adobe Portable Document Format (**PDF**) through the RDS website

http://www.homeoffice.gov.uk/rds

Email: publications.rds@homeoffice.gsi.gov.uk

ISBN 1 84473 732 2
© Crown copyright 2005