

# Issues surrounding the delivery of prison drug services in England and Wales, with a focus on Black and minority ethnic prisoners

Jane Fountain, Alastair Roy, Sundari Anitha,  
Kate Davies, Jonathan Bashford and Kamlesh Patel

Centre for Ethnicity and Health  
Faculty of Health



2007

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*For copies of this report, please contact:*

Professor Jane Fountain  
Centre for Ethnicity and Health  
Faculty of Health  
University of Central Lancashire  
Preston PR1 2HE  
UK

[JFountain1@ulcan.ac.uk](mailto:JFountain1@ulcan.ac.uk)

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# Executive Summary

Drug services in prisons in England and Wales are provided by a combination of external drug service providers, prison healthcare staff, prison officers, and probation staff.

The latest statistics available at the time of the study showed that there were over 70,000 prisoners in England and Wales. Around one quarter of them were members of Black and minority ethnic communities, and the proportion in each prison ranged from 4% - 67%.

Other than civilian drug workers, many of those working in prisons have a limited knowledge of drugs and drug services.

Information on prison drug services is generally given to prisoners at induction sessions, but may not be assimilated nor acted upon at that time, as inductees may be preoccupied with other concerns, and reluctant to reveal immediately to staff and other prisoners that they have a drug problem.

Black and minority ethnic prisoners may rely on peers as sources of information about drugs and drug services to a greater extent than white prisoners.

Some of those working in prison drug services - particularly prison officers - have received insufficient training for this work.

Positive aspects of prison officers' involvement in drug service delivery were reported, such as increased appreciation of these services by other officers. However, prison officers who also work as drug workers are regularly redeployed to other operational commitments, and prisoners are suspicious of their dual roles. There is some tension between civilian drug workers and prison officers around the health-focussed aims of drug services and the secure custody focus of the Prison Service.

It was perceived that the introduction of CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services) has achieved a significant and positive impact upon prison drug services, but that there is a high demand for these services and insufficient resources to meet it. Therefore, heroin users are reported to be prioritised because they are perceived as the most problematic drug users.

Waiting times and a lack of transparency in the application process for drug services discourage many prisoners from accessing them. Where those perceived to be queue-jumpers are predominantly white, the opinion that drug services discriminate against Black and minority ethnic prisoners is reinforced.

Waiting times of several days to be tested for eligibility for detoxification services mean that some heroin and cocaine users return negative drug tests and are therefore not entitled to them.

Drug detoxification and the prescription of medication to ease withdrawal symptoms is usually managed by a prison's healthcare department, but, in some prisons, there is a poor professional relationship between this department and CARATS, which negatively impacts on the provision of drug services.

Some prisoners are perceived to access drug services not because they want to address their drug use, but to enhance their parole application, take advantage of the better facilities and privileges on drug-free wings, or simply to get out of their cells and talk to someone.

Drug testing is perceived as contributing to a change from cannabis to heroin use by prisoners, because cannabis can be detected in the body for 28 days and heroin for only two or three days.

Prisoners who have English language and literacy problems are disadvantaged in terms of accessing drug services. For example, they find it particularly difficult to recall information given at induction, and the selection criteria for participants for some types of rehabilitation programmes require certain levels of literacy and fluency in English.

The lack of respect for confidentiality, the lack of suitable environments in which to deliver drug services privately, and prisoners' fears of negative reprisals from prison officers if they are known to be using drugs are reported to be major barriers to prison drug services.

Another major barrier, especially for young males, is the stigma attached to the use of drugs (other than cannabis, and especially heroin and crack cocaine) and to help-seeking. In the macho environment of male prisons, drug users and help-seekers can be bullied and blackmailed. The cultural and religious stigma attached to drug use by some Black and minority ethnic communities means that fear of family and community discovering their drug use prevents some prisoners from these communities accessing drug services.

Effective throughcare - drug services provided from an individual's first contact with the criminal justice system until after their release - is crucial to sustaining any achievements made by drug users in prisons, but prison drug services have found it extremely difficult to deliver throughcare, especially in facilitating post-release support in the community. There is a lack of co-operation between some prisons and community drug services, and where it exists, is not always unproblematic due to, for example, funding issues, or because a prisoner's home is in a different part of the country from the prison.

Newly-released prisoners are vulnerable to a return to drug use, and may also have to deal with a lack of accommodation, employment, and, particularly in the case of those from some Black and minority ethnic communities, problems reintegrating with their family and community, because of the double stigma of having been in prison and of using drugs.

There are some examples of good practice, but overall, little consideration has been given to the specific needs of Black and minority ethnic prisoners in the development and delivery of prison drug services: the ethnicity of clients is not consistently monitored across all drug services; there are few current and planned drug services targeting Black and minority ethnic prisoners; training on diversity and cultural competence is inadequate; and there is lack of strategic lead on ethnic diversity.

The result is that Black and minority ethnic prisoners are under-represented as prison drug service clients. They are reticent to approach drug services due to fears of experiencing a lack of cultural understanding, overt and institutional racism, and because of the lack of Black and minority ethnic staff (both in the Prison Service in general and in prison drug services specifically). In short, many Black and minority ethnic prisoners see these services as run by white people for white people.

This report demonstrates that whilst there are aspects of prison drug services that require development for their users and potential users, there are clearly differential impacts for Black and minority ethnic prisoners. In effect, this report constitutes a race equality impact assessment as required by the Race

Relations (Amendment) Act 2000. To remedy the differential impacts it identifies, the authors recommend the adoption of a whole systems approach to prison drug service development that will directly result in sustainable improvements for Black and minority ethnic prisoners. This approach is necessary because actions are required at national, area, and local levels, and, to be successful, these must be supported by a robust infrastructure for the performance management of race equality.

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This report is a shortened version of the one delivered to the Prison Service Drug Strategy Unit (Fountain et al., 2004), which provides more detail of the methods used for the study, the results, and of previous relevant research.

The study reported here also formed the basis of a series of seminars run by the National Offender Management Service (NOMS) Drug Strategy Unit (DSU) on the drug service needs of Black and minority ethnic prisoners. Following these seminars, the Prison Service commissioned the Centre for Ethnicity and Health to produce a practice guide to support those responsible for the development and delivery of drug services (Roy et al., 2007).

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# Acknowledgements

The authors gratefully thank a total of 334 individuals - who must remain anonymous - who gave their time to be interviewed, complete questionnaires, or participate in focus groups. They comprise prisoners, ex-prisoners, prison officers, prison drug workers (prison officers and civilian staff), members of Independent Monitoring Boards (IMBs), members of Black and minority ethnic communities, and representatives of organisations working with prisoners, ex-prisoners, and their families. We are grateful to the prison Area Drug Co-ordinators and their representatives, and to the external prison drug service providers, for completing detailed questionnaires.

Without the co-operation of the governors of eight prisons, and of those who facilitated the research team's access to prisoners and staff in these prisons, the prison-based elements of this study could not have taken place. Their assistance is much appreciated, as is that of the chairs of these prisons' IMBs who facilitated the interviews with board members.

We also express our thanks for their assistance and support during the project to those in the Drug Strategy Unit (formerly at the Prison Service Headquarters and now located within the NOMS Headquarters) - Martin Lee (Head of Unit), Cath Pollard (Section Head) and Firoza Saloo (CARATS / Alcohol Policy Manager) - and, at the Home Office, Malcolm Ramsay (Principal Research Officer) and Lan-Ho Man (Research Officer).

The assistance of several colleagues with aspects of this project is much appreciated: from the Centre for Ethnicity and Health, Nicole Crompton (Research Assistant), Eleanor Peters (Senior Lecturer - Research), and Viv Ahmun; and from the Lifeline Project, Noreen Sheikh (Senior Manager).

Finally, we are grateful to several organisations - especially Adfam - working with prisoners, ex-prisoners and their families for their help, advice and contacts.

# The Centre for Ethnicity and Health

Faculty of Health, University of Central Lancashire

<http://www.uclan.ac.uk/facs/health/ethnicity/>

Head: **Professor Lord Kamlesh Patel OBE**

The Centre for Ethnicity and Health is a specialist research and education centre with a focus on the health and social care of diverse groups who experience discrimination and/or disadvantage, including Black and minority ethnic communities; refugees and asylum seekers; offenders; people with disabilities; mental health service users; lesbians, gay men, bisexual and transgendered people; older people; and young people at risk of developing health and social harms. The Centre utilises both qualitative and quantitative research methods in such a way that its work has practical applications and its findings assist in the evaluation and improvement of services and community relations.

The Centre's main current research activities lie in the fields of community engagement and organisational change in the context of equality, drugs, alcohol, crime, mental health, and regeneration. The Centre is also developing an innovative research programme in philosophy, diversity and mental health, with a twin focus on user and citizen centrality and high-level conceptual analysis. In addition, future research will include a focus on Black and minority ethnic elders' needs and usage of services across a range of sectors. The guiding ethos that underpins the Centre's community-based research is that the process is as valuable as the findings, and, to this end, acclaimed models of community engagement and organisational change have been developed.

To compliment the Centre's research portfolio, teaching and learning activities are in continual development, with the aim of contributing to knowledge, expertise, and good practice in the fields of ethnicity and health. A wide-ranging and dynamic educational portfolio has been developed, including suites of courses ranging from one-day workshops through to Master's level study on equality, diversity and community engagement.



# Terminology

## Black and minority ethnic

The authors are very conscious that various terms are used to refer to the many diverse communities in the UK. We prefer 'Black and minority ethnic groups / communities.' This reflects that our concern is not only with those for whom 'Black' is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: 'Black and minority ethnic' also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be 'Black,' but who nevertheless constitute a distinct ethnic group.

## Problematic drug use

The definition of drug misuse used by the National Treatment Agency for Substance Misuse (NTA, 2003) also serves as the definition of problematic drug use used throughout this report:

*...the illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking which causes harm to the individual, their significant others or the wider community. By definition those requiring drug treatment are drug misusers.*

## Prison / establishment

Fieldwork for this study revealed that HM Prisons and Young Offenders' Institutions in England and Wales are described interchangeably as 'prisons' and 'establishments.' In this report, we have also used both terms.

# 1

## Rationale for the Study

Recognition of the prevalence of drug use amongst prisoners (for example, Singleton et al., 1998; Strang et al., 1998; Borrill et al., 2003a) has resulted in expansion of prison-based drug services, but the perceptions and experiences of these services remain hitherto unexplored, particularly those of Black and minority ethnic prisoners. Previous reviews of issues related to race in prisons (such as CRE, 2003) have not specifically addressed drug services.

The result is that HM Prison Service has limited awareness of factors facilitating or hampering access to drug services by prisoners, and of their expectations as potential consumers of those services. This is particularly pertinent to Black and minority ethnic prisoners, as work commissioned from the Centre for Ethnicity and Health has revealed that Black and minority ethnic populations face many barriers to drug treatment, education, and prevention services. These include a lack of cultural sensitivity by the service, a distrust of confidentiality, communication problems because of language, a lack of awareness of drugs and drug services, the stigma surrounding drug use within some communities, and the failure of drug services to address the needs of Black and minority ethnic drug users (for example, Bashford, Buffin and Patel, 2003; Fountain et al., 2002, 2003; Patel et al., 2004; Sangster et al., 2002).

The study reported here was therefore commissioned by HM Prison Service Drug Strategy Unit (now NOMS Drug Strategy Unit) to provide an overview of the issues surrounding the delivery and development of drug services, particularly to Black and minority ethnic prisoners. The study's aims were:

- to identify factors facilitating or hindering access to prison drug services;

- to distinguish those factors affecting Black and minority ethnic prisoners;

- and to provide recommendations for areas of work requiring attention to ensure an ethnically diverse client group is reached and is in keeping with the requirements of the Race Relations (Amendment) Act 2000.

This research commission supports the Prison Service's commitment to developing the knowledge base on prison drug services, complementing, for example, Ramsay (2003), who reports on the findings of seven studies exploring a range of issues in relation to prisoners, drug use, and drug services. Practical solutions are offered regarding areas of work that require attention, informed by the data collected throughout the project and reconciling any different perceptions of what is required.

To gather data on experiences and perceptions, the research used qualitative methods, and although interviewers had a list of themes to guide interviews, not all informants discussed a particular issue, and indeed were encouraged to raise their own in response to each theme. It is therefore often meaningless to give the proportion who noted a particular topic, although atypical issues raised by only one or two informants have not been included in this report. Nevertheless, as intended, the combination of qualitative and quantitative research methods used for this study has resulted in a valid overview of prison drug services, especially in relation to Black and minority ethnic prisoners: some data were collected from all 135 establishments in England and Wales that provide drug services. In addition, the study has provided information that could be used to inform the construction of a larger-scale survey.

Interviews with prisoners, prison officers, drug service providers, and members of Independent Monitoring Boards (IMBs) were conducted in eight prisons, in order to identify the issues that were relevant to the study aims. Although these were chosen in consultation with DSU to cover a range of geographical locations, gender, age, prison category, and proportion of Black and minority ethnic prisoners, it cannot be guaranteed that the results from this component can be extrapolated to all prisons, prisoners, prison drug service staff (prison officer and workers from external drug service providers), and IMB members. As it was not the intention of this project to comment on nor compare the situation in the eight prisons, and because all interviewees were promised confidentiality and anonymity, this report will not present information by which these establishments can be identified.

## 2

# Methods

This section outlines the 13 data sources used for this study, outlines data analysis methods, and lays out the structure of the rest of the report.

## 2.1 Data sources

In order to achieve the study's aims, the project reviewed relevant literature in order to identify themes for the research instruments, collated the available relevant statistical data, mapped existing prison drug services, and explored a range of perspectives on the issues surrounding this provision. In total, data were collected from 334 individuals, who were interviewed, completed questionnaires, or participated in focus groups.

Individuals and organisations were chosen to represent as wide a range of experiences of prison drug services as possible in view of the resources allowed for the study. Nine separate research instruments were devised to collect data from them, although they had some questions in common, such as those on barriers to, and the development of, prison drug services. The sample and research instruments to gather data from them comprised:

Prison Service Area Drug Co-ordinators or their representatives representing all 15 prison areas in England and Wales (N=46): self-completion questionnaire. Data were returned on 98.5% (133) of the 135 establishments that provide drug services.

All external prison drug service providers (N=22): self-completion questionnaire. Data were returned for 88.5% (115) of the 130 prisons in which drug services are provided by external organisations.

Black and minority ethnic prisoners receiving drug treatment services in 8 prisons (N=45): individual semi-structured interviews.

White prisoners receiving drug treatment services in 8 prisons (N=45): individual semi-structured interviews.

Black and minority ethnic prisoners not receiving drug treatment services in 8 prisons (N=31): individual semi-structured interviews.

White prisoners not receiving drug treatment services in 8 prisons (N=28): individual semi-structured interviews.

CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services) and other drug workers (prison officers and civilian staff), and prison officers (both with and without responsibility for drug issues) in 8 prisons (N=38): individual semi-structured interviews.

Members of Independent Monitoring Boards in 8 prisons (N=25): individual semi-structured interviews.

Ex-prisoners from Black and minority ethnic communities (N=8): individual semi-structured interviews.

Black and minority ethnic community members (N=27): three focus groups - one for men, one for women and one for young people.

Representatives of organisations working with prisoners, ex-prisoners, and their families (N=19): individual semi-structured telephone interviews.

In addition to the above data sources, it became clear once fieldwork had begun that the experiences and observations of the research team's fieldworkers were an additional source of valuable information, and these were noted and analysed along with the other data.

Small payments to prisoner-interviewees were made to compensate them for their time. The nature of these varied between prisons, but was usually £3 - £4 of telephone credits or canteen vouchers (the maximum that could be negotiated with the prison authorities). All focus group participants were paid £15.

## 2.2 Data analysis

Centrally-held statistical data and some results from the questionnaires for Area Drug Co-ordinators and external drug service providers were used to map existing prison drug service provision and to report on ethnic monitoring of prisoners, prison staff, and drug service clients.

Qualitative data from the questionnaires for Area Drug Co-ordinators and external drug providers, and results from all the other data sources (detailed in section 2.1 and including the relevant literature and other documents) were collated thematically, according to the themes that most consistently arose and that are pertinent to the provision of prison drug services for all ethnic groups and specifically for Black and minority ethnic prisoners. The analysis is therefore firmly grounded in the data received from informants during this study.

The use of a thematic analysis makes it possible to report on a wide range of experiences and perceptions concerning prison drug services; to identify areas of consensus and divergence on specific issues; and to recommend how prison drug services can be developed to address the needs of all prisoners.

## 2.3 Report structure

**In sections 3 - 5**, centrally-held statistical data and some results from the questionnaires for Area Drug Co-ordinators and external drug service providers have been used to map prison drug service provision; ethnic monitoring of prisoners, prison staff, and drug service clients; and initiatives designed specifically for Black and minority ethnic prisoners.

**Sections 6 and 7** present the results of the thematic analysis of the qualitative data collected from the study participants. Issues relating to all prisoners are reported, and the particular implications for Black and minority ethnic prisoners are highlighted. In these sections, the key issues identified by the data are:

## **Section 6: Factors affecting the accessibility of prison drug services**

These factors comprise:

- Knowledge and attitudes regarding drugs and drug services.
- Prison officer-civilian drug worker relationships.
- Prison officers as drug workers.
- Perceived ease of access to prison drug services.
- Motivation for accessing prison drug services.
- Confidentiality.
- Stigma.
- The extent to which prison drug services address the needs of an ethnically diverse prison population.

## **Section 7: Experiences and perceptions of specific prison drug services**

Results are presented on interviewees' experiences and perceptions of:

- Induction.
- Detoxification.
- 1:1 counselling.
- Groupwork.
- Drug testing.
- Services for users of drugs other than heroin.
- Throughcare.

Finally, **section 8** considers the results of the study to provide recommendations for areas of work requiring attention to ensure an ethnically diverse client group is reached and is in keeping with the Race Relations (Amendment) Act 2000.

## 3 Prison Drug Services

This section maps prison drug services, beginning with those reported by Area Drug Co-ordinators and continuing with data collected from external drug service providers.

At the time of the study, the 137 prisons in England and Wales were divided into 15 areas - West Midlands; East Midlands (South); East Midlands (North); North East; North West; Yorkshire & Humberside; Kent, Surrey & Sussex; Eastern; London; Wales; Thames Valley, Hampshire, Isle of Wight; South West; Female Estate; High Security; and the Juvenile Operational Management Group. Three of these areas were not geographically-based (Juvenile Operational Management Group, Female Estate and High Security), but since this study was conducted, the establishments in the female estate have become part of the geographical areas in which they are located.

Drug services in prisons in England and Wales are provided by a combination of external drug service providers, prison healthcare staff, prison officers, and probation staff. For the purposes of mapping these services, they were categorised into twelve types:

- detoxification;
- methadone maintenance;
- crack cocaine-specific services;
- complementary treatment;
- intensive rehabilitation programme;
- CARATS assessments;
- CARATS 1:1 counselling;
- CARATS groupwork;
- hepatitis B immunisation;
- harm reduction measures;
- services for the families and carers of drug-using prisoners;
- and voluntary drug testing.

The authors recognise that drug testing is not a service in the sense that the others on the list above are. However, throughout this report, data on testing are included with data on services because, as will be shown, the policy of testing and the consequences of test results impact considerably on perceptions and experiences of prison drug services.

### 3.1 Prison drug services delivered in England and Wales

The prison drug services reported by Area Drug Co-ordinators at the time of the study are shown in the appendix (table 1) and discussed in this section. Data were received on 133 of the 135 establishments in which drug services are provided.

The drug services most commonly delivered in prisons are the assessment and 1:1 counselling elements of Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS). Crack cocaine-specific services are least often provided.

Detoxification, complementary treatment, intensive rehabilitation programmes, CARATS, and voluntary drug testing are delivered in some prisons across all 15 prison areas. The other services in the list above are not delivered in every area.

**3.1.1 Detoxification:** delivered in 73 prisons (55% of 133 establishments from which data were received from Area Drug Co-ordinators)

Detoxification is available to prisoners in all 15 areas. This service is not intended to be offered in all prisons and is mainly provided in remand centres and local prisons.

The drug most often prescribed for detoxification (in 24 prisons) is lofexidene (BritLofex), followed by dihydrocodeine (DF118) in 20 prisons.

It was reported that one prison, despite their policy to offer buprenorphine (Subutex), could not do so *'because of non-secure medical boxes,'* and that another could not offer a detoxification service at all because there was *'not enough healthcare cover.'*

**3.1.2 Methadone maintenance:** delivered in 32 (24%) establishments

Methadone maintenance is available to prisoners in ten of the 15 areas, and especially to females and those in prisons in Wales. This service is available in 13 of the 17 establishments that comprise the female estate, and all the four prisons in Wales.

Methadone maintenance is not available in any establishment of the Juvenile Operational Management Group, nor in prisons in the East Midlands (South), East Midlands (North), London, and the South West areas.

**3.1.3 Crack cocaine-specific services:** delivered in 27 (20%) establishments

Crack cocaine-specific services are delivered in just over half (8 of 15) of the prison areas, and, overall, in one in five prisons.

Reports of crack cocaine-specific services overwhelmingly consist of 1:1 counselling (in 11 prisons) and/or groupwork (in 15 prisons), in which the crack cocaine-related component ranges from a one-off session of two hours to two sessions a week over a six-week period.

**3.1.4 Complementary treatment:** delivered in 94 (71%) establishments

Complementary treatment was reported from every prison area, and is provided in all the establishments in the West Midlands; Yorkshire and Humberside; Wales; the South West; and the High Security areas. The Kent, Surrey & Sussex area has the smallest proportion of prisons in which complementary treatment is delivered.

By far the most common type of complementary treatment is acupuncture (usually auricular), delivered in 63 prisons, followed by yoga (in 12).

The type of complementary therapy was unspecified for 25 prisons, but the main other reported therapies were relaxation, massage, and drama and art. EST (Erhard Seminar Training), meditation, drumming and Tai Chi were reported in one prison each.



### **3.1.5 Intensive rehabilitation programmes:** delivered in 62 (47%) establishments

Prisons across all 15 areas provide some form of intensive rehabilitation programme, overwhelmingly (in 40 prisons) Cognitive Behavioural Therapy or P-ASRO (Prisons - Addressing Substance Related Offending), a highly structured cognitive behaviour programme specifically aimed at reducing offending linked to substance use. The abstentionist 12-Step (or Minnesota) method of rehabilitation is available in 12 prisons, and the Therapeutic Community (TC) method in five.

Other named intensive rehabilitation programmes, operating in a total of eight prisons, include STAR (Substance, Treatment, Awareness, Rehabilitation), LEAP (Leyhill Enhanced Addiction Programme), MAD (Moving Away from Drugs), Penthouse, and Focus.

### **3.1.6 Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS)**

CARATS' procedures to meet the non-clinical needs of prisoners are to assess prisoners who have been referred to the service on reception / induction / after detoxification; refer prisoners who require further intervention to an appropriate drug programme at any time during their sentence; provide counselling or groupwork where necessary; and, where CARATS clients are not being referred to a statutory body or community drug agency on release, provide them with post-release support. Area Drug Co-ordinators were asked about three types of CARATS, and these were reported from all prison areas as follows:

**CARATS assessments** are delivered in 130 (98%) establishments from which data were received from Area Drug Co-ordinators and their representatives.

**CARATS 1:1 counselling** is delivered in 130 (98%) establishments.

**CARATS groupwork** is delivered in 111 (83%) establishments.

### **3.1.7 Hepatitis B immunisation:** delivered in 97 (73%) establishments

Hepatitis B immunisation is offered in some prisons in every area except the South West, and in every prison in the North East, London, and Wales.

### **3.1.8 Harm reduction measures:** delivered in 99 (74%) establishments

These services were reported from every prison area except the South West and in all prisons in the North East, London, and Wales.

Reported harm reduction measures largely consist of information given on a 1:1 basis, via groupwork, and/or by written means such as leaflets. Issues covered by these methods include drug education, safer injecting, tolerance levels / overdose awareness and prevention, information on communicable diseases / blood-borne viruses, and relapse prevention. This information is given at induction, and/or during the sentence, and/or on release, and may be incorporated into other elements of drug services, including CARATS.

Condoms were reported to be supplied by two prisons and sterilising tablets for injecting equipment by one.

#### **3.1.9 Services for the families and carers of drug-using prisoners:** delivered in 34 (26%) establishments

Four prison areas - covering a total of 38 prisons - reported that they had no services for the families and carers of drug-using prisoners: East Midlands (South); North East; Kent, Surrey & Sussex; and the South West. The areas with the highest proportion of prisons delivering these services are London and the Juvenile Operational Management Group.

There are specialist family workers in 14 prisons, based in their visitor centres, and Adfam operate in ten prisons (including all six London prisons).

The other main service for the families and carers of drug-using prisoners is the provision of information (usually leaflets) in visitor centres.

Eight prisons involve families in end-of-rehabilitation programme reviews or case conferences, and three have links with prisoners' family support agencies based in the community.

#### **3.1.10 Voluntary drug testing (VDT)**

VDT is conducted on those who volunteer for testing, some of whom may be accommodated on a drug-free wing of the prison. Area Drug Co-ordinators reported that:

wing-based VDT is conducted across all prison areas, in a total of 116 (87%) establishments;

and VDT in a general location is conducted in every prison area except Wales, in a total of 106 (80%) establishments.

## **3.2 Services delivered by external drug service providers**

At the time of the study, there were 22 external prison drug service providers in England and Wales, and data were received on their activities in 115 prisons. Of the 135 establishments that deliver drug services, five have no external drug service provider, but provide drug services 'in house,' and data were not received for a further 15.

Six external providers serve only one prison each. The number of prisons served by the other 16 ranges from 2-40, although only four providers serve more than ten prisons.

The main role of external providers is providing CARATS. Seventeen of the 22 provide this service, to a total of 114 prisons. Three providers deliver only CARATS. In addition:

Twelve external providers supply rehabilitation services to a total of 34 prisons.

Seven external providers provide referral on release / throughcare services, to a total of 50 prisons. Although these services can be part of CARATS, these providers reported them separately.

Three external providers provide detoxification services, to a total of four prisons.

Seven external providers supply other drug services, to a total of 17 prisons. They include providers who specifically stated that they provided harm reduction / minimisation services (two providers in five prisons). However, other providers' omission to list harm reduction as a specific service does not necessarily mean that it is not provided as an element of their other services. 'Other drug services' also include *'family worker'* (one provider in one prison); *'detox support'* (one provider in six prisons); and *'motivational interviewing'* (one provider in one prison).

## 4

# Ethnic Monitoring

This section presents data on the ethnic monitoring of prisoners, prison staff, and prison drug service clients. The actions necessary by public authorities to meet the requirements of the Race Relations (Amendment) Act 2000 stress the role of ethnic monitoring (CRE, 2000), which is necessary to determine current use of services; identify gaps; assess needs; improve quality; evaluate changes; achieve equal access; provide a baseline for planning; allocate resources more equitably; and to measure improvements.

## 4.1 Ethnicity of prisoners

In February 2003 (the latest statistics available at the time of the research), the total number of prisoners in England and Wales was 72,231. Of these, 17,651 (24.5%) were from Black and minority ethnic communities, and their ethnicity was:

54,501	(75.5%)	white
11,884	(16.5%)	Black
3,431	(4.8%)	Chinese and other
2,336	(3.2%)	South Asian
79	(0.1%)	unrecorded.

As shown in table 2 (in the appendix), the proportion of Black and minority ethnic prisoners in each of the 137 establishments in England and Wales ranges from 4% - 67%.

## 4.2 Ethnicity of prison staff

The ethnicity of prison staff across England and Wales in December 2003 is also shown in table 2. The proportion of Black and minority ethnic staff across prisons ranges from 0% - 33.8%. Interpretation of these data should consider that not all those working for the Prison Service come into contact with prisoners: a quarterly (October - December 2003) review of staff profiles and projections supplied to the research team by the Prisons Research Section of the Home Office Research, Development and Statistics Directorate (RDS), reveals that Black and minority ethnic staff are concentrated in administration roles.

## 4.3 Ethnicity of prison drug service providers

When this study was conducted, the ethnicity of internal and external prison drug service providers was not monitored centrally, although plans to do so were underway.

## 4.4 Ethnic monitoring of prison drug service clients

The extent to which ethnic monitoring of drug service clients is conducted in each prison was assessed from data collected from Area Drug Co-ordinators and their representatives, from external drug service providers, and provided to the research team by DSU and RDS:

- The drug services for which ethnic monitoring is most often conducted are CARATS (assessments, 1:1 counselling and groupwork) and intensive rehabilitation programmes.

- The ethnicity of clients receiving prescribed medication is not as well-monitored: ethnic monitoring of clients is conducted in less than half of the prisons delivering detoxification and in only around a quarter of those where prisoners receive methadone maintenance.
- Of those prisons carrying out voluntary drug testing, around two-thirds monitor the ethnicity of those tested.
- The ethnicity of recipients of hepatitis B immunisation is monitored in less than half of the prisons providing this service.
- Less than one-third of prisons where services for the families and carers of drug users are provided monitor the ethnicity of the recipients.
- Prisons in some areas report more ethnic monitoring of drug service clients than others. Two areas - Kent, Surrey & Sussex and Thames Valley, Hampshire & Isle of Wight - report that ethnic monitoring is conducted of clients of all drug services in all prisons, whereas in the North East and in Wales, the ethnicity of clients is not monitored for seven of the twelve types of drug services delivered in the areas.
- 20 of the 22 external drug service providers conduct ethnic monitoring of their clients in prisons. Overall, the ethnicity of external providers' clients in only three prisons is not monitored.
- Data on the ethnicity of 44,498 CARATS clients show that the ethnic categories include '*Unknown*,' and although, overall, this category comprised only 5% of the total of CARATS clients across 133 prisons, in two prisons, the ethnicity of 30% and 40% of CARATS clients is unknown.

## 4.5 Accessibility of the results of ethnic monitoring

If the results of ethnic monitoring are not available for those who plan and deliver services to act upon, the collection exercise is meaningless. Therefore, where Area Drug Co-ordinators and external drug service providers reported that ethnic monitoring of drug service clients was conducted, they were asked for the location of the results.

It was not one of the study's aims to collect and analyse these statistics, so it is unknown if they are readily available from the cited sources. However, it is clear that data on the ethnicity of prison drug service clients are not available from a central location. A wide variety of sources was given by Area Drug Co-ordinators and external drug service providers, ranging from the name of an individual (frequently with no indication of their role) through to imprecise locations such as '*healthcare*,' '*Home Office*,' '*Headquarters*,' '*the prison*,' and '*prisoners*' records.'

## 5 Drug Services Targeting Black and Minority Ethnic Prisoners

This section presents the results of items in the questionnaires for Area Drug Co-ordinators and for external drug service providers designed to discover whether any current and planned drug services are targeted at Black and minority ethnic prisoners and, if so, the nature of these.

### 5.1 Current drug services targeting Black and minority ethnic prisoners

As discussed in section 4, all 137 prisons in England and Wales have some Black and minority ethnic prisoners, with the proportion ranging from 4% - 67%. However, as shown in table 3 (in the appendix), Area Drug Co-ordinators and their representatives reported drug services targeting this population in only three (2.25%) of the 133 prisons for which they provided information. These services consisted of drugs information leaflets provided in different languages in one prison, and an external Black and minority ethnic community drugs agency contributing to drug services in two prisons.

An Area Drug Co-ordinator wrote of the difficulties in providing drug services targeting Black and minority ethnic prisoners across the whole of England and Wales:

*Specific drug services for people from either Asian or black minority ethnic groups varies [in prisons] across the country...it is difficult to get specialist workers or access to dedicated groups for Asian or black minority groups in geographical areas where the Asian or black minority population is low. This impacts on prison establishments who may have a high cross-section of people [prisoners] from Asian or black minority ethnic groups, in that we can't get the support of external groups because of travel/logistical problems etc.*

Fourteen (64%) of the 22 external drug service providers reported initiatives targeting Black and minority ethnic prisoners, although three reported that they are not available in all the prisons they serve. In some cases, however, although commendable, it was difficult to ascertain how, or if, the reported initiatives had translated into practice: examples include: 'Race Relations Officer available,' 'Advised [Black and minority ethnic drug agency] that Black and minority ethnic prisoners under-represented as CARAT clients,' and 'Staff attend race relations meetings and diversity training.'

Nevertheless, nine (41%) external drug service providers were taking proactive, practical approaches to improving access to drug services by Black and minority ethnic prisoners, including by directly asking prisoners from these populations if they needed help with a drug problem; increasing user involvement in service development and delivery, to orientate services more to the needs of these prisoners; and collaborating with an agency that works with Black and minority ethnic drug users in the community. Four providers were making attempts to recruit Black and minority ethnic staff; four were investigating the drug service needs of Black and minority ethnic prisoners; three had submitted proposals for funding to develop services for Black and minority ethnic prisoners; and three were running language / literacy initiatives.

The clients of 14 (64%) of the external drug service providers have access to translation / interpretation services, although some providers reported that these services were not available across all the prisons they served, and/or the provider was reliant on the prison supplying them, and/or the service consisted of translated leaflets only.

Twelve (55%) of the external drug service providers provide Black and minority ethnic prisoners with information about / access to Black and minority ethnic organisations that offer support and/or advice to prisoners whilst in prison and/or on release. However, one offers them only after the client has been released from prison; one provides them only if requested by prisoners; one does not offer them routinely, and provision is *'dependent on the individual worker';* and two do not offer these services in all the prisons they serve.

## 5.2 Planned drug services targeting Black and minority ethnic prisoners

Various developments of new or existing drug services in some or all of the prisons in their area were reported by Area Drug Co-ordinators from 12 of the 15 prison areas. No developments were reported from the West Midlands area and data were missing for the South West and London areas. However, few of the planned initiatives target Black and minority ethnic prisoners and eight Area Drug Co-ordinators and/or their representatives made specific comments on this. For example:

*This [crack cocaine-specific] service will be available to all prisoners regardless of colour, ethnic group or religion.*

*None of these [drug service developments] are race specific.*

There are only six reports from Area Drug Co-ordinators of planned drug service developments targeting Black and minority ethnic prisoners, covering a total of 28 (21% of prisons in which drug services are provided), although all these were at the development stage, including two needs assessments. For example the Female Estate had co-operated on the development of a course for drug importers in three prisons *'targeted at the large number of primarily Jamaican Foreign Nationals,'* and in Wales, the development of prisoner peer training groups was actively seeking volunteers from Black and minority ethnic groups.

The following two sections of this report largely comprise qualitative data on experiences and perceptions of prison drug services. In these sections, 'nic' following the source of a quotation from a prisoner indicates that they were not in contact with prison drug treatment services at the time of the interview, and 'ic' indicates that they were.

## 6

# Factors Affecting the Accessibility of Prison Drug Services

The experiences and perceptions of factors affecting the accessibility of prison drug services reported by the informants to this study, and which comprise the elements of this section, were knowledge and attitudes regarding drugs and drug services; prison officer-civilian drug worker relationships; prison officers as drug workers; perceived ease of access to prison drug services; motivation for accessing these services; confidentiality; stigma; and the extent to which the needs of an ethnically diverse prison population are addressed. Informants' perceived additional implications for Black and minority ethnic prisoners are highlighted.

## 6.1 Knowledge and attitudes regarding drugs and drug services

### 6.1.1 Knowledge and attitudes of prison officers regarding drugs and drug services

Prison officers are the literal and metaphorical gatekeepers to prison services. Previous studies (Hucklesby and Wilkinson, 2001; Mair and Barton, 2001) have shown that prison officers' knowledge of drug services and their attitude towards drug users are central facets of the accessibility of the services and vital to the successful implementation of the Prison Service Drug Strategy (HM Prison Service, 2003a), now subsumed into the NOMS drug strategy (NOMS, 2005).

Although many of the prison officers interviewed during the study were in some way involved with drug services, interviews with other officers supported the observations of drug workers and prisoners that the knowledge of generic officers in relation to drugs and drug services is extremely limited:

*...prison officers are nowhere near knowing enough about drugs. Half of them wouldn't be able to recognise cannabis if they saw it under their nose. (Senior prison officer)*

*I should know more. Most prison officers don't know what CARATS stands for. I really don't think a lot of staff know. (Senior prison officer)*

*All officers need training on drugs. They view us drug users as scum. They will turn down a cry for help. (Black British, ic)*

*We treat it [drug use] as an illness and they [prison officers] treat it as a weakness. (Civilian CARATS worker)*

However, despite these comments, many of the civilian drug workers reported that the awareness and appreciation of drug services by most prison officers had increased:

*I think they are a lot more aware now. And there is a lot more interest shown. When I first started, we were seen as the do-gooders, but we have gone past that now and we do get phone calls from officers saying 'this person is really suffering, I think he really needs to see you.' That is positive - they are actually recognising people are suffering. (Civilian CARATS worker)*



*...they do understand that they are not getting as many prisoners withdrawing [from drugs]. Officers were at one point facing these guys first thing in the morning, withdrawing and having some real problems. (Senior prison officer)*

### 6.1.2 Knowledge and attitudes of IMB members regarding drugs and drug services

An appropriate knowledge of the services available in prison is a key aspect of an effective monitoring process, but most IMB members displayed little knowledge of drugs and drug services. Whilst most knew that drug services were provided in the prisons they monitored, their responses indicated little knowledge of what these entailed, as summed up by one IMB member who had an interest in drug use:

*They [IMB members] are white middle class people. They don't care. Not familiar with drug addiction, so easy to say 'they [drug users] ought to be stronger.' (IMB member)*

That said, individual IMB members have specific areas of responsibility, and given the range of issues they are responsible for, many felt that it was not possible for them to keep fully informed about drug use and drug services in prisons. Nevertheless, during their visits to prisons they are all likely to encounter prisoners presenting with drug service-related issues, and whilst acknowledging the workload of members of this voluntary body, it is clear that they do not have the information necessary for them to monitor drug services effectively.

### 6.1.3 Drug training for those working in prisons

The Advisory Council on the Misuse of Drugs (ACMD, 1996) stress the importance of drug training for prison officers, but also that it is often the first victim of budget and staffing constraints. In the current study, the most commonly expressed responses from prison officers when they were asked if prison officers knew enough about drugs and drug services focussed on limitations in training:

*I did eleven weeks' training in January [as a new officer]. One day was drugs training. (Prison officer)*

In common with the findings of the CARATS Interim Review (HM Prison Service, 2003b), a number of officers who were working in drug services, including in detoxification units, reported that they had moved into these areas with good intentions, but with little or no appropriate training and were expected to 'learn on the job.' Other officers agreed that this was the case:

*There are eighteen staff [prison officers] on this [Drug Services] Unit plus three seniors. Three of those staff are experienced officers, the rest are all brand new and they have had no drug training whatsoever... they should go on drug courses first... I thought it would have been a priority on a unit like this. (Prison officer)*

*Typical Prison Service, they don't bring the expertise in...The prison is run on well-thinking officers and staff who are trying to do the right thing for the prisoners that have got these problems. (Senior prison officer, Drug Services Unit)*

The lack of drug training was a source of frustration for some officers who, on commencing this work at least, felt ill-equipped to undertake drugs work with confidence, and for civilian drug workers who had to work alongside them.

Lack of training of some CARATS civilian staff was also reported. For example, in one prison, the research team were told that a member of the CARATS administrative staff had been offered the opportunity to work as a drug worker, despite their lack of appropriate training. In another prison, a member of a CARATS administrative team was assessing prisoners to determine their selection for groupwork, and also conducting groupwork, despite having received no training to undertake this role.

There was a reported disparity between the training available for civilian drug workers, who received this from the external drug service provider for whom they worked, and prison officers who were also drug workers, whose training was provided by the Prison Service:

*Here, the staff [prison officers working as drug workers] are not trained. The counsellors have limited knowledge on addiction and motivation... [there is a] lack of understanding... 'once a drug taker always a drug taker.' I would not allow untrained staff - which does not mean two days' training - to counsel. They should get decent counsellors [who] know proper methods of reflection to bring change in people. Confrontational methods do not work... With prison officers, it is a part of their job to be confrontational, so it does not work. That is why they need outside civilian staff for whom it [confrontation] is not their method of working. (Afghan, ic)*

Some external drug service providers were reported to be demanding minimum levels of training for all those delivering drug services in prisons, and, in one area, staff working within combined teams of prison officers and civilians had been able to access joint training provided by the external provider. This example of good practice ensured that prison staff have the appropriate knowledge, and also breaks down barriers between them and civilian workers.

To increase their knowledge of drugs and drug services, suggestions made by IMB members focussed on the need for training (some suggested presentations by drug service providers), and a better exchange of information between members with specific responsibility for drug services and other members.

#### **6.1.4 Prisoners' knowledge of drug services**

All prisoners interviewed for this study were asked about the drug services that were available in the prison they were in. Most of those in contact with drug services were aware of the range available, and amongst the non-drug service users, approximately half had heard of CARATS or had some idea of the nature of the services available. The remainder were unaware of the drug services offered by the prison, and some said they had not received any information on these at induction.

Many prisoners - both white and Black and minority ethnic - reported that they had obtained information on drug services informally, from other prisoners or prison officers, or via written means, such as leaflets. Some prisoners indicated problems with understanding written information about drug services because of English language difficulties or poor literacy skills.

#### 6.1.4.1 Peer education and support

The peer support approach to drug services is identified in the CARATS Interim Review (HM Prison Service, 2003b) and by Borrill et al. (2003a) as having particular value and warranting wider application. This study found three examples of prisoner involvement in drug services in the prisons visited by the researchers. In a prison in the High Security estate, for example, a Prisoner Advice Drug Service (PADS) was in operation. This programme trains graduates of drug courses to deliver information to other prisoners about drugs and drug services. Officers co-ordinating PADS felt that it provided prisoners with the important opportunity to assess drug services and obtain assistance with referral without approaching staff:

*...this system works well. Prisoners refer others that wouldn't approach alone. (Prison officer - drug worker)*

Prisoners and staff in other establishments made requests for similar schemes:

*There is a need to utilise prisoner knowledge more, empower prisoners more. There should be more focus groups where we consult them on drug issues to shape our service. (Civilian CARATS worker)*

*...they should involve inmates rather than officers. (Greek Cypriot, nic)*

*Have more prisoners and ex-users, because they will get through to those who don't want to stop using [drugs] now. (Black African, ic)*

Whilst prisoners providing advice and information to other prisoners may raise security concerns amongst some prison officers, it is significant that a PADS is operating in a high security establishment. However, a small number of prisoners feared that, in such schemes, the prisoner-advisors would not maintain confidentiality and were concerned that information would be passed onto other prisoners and used to bully or blackmail drug users (as discussed in sections 6.7.1 and 6.7.2).

#### 6.1.5 Knowledge and attitudes regarding drugs and drug services: additional issues for Black and minority ethnic prisoners

Issues that impact particularly on Black and minority ethnic prisoners were the lack of awareness of drug services amongst foreign nationals, and differential sources of information on drug services.

##### 6.1.5.1 Awareness of drug services amongst foreign nationals

The level of awareness of prison drug services was particularly low amongst foreign national prisoners - especially females - most of whom were serving long-term sentences. Several of these interviewees said they had not received any information on drug services at any point during their sentence:

*Been here for three years - don't know what CARATS do. (Indian, nic)*

*I have been here since September 2002 but was never told about CARATS. (Black Caribbean, nic)*

#### 6.1.5.2 Sources of information

Some Black and minority ethnic community members and ex-prisoners felt that the unsupportive approach of some prison officers to drug users, coupled with discriminatory attitudes exhibited by some officers to Black and minority ethnic prisoners, meant that these prisoners are reluctant to ask officers for information about drug services. For example:

*The officers are not good. You [Black and minority ethnic prisoners] have to work out who to ask for things from, you learn who not to ask. The system should be working with you not against you. (Ex-prisoner, mixed race - Pakistani and white)*

The study found some evidence - although not conclusive - that Black and minority ethnic prisoners rely on peers as sources of information on drugs services to a greater extent than white prisoners. The reliance on peers for information may be explained by a general distrust of 'officials' amongst Black and minority ethnic communities, which can lead to an unwillingness to access drug services (Fountain et al., 2003). If these observations are accurate, peer support may offer particular value if Black and minority ethnic prisoners can be recruited to this role. Peer support initiatives could assist in meeting the needs of Black and minority ethnic prisoners in establishments that currently have low numbers of Black and minority ethnic drug workers, and in prisons where drug teams are ethnically diverse, would be an additional resource.

## 6.2 Prison officer-civilian drug worker relationships

In some prisons, CARATS are delivered entirely by civilian staff and other functions of the Drug Services Unit, such as searching and testing for drugs, are conducted by prison officers. In others, civilian staff and prison officers collectively deliver CARATS.

Despite some prison officers' attitudes to drug use and drug services, as discussed above, many of the civilian drug workers reported that they had developed workable relationships with the majority of officers (as also reported by Brookes, Mason and Mason, 2003 and by Mair and Barton, 2001). Nevertheless, despite these improvements, some drug workers (both prison officers and civilians) commented on the low status of drug services in prisons, that conflicts between prison officers and civilians remained, and that the lack of co-operation of prison officers hindered their work. For example, a number of civilian workers reported terms such as 'Care Bears' and 'Do-gooders' used by officers to describe them, and that some officers completely rejected the need for work with drug-using prisoners:

*Their [prison officers'] attitude [to drug users] is, 'just pull yourself together and get on with it.' (Civilian CARATS worker)*

When discussing access to drug services, civilian drug workers, some of whom had previously worked in community drug teams, were more likely to stress the importance of increasing the points of, and opportunities for, engagement with prisoners. Prison officers were more likely to emphasise the twin responsibilities of care and control. Prison officers' attitudes may reflect a conflict between the health-focussed aims of drug services and the secure custody focus of the Prison Service (Swann and James, 1998):

*The main problem for me is POs [prison officers] who don't believe in the [drug] programmes - the 'bang-'em-up' brigade. (Prison officer - drug worker)*

Two civilian CARATS workers (working in different prisons) who had been in post for a number of years, spoke at length about the frustrations of attempting to deliver quality, accessible services within a secure environment. They suggested that whilst some of the security concerns were clearly justified, on occasion they represented little more than a 'catch-all defence mechanism.' Civilian staff understood and supported prison officers' security concerns, but some reported an over-focus on these. However, a working relationship with prison officers was essential for them to access their clients:

*We have to go through officers to see clients - we are reliant on officers to get to client groups. (Civilian CARATS worker)*

The focus on security was also reported by some civilian workers to prevent them from undertaking work with prisoners' families. They viewed communication with prisoners' families as potentially beneficial in addressing post-release drug use, but some officers saw this as a security risk.

Several civilian drug workers suggested that pressures and disagreements with prison officers led to a high turnover rate amongst civilian staff:

*You get defeated by the prison officer role...you get defeated by all this [security focus]. That is why the turnover is so high amongst the [civilian drug service] staff. (Civilian CARATS worker)*

## 6.3 Prison officers as drug workers

Overall, despite the problems reported above, drug service teams comprising prison officers and civilian workers were reported to be working well, and the officers involved in CARATS interviewed for this study were enthusiastic about contributing to the service. In one prison, prison officers working in the drug-free wing had been selected specifically because they had indicated a positive commitment to working with drug users. This was felt to benefit the atmosphere within the wing and thus the success of services delivered there:

*The officers are involved in providing services and are encouraged to be involved. This is a nicer wing than others - this is down to the staff. When we set up this wing, we asked who [prison officers] wanted to be here. So everyone who is here wanted to work on these things [drug issues]. (Senior prison officer)*

Many drug workers commented upon the commitment of prison officers as an element of the success of CARATS, and some prison officers not directly involved in drug service delivery also reported positive feedback from prisoners on drug service staff who were also prison officers.

Civilian workers within joint teams highlighted that prison officers' involvement had helped the process of acceptance of drug services within the prison system, although some qualified this by adding that the benefit of this was principally of an operational nature, rather than an enhancement of the quality of the service:

*The main benefit of having prison officers in the team is that it makes our work easy. It makes the prison system less suspicious of us, and improves our access to the prisoners. But that is actually a benefit for us, not the prisoners. (Civilian CARATS worker)*

Prison officers involved in CARATS and other drug services also spoke positively of the contribution made by civilian staff to the development of drug services in prisons:

Interviewer: *What's the best thing about prison drug services?*

*The engagement of staff from outside services. Their skills came in and changed the general skills of staff and people's opinions. (Prison officer - drug worker)*

Despite these positive aspects of prison officers' involvement in drug service delivery, the study also revealed some negative aspects, concerning the effect of operational priorities and their dual role.

### 6.3.1 Operational priorities

The involvement of prison officers in drug service delivery was felt by many civilian drug workers to be compromised by other operational priorities. A number commented that officers tended to see themselves - and to be seen by the prison service - first and foremost as officers. One result of this situation is regular redeployment of officers to attend to other operational commitments, as also reported by Brookes, Mason and Mason (2003). This was reported to cause difficulties in planning work, drug staff shortages, and cancelled appointments with prisoners, often at short notice. Many prison officers and drug workers felt that CARATS would be improved if drug workers who were also prison officers had ring-fenced responsibilities:

*CARATS is often only me and the other [external drug service provider] worker, because the officers could be deployed anywhere. At the end of the day, the prison officer CARATS workers are officers. If officers and civilian workers have to work together, they [officers] have got to be fully deployed [to drug services]. (Civilian CARATS worker)*

### 6.3.2 Dual role of prison officers

The use of uniformed prison officers as CARATS workers was suggested by many civilian workers to make some prisoners suspicious and was a potential disincentive to their engagement with drug services:

*...[prisoners are] scared to come forward because they see CARATS workers as prison officers. Women civilians would seem more approachable. It is an issue of trust. (Employment Training Co-ordinator in a prison)*

*The prisoners may be speaking to an officer about a drug issue and in the evening the same officer may be locking them up. (Civilian CARATS worker)*

As Hucklesby and Wilkinson (2001) and Malloch (2000) suggest, the dual role of officers means that their involvement in the delivery of services is often inherently problematic because of confidentiality issues. In the present study, too, some prison officers recognised that undertaking the dual role often placed them in contradictory situations:

*At times they [prisoners] tell you security-related stuff and what are you supposed to do? (Prison officer - drug worker)*

Another example is drug testing. In some prisons, those involved in testing were in a separate team and based in a separate location to CARATS and other drug services. This communicated a very clear message about the separate nature of these roles and of those undertaking them. In other establishments, these boundaries were more blurred. Prison officers in some drug teams could be asked to undertake testing of prisoners, although some of these said that when this eventuality arose they asked someone else to do it:

*It's a hot potato. As a CARATS worker or [rehabilitation programme] tutor we get info [on a prisoner's drug use] and then may get put on drug testing and it looks bad to the prisoners...I've always expressed that worry that it's a threat to my credibility as a tutor. (Prison officer - drug worker)*

## 6.4 Perceived ease of access to prison drug services

Drug services in different establishments face different challenges in terms of their accessibility. For example, local prisons experience a high throughput of prisoners on a weekly basis, meaning there is only a short period of time to implement useful interventions. This presents very different drug service access issues than those faced by the high security estate, where prisoners may be serving long sentences and may need escorting by a prison officer whenever they leave their cell. In all the prisons visited for this study, prison officers and drug workers commented on the high demand for CARATS, and a shortage of staff to meet it.

The most common response from Area Drug Co-ordinators and their representatives when asked about barriers to prison drug services was that there were none. This response was given on a total of 24 (52%) of 46 questionnaires. Many IMB members also denied that there were any barriers:

*They [drug-using prisoners not accessing services] don't want help, because they have all the information, yet they are not asking for help.*

Whilst the majority of prison officers and drug workers reported that drug services were, in general, well publicised and accessible, they recognised that a range of issues had the potential to impact upon the accessibility of these services.

All prisoner and ex-prisoner interviewees were asked if they knew how to access prison drug services. The responses of drug-using prisoners who were not in contact with drug services suggested that this was not always because they were unaware of them: many were familiar with the access process. Some of

those who were receiving drug services thought that access had been easy, but more who were receiving - or waiting to receive - services described a complicated process and raised the concerns about accessibility discussed below. Some felt that access was made easier if they fitted the relevant target criteria, such as returning positive drug tests, and a few agreed with Barton (1999), who highlights that drug services within the criminal justice system often prioritise the crime-needy over the health-needy:

*Most officers... see it [drug use] as a problem if it is connected to re-offending, else they are just not interested. (White other, nic)*

Some of those in prison for the first time found it especially difficult to access drug services, and other prisoners suggested that 'first-timers' should be a focus of concern and that there should be more information on these services available to them.

Three major issues were raised by the study participants in terms of ease of access to prison drug services: there is a lack of transparency in the application process and limited communication about assessment decisions; waiting times are too long; and access is difficult for those with language and literacy problems.

#### 6.4.1 The application process

CARATS are usually accessed by filling in an application form and placing it in a box on the wing or handing it to a personal officer. Some drug workers told the research team of prisoners' concern about rumours of 'lost' application forms within a system prisoners believed was vulnerable to the actions of cynical officers, and indeed, many prisoners reported that they had made applications to see CARATS staff but had not received any response.

The main problems identified by prisoners and ex-prisoners in relation to applications for drug services related to a lack of transparency in the application system and limited communication about assessment decisions. This meant that they were unsure what the next step was, when it would happen, or indeed whether it ever would. For example, some prisoners were told that appointments were made in chronological order, but reported that others who had come to the prison after them were queue-jumping:

*It is not transparent - I cannot see myself moving up [the waiting list]...I have seen people who have come in and put in an application after me get in. (Black Caribbean, ic)*

In addition, many prisoners who had received an initial assessment reported that they were not told if they would subsequently be seen by a drug worker, or that they had been moved to a different establishment shortly afterwards and their appointment appeared not to have followed them. Some had been told that their application was not considered a priority, and they did not know when they would be seen.

Prisoners in all the establishments visited for this study reported that one means of accessing drug services was through a verbal request to a personal (prison) officer. However, as discussed in sections 6.1.1 and 6.1.3, and also by Mair and Barton (2001), although personal officers have the greatest involvement with drug issues, many have a low level of knowledge of these issues. This provides further evidence that prison officers' knowledge of drug services are key to the services' accessibility.



#### 6.4.2 Waiting times

In the prisons visited for this study, waiting times for CARATS appointments varied from one or two days to one or two weeks. Prisons in which the CARATS team was comprised of a combination of prison officers and civilian staff have the advantage of offering prisoners some access to drug services at the weekends, although prison officers' deployment to operational commitments could detrimentally affect this provision (see section 6.3.1). Where CARATS teams were comprised solely of civilians, the lack of weekend provision was reported: of specific concern were prisoners needing detoxification services who arrived at weekends, particularly bank holiday weekends, when they may have to wait three or four days for an appointment to access detoxification. In some circumstances, the wait means that prisoners return a urine test that tests negative for drugs and are therefore not entitled to detoxification services.

In terms of drug services other than assessments that are part of CARATS, a few of the Area Drug Co-ordinators, external drug service providers and IMB members thought that waiting lists - which most explained as due to staff shortages - was a major factor that discouraged prisoners from attempting to access drug services.

Waiting lists may impact particularly on prisoners who are serving short sentences, as they may not get access to services until just before release. Drug workers reported frustration that they have only a short period of time with such a prisoner, at a time when they are focussed only on release rather than addressing their drug use. There is therefore little possibility of providing a useful intervention, which is demoralising for drug workers, as an IMB member noted:

*I think it [waiting lists] is such a big problem that staff are overwhelmed... I feel very sorry for the staff... They [prisoners] are very demanding customers and there for a short space of time and staff don't have the opportunity to do much...So they get quite discouraged. A couple of staff have been transferred because they can't hack it any more.*

Although reports to this study of excessive waiting times were the exception, a small number of prisoners reported waiting times for drug services of several months:

*Had to put an application in three times before I was seen. It took three months to be seen...it's hard to get in touch with drug services...Your application just gets filed. (White British, ic)*

For some prisoners, the time spent waiting to access drug services left them feeling highly vulnerable and one reported that his inability to cope with the delays had led to a relapse:

*...takes three or four weeks for them to get in touch and in that time you get frustrated and get a bag [of heroin]. (Black African, ic)*

#### 6.4.3 Language and literacy

Literacy levels amongst prisoners are lower than in the general population (Niven and Olangundoye, 2002) and some prisoners, prison officers and drug workers identified this as a barrier to drug services:

*I have heard people say, 'I cannot talk to them [drug services] because I am dyslexic, there is too much paperwork involved [in applying for drug services].' (White British, ic)*

*Some people cannot read and write so cannot put in an application. (White British, ic)*

Prisoners who commented on literacy issues tended to discuss the experiences of other prisoners, although the researchers felt on occasion that respondents may have been discussing their own. If so, it reflects the embarrassment prisoners may feel about conceding that they had literacy difficulties.

Whilst acknowledging that interpretation services were available in some prisons, language was the most commonly cited barrier to accessing drug services from most interviewees from organisations working with prisoners, ex-prisoners, and their families. A few of these study participants pointed out that for those who could not communicate well in English, the situation inside prison was similar to that outside, where their access to any service was curtailed.

Six (27%) of the 22 external drug service providers thought that language was a barrier to drug service access. Translators and interpreters from local networks were used by one provider, but it was pointed out they were difficult to find for establishments in isolated rural areas.

Two external providers thought that the CARATS appointment system discriminated against those with English language difficulties:

*To see a CARAT worker, prisoners have to get an appointment slip. If appointments are missed more than twice, the prisoner is struck off the register. Unfair practice for those who are unable to read English.*

#### **6.4.4 Perceived ease of access to prison drug services: additional issues for Black and minority ethnic prisoners**

Borrill et al. (2003b) identify a general level of unmet demand for drug services amongst Black and minority ethnic prisoners, and many prison officers and drug workers interviewed for the current study agreed. Some were unsure of the reasons:

*...some problems with Asians here. Don't know why - they don't access. (Prison officer - CARATS worker)*

The majority of IMB members strongly denied that Black and minority ethnic prisoners face more barriers to drug services than their white counterparts, however, and some Area Drug Co-ordinators agreed:

*All services are provided equally to prisoners irrespective of ethnicity, gender or religious beliefs. (Area Drug Co-ordinator)*

Perceptions of issues that particularly affected access to drug services by Black and minority ethnic prisoners focussed on the low numbers of Black and minority ethnic staff and racism and discrimination, and these are discussed in section 6.8.

## 6.5 Motivation for accessing prison drug services

A large proportion of prison officers, drug workers, prisoners, and ex-prisoners raised the issue of prisoners accessing drug services for what some described as the ‘wrong’ reasons (also discussed by Mair and Barton, 2001).

### 6.5.1 ‘Game playing’

The term ‘game playing’ was often used to describe the advantages for prisoners who accessed drug services in order to enhance their parole application:

*Lots of prisoners don't refer to CARATS for genuine reasons - it is to get ticks in parole boxes. (Civilian CARATS worker)*

*Some lads are using the TC [therapeutic community] as a feather in their cap - they get parole if they complete TC successfully. (White British, nic)*

*I came to the [drug-free] wing after applying for a drugs course - to help with my parole. (Black Caribbean, ic)*

Many prisoners are required to attend drug-related courses as an aspect of sentence planning, and a probation officer pointed out that the issue of internal versus external motivation to engage in with drug services is one regularly facing drug services throughout the criminal justice system. Some drug workers found it frustrating that the demands of sentence planning meant they had to work with prisoners who had no other motivation:

*The sentence plan recommends doing courses [groupwork]. Linking parole to courses has problems. They must find another way for determining parole. (Civilian CARATS worker)*

Prisoners attending groupwork sessions who told the researchers that they genuinely wanted to address their drug-using behaviour expressed particularly strong views about the presence of others who were ‘playing the game.’ These individuals often felt those who were ‘just along for the ride’ prevented them from making the most of the opportunity, and devalued the personal investment they were making.

However, despite the perceived advantages, a number of prison officers and drug workers suggested that some prisoners would not approach drug services regardless of the level of need, because they were not currently ready to engage in a process of change and were content to continue to use drugs (as also noted by Bullock, 2003a). Others explained the reticence of some prisoners to seek support as:

*There is a sense of ‘I can deal with it’ - they don't think they need help. (Civilian CARATS worker)*

### 6.5.2 Better facilities on drug-free wings

In many prisons, Voluntary Testing Units (VTUs), also known as drug-free or enhanced wings, operate in an attempt to encourage prisoners who agree not to use drugs and to undertake Voluntary Drug Testing (VDT).

The fieldworkers for this study noted that the conditions in VTUs were markedly better than on general wings. For example, facilities in one included single cells with televisions (on other wings in the same prison, prisoners shared four-person cells and the television was in a communal area), more association time and, for those prisoners accessing drug services, more time at the gymnasium, and more visiting time. Many prisoners, prison officers, and drug workers commented on the effect of this situation on motivation to access drug services:

*...lads can lead people [drug service workers] on because they want enhanced cells...* (Prison officer)

Interviewer: *Why did you decide to get help with your drug use?*

*On [the drug-free] wing you get TV and single cells.* (Black Caribbean, ic)

Some prisoners reported that although a transfer to a drug-free wing could involve several months of good behaviour, the process could be accelerated by pretending they needed help with drug use. This situation caused resentment amongst some, however, who felt that others had a greater need for drug services:

*People are on this wing [VTU] because of the single cells and the TV. Those who really need help are not here.* (White British, ic)

### 6.5.3 'Someone to talk to'

Several prisoners, especially young people and females, reported that they (and other prisoners) made appointments to see drug workers because they wanted to get out of their cells and talk to someone, rather than because they wanted to address a drug problem. It was suggested by prisoners that if there were other support structures for these prisoners, drug services could be more effectively targeted at those who 'really' need them:

*When people get CARATS workers for nothing, it takes time that they could have given me off me. If there were other services, like counselling, people would use that.* (Mixed race - Iraqi-Lebanese, ic)

## 6.6 Confidentiality

Maintaining the confidentiality of drug service clients in a prison setting raises different issues from those encountered in the community. However, whilst few prisoners may be able to access prison drug services in total secrecy, this section shows that confidentiality is breached by the physical environment in which drug services are delivered, and by the actions of prison officers and drug workers. The lack of respect for confidentiality, exacerbated by the lack of suitable environments in which to deliver drug services privately, and the fear of reprisals from prison officers if identified as a drug user act as barriers to drug service access by prisoners.

### 6.6.1 Respect for confidentiality

Only a few Area Drug Co-ordinators and their representatives identified a lack of confidence in the confidentiality of prison drug services as a barrier to their access. The comments all related this to the

lack of private space in which clients could be seen. To illustrate the lack of recognition of confidentiality as an issue by this group of interviewees, in order to show that ethnic monitoring was conducted in one area, an Area Drug Co-ordinator sent the research team a list of drug service clients, complete with their names and prison numbers.

Some prison officers and drug workers maintained that poor respect for confidentiality - especially by wing officers - meant that some prisoners were reluctant to approach any prison service, regardless of need:

*We phone the wing [to contact prisoners] and they [wing officers] shout out, so everyone knows. (Prison officer - CARATS worker)*

Indeed, one of the most frequently cited concerns of prisoners across all prisons visited by the research team was the lack of trust in the confidentiality of the prison's drug services, particularly by those prisoners who were not in contact with them. A small number of prisoners suggested that drug workers would divulge details of their drug use or the content of counselling sessions not only to prison staff, but also to other prisoners, but overall, prisoners expressed lower levels of trust in confidentiality - particularly about current drug use - where prison officers were involved in the delivery of drug services:

*Some women don't want to talk to the CARATS workers because they are still a screw [prison officer]. (White British, ic)*

*Some... are put off by uniformed CARATS workers - If they were not in uniform, some would access them [drug services] more. (Black Caribbean, ic)*

Prisoners' concerns about the lack of importance attached to confidentiality by prison officers were highlighted by fieldwork observations. In two of the prisons visited, the prison officers in the CARATS team pressed the research team for information given by prisoners during interviews. A civilian CARATS worker in another prison also disregarded confidentiality: the researchers were told details, including the prisoner's name, about a 1:1 session that had just been conducted. Later, the researchers overheard the same worker discuss the prisoner with a prison officer and divulge information from the session.

### 6.6.2 Suitable environments for delivering drug services

Prison overcrowding leads to competing demands for resources and space and this impacts on the delivery of drug services. The issue of suitable environments for undertaking drugs work was raised by prison officers, drug workers, and prisoners in all of the prisons visited during this study. They commented particularly on the difficulties of finding somewhere for 1:1 sessions:

*The problem we sometimes have is finding somewhere suitable, private and confidential, because you can't do some of those sessions on the landing... (Civilian CARATS worker)*

*When they come to you, half the time they talk to you through the door they don't even open the door... They are civilian workers so they don't have keys for the doors... You don't exactly feel like opening up in front of your pad[cell]mate. (Mixed race - Black Jamaican and White British, ic)*

*[A drug worker] talked to me through the flap [in the cell door] - I told her to piss off to be honest.*  
(White British, ic)

CARATS teams in the prisons visited for this study were based in a number of locations including in Portakabins and on various wings, including the induction wing and the drug-free wing. Where space was at a premium, the following were reported or observed:

Prisoners who wanted to see the CARATS team had to queue outside the door of the Drug Strategy Unit in a central corridor, and speak with CARATS staff through a hatch.

A Drug Services Unit was located on the voluntary testing wing, which means that during association time, any prisoner in that wing can see who is accessing drug services.

A drop-in was only open for a short time, which meant there were queues outside the room:

*There are eight or nine people behind you, so there is no privacy.* (Black Caribbean, ic)

*If you have four or five people in front of you, you don't want to hang around because you don't want to be seen.* (White British, nic).

1:1 counselling sessions were conducted in the open-plan CARATS office. Not only was this in the same room as other CARATS staff, including the administrative staff, but other prisoners were also present, having sessions with other CARATS workers.

Even when attempts were made to ensure privacy, confidentiality was still compromised:

Interviewer: *What's the worst thing about prison drug services?*

*They [CARATS workers] come to your wing and take you to your room [cell] in front of everyone.*  
(White British, nic)

As suggested by PSO 3630 and the CARATS' Interim Review (HM Prison Service, 2003b), several prison officers and drug workers recommended that CARATS teams should be located near or in the same building as other healthcare services, because this would not only promote interdepartmental co-operation but afford prisoners greater confidentiality, as they could tell others they had an appointment with healthcare services rather than with a drug worker.

### 6.6.3 Fear of reprisals from prison officers

Malloch (2000) and Turnbull, Stimson and Stillwell (1994) highlight a reticence amongst some prisoners to reveal drug use due to fears of negative repercussions, including increased surveillance. The findings from the current study support this. Some prison officers and drug workers thought that prisoners' concerns about confidentiality were rooted in the stigma attached to drug use and help-seeking (discussed in detail in section 6.7), but some IMB members were aware that some prisoners were reluctant to approach drug services due to a fear of reprisals from prison officers. Indeed, many prisoners

and ex-prisoners felt that contact with drug services may result in unwanted attention from prison officers, such as not being trusted and hence finding it difficult to obtain the more popular work in the prison, having more attention paid to them during visits, and, especially, that the chances of being tested for drug use would increase:

*Some people are put off because once you see the DSU [Drug Services Unit], the screws will be on you. You stay away to keep the heat off you. (Black British, ic)*

*In fact, what they [prison officers] do, once they know you're using drugs, they'll start using you as a guinea pig, they will pick on you and test you regular. (Ex-prisoner)*

Prisoners' concerns were exacerbated by the dual role of prison officer-drug worker, because it was felt that confidentiality would be breached. In one prison, for example, a prison officer who acted as drug counsellor during the week administered mandatory drug tests over the weekend, and in another, the Drug Strategy Manager had previously been a dog handler, involved in searching prisoners' cells for drugs. The contradictions in such situations were recognised by some prison officers, too, who described situations when they may be obliged to reveal information given to them as drug workers by prisoners, as discussed in section 6.3.2.

#### **6.6.4 Additional confidentiality issues for Black and minority ethnic prisoners**

Abdulrahim (1994) and Perera, Power and Gibson (1993) maintain that confidentiality is an issue which differentiates Black and minority ethnic drug users from their white counterparts. These studies emphasise that Black and minority ethnic drug users are more concerned about confidentiality than white drug users, and will not approach services unless they are certain that confidentiality will be maintained. Wanigaratne et al. (2003) stress that additional attention should be paid to confidentiality in meeting the needs of Black and minority ethnic drug users, and that this may include explaining exactly what confidentiality means in the prison context and exactly who will have access to information provided.

Whilst, in the present study, the issue of confidentiality was raised as a concern by many prisoners from all ethnic groups, it had additional implications for prisoners from Black and minority ethnic communities and was mentioned by them much more frequently. The stigma associated with use of some drugs by some Black and minority ethnic communities (section 6.7.4.1) also means that drug-using prisoners from those communities attached particular importance to the context in which drug services are delivered. They specifically valued privacy, as this enabled them to hide their drug use from other prisoners, including members of their own communities: fears that confidentiality would be breached led to concerns that they would be shunned by some other prisoners of their ethnic group. For some, the concerns over maintaining these relationships outweighed the possible benefits of approaching drug services.

## 6.7 Stigma

Stigma describes a characteristic or behaviour that labels its bearer as different from ‘normal’ people and attracts social sanctions. The term stigma captures a combination of feelings such as shame, blame, secrecy and low self-esteem, which are perceived by the stigmatised and their associates and also indicate society’s judgement of them. Of course, what is ‘normal’ behaviour varies according to the ‘society’ in which it occurs, so, for example, the stigma attached to certain behaviour in prisons may be exaggerated or understated in the community, or behaviour that is stigmatised by some ethnic groups may be seen as normal by others.

Stigma and embarrassment were the reasons most frequently offered by prison officers and drug workers to explain why some prisoners do not access drug services (see also Swann and James, 1998).

There is a distinct gendered aspect to this issue: very few female prisoners reported concerns about stigma, of either drug use or help-seeking.

### 6.7.1 The stigma surrounding drug use

Younger prisoners were more likely than older prisoners to report a stigma attached to the use of drugs, although there was little evidence from any age group of any stigma in using cannabis. Many prisoners - particularly young men - reported that the stigma attached to drug use in prison led to social sanctions from other prisoners:

*If you look like you are taking drugs, you will get taunted, and there will be fights. (White English, ic)*

*They [drug users] are ashamed to let others know they use because they would diss [disrespect] you. (Black British, ic)*

The use of heroin and crack cocaine was particularly stigmatised by prisoners of all ages, and this was linked to some users of these drugs not accessing services:

*It can be a big deal and can be embarrassing especially for users of crack and heroin [to contact drug services]. Others know what's up and that is very hard. (Black British, ic)*

*They don't want to be labelled a 'junkie' or a 'crack-head' and so may not come forward. (Civilian CARATS worker)*

*It could be that people will not accept help because they will be bullied [by other prisoners]... Drug users who are on crack and heroin would be particularly targeted because they are seen as outcasts. (White British, ic)*

As discussed in section 6.1.4.1, such fears may also inhibit the development of effective peer education and support initiatives.



### 6.7.2 The stigma surrounding help-seeking

Cope (2000 p.359), from a study of male young offenders, reports that *'appearances in the very masculine environment of prison are vital,'* and findings from the current study support this. A reluctance to seek help for drug use was seen to affect male prisoners particularly, and especially young males, who, prison officers, drug workers, and IMB members reported, wished to maintain an appearance of invulnerability:

*...only a small number would refer themselves. This is because of shame, the concept of pride in not wanting to admit to having a problem.* (Civilian CARATS worker)

*Lots of people here need drug services, but few ask. This is because of the stigma of being seen to ask for help. This is seen as being weak - it is a macho thing. Everyone wants to be seen as a big hard man.* (White British, nic)

That said, some prison officers and drug workers in all the prisons visited for this study suggested the stigma of approaching services was decreasing.

Some drug-using prisoners' concerns about help-seeking focussed on the perceived and experienced responses from staff:

*...stigma - due to which I also denied I had a problem. This is from officers who label you as 'smackhead.'* (White British, ic)

*Not all are getting services because it takes a lot of guts to say you have got a problem. [Drug users say] 'I am not going to tell the nurse in case they laugh at me.'* (White Irish, ic)

### 6.7.3 Being seen as an informer

Some prisoners felt that accessing drug services may lead to other prisoners seeing them as 'grasses' (informers). Some were suspicious about any contact between prisoners and services, and these suspicions were heightened by the involvement in drug services of uniformed officers:

*It is about bravado, ego. If seen as seeking help, mixing with the other side, you are seen as a grass.* (White English, ic)

*If you say you are seeing CARATS, the other prisoners think, 'oh, a grass.' It causes problems on the wing and when you are trying to score [obtain drugs].* (Black African, ic)

#### 6.7.4 Additional stigma issues for Black and minority ethnic prisoners

The participants in this study most often discussed stigma and its impact in relation to Black and minority ethnic prisoners, in terms of drug use, help-seeking, and these prisoners' families and communities.

##### 6.7.4.1 Drug use

As also reported by Borrill et al. (2003a), the stigma surrounding the use of heroin was expressed most strongly and most often by Black and minority ethnic inmates, particularly those who identified as 'Black,' although crack cocaine use attracts less stigma amongst them:

*I didn't want anyone to know I was using smack [heroin] - it's dirty. My friends have all taken crack but... But I felt ashamed taking smack. It's the way I was brought up - 'smackheads are dirty and they're thieves.'* (Mixed race - Black Jamaican and White English, ic).

*Many of the Black lads may not want to admit to using heroin - even crack use is a problem, but admitting to heroin use will be a complete loss of face. There is a lot of posturing here - they don't want to be seen as weak in front of each other.* (Civilian CARATS worker)

In the focus group for young Black Caribbean and mixed race (white and Black Caribbean or Black African) people, there was a lengthy discussion on heroin use by Black and minority ethnic prisoners, and the stigma attached to this was clearly expressed. Some participants believed that heroin use was exclusive to white prisoners, as 'our people' would never be 'bagheads' (heroin users). However, others in the group felt that the situation was changing, and drug use by prisoners mirrored what was happening in the community: 'You only have to go out on the street to see plenty of Black bagheads.'

Injectors of heroin attracted even more stigma amongst the majority of Black and minority ethnic prisoners interviewed for this study:

*I use heroin but do not think that other Black people should inject heroin. If others here knew you were injecting, you would get no ratings, no respect. It's bad enough taking heroin, but injecting...* (Black British, ic)

*More Black people are using heroin now than before, but if a Black man injects, his family and friends look at him like he is a piece of shit.* (Black Caribbean, ic)

##### 6.7.4.2 Help-seeking

Few external drug service providers and Area Drug Co-ordinators identified stigma as a barrier to drug service access, and those who did referred to the issue only in relation to Black and minority ethnic prisoners. Two of the 22 external providers asserted that, because of the stigma

attached by prisoners to engagement with drug services, only ‘confident’ Black and minority ethnic prisoners access them. A few prisoners, however, explained the stigma attached to help-seeking by Black and minority ethnic prisoners as an issue involving white ‘authority figures:’

*It is mostly about the authorities knowing. They cannot relate to the white authority figures. Similarly, they cannot relate to those delivering the services - seen as all-white authority figures.*  
(Afghan, ic)

#### 6.7.4.3 Family and community

Many of this study’s participants reported that the cultural and religious stigma attached to drug use by some Black and minority ethnic communities may act as a barrier to prisoners from these communities acknowledging their drug use and seeking help. For some male prisoners, fear of their family or their community discovering their drug use was an important factor in preventing them from accessing drug services, and whilst it is not clear that this is an issue solely affecting Black and minority ethnic prisoners, it was raised only by them.

The importance of this issue to some communities can be explained using the South Asian community as an example. In this community, individuals are not necessarily viewed as autonomous but are defined, at least in part, by their role and position within a wider network of kinship ties and family relationships, and their ability to function within the parameters of those roles. The corollary of this is that these significant others are also responsible for maintaining this close network of relationships and the rules governing morality within this context. Therefore, any failing is that of this collective, rather than just of the individual. Given this, the stigma of an individual’s drug use may be felt amongst the family, a wider network of associates, or indeed the whole community, who experience the loss of status or the social sanctions that stigma attracts as shame and dishonour (Wanigaratne, 2003).

In contrast, a few interviewees felt that Black and minority ethnic prisoners faced fewer barriers to accessing drug services inside prisons than they did in the community:

*In prisons, they form a captive audience...in the community, the pressures from the family and the community, as well as the fear of retribution for disclosing drug use, act as barriers to accessing drug services. In prisons, the Black prisoners are away from these barriers.* (Representative of an organisation working with prisoners)

Other representatives of organisations working with prisoners, ex-prisoners and their families stressed that Black and minority ethnic communities should be more ‘open to change’ and address the stigma attached to drug use that hinders access to drug services both in the community and in prison.

## 6.8 The extent to which prison drug services address the needs of an ethnically diverse prison population

PSO 3630 requires CARATS to acknowledge and respond in positive and practical ways to the diverse needs of the different elements of the prison population. However, as shown by the data in this section, little consideration has been given to the specific needs of Black and minority ethnic prisoners in the development and delivery of drug services. This is in contravention of the Race Relations (Amendment) Act 2000, that places a general duty on public bodies to promote race equality, eradicate discrimination and to have clear race equality plans.

This section begins with an examination of the ethnic ratio of prisoners and prison staff, and continues by reporting the perceptions and experiences of the study participants on prison drug services as '*a white service for white people*,' cultural competence, diversity training, racism and discrimination, and the extent to which the Prison Service has considered ethnic diversity at a strategic level.

Only a small number of prison officers and drug workers thought that the Prison Service took ethnic diversity issues seriously, but used as evidence only the number of posters in prisons which draw attention to these issues. One interviewee offered the following overview of the current situation:

*They [the prison] try too hard and keep putting things in place, but it is not a natural process. They know they have to do it, rather than wanting to do it. (IMB member)*

Others' overviews were more damning:

*Race and ethnicity are not an issue for planning and delivery of drug services. (Prison officer - CARATS worker)*

### 6.8.1 The ethnic ratio of prisoners and staff

Targets have been set for the proportion of Black and minority ethnic staff in each prison, and 86 (67%) establishments are reported by the Prisons Research Section of RDS to be on schedule to meet these. The latest statistics available at the time of the study show that prisons in some areas are exceeding these targets, particularly those in the London area and in the Juvenile Operational Management Group.

However, comparing the targets to the proportion of Black and minority ethnic prisoners produces varying ratios of Black and minority ethnic staff: Black and minority ethnic prisoners across England and Wales, as illustrated by the table opposite.

Situation at February 2003	Prison A	Prison B	Prison C
Prisoners from Black and minority ethnic groups	50.9% (232) of 455	56.7% (717) of 1,264	7.5% (14) of 186
Target for Black and minority ethnic staff	2.0%	25.0%	0.8%
Therefore, target Black and minority ethnic staff: Black and minority ethnic prisoner ratio	1:38.7	1:4.4	1:14.0

Calculated from data received by the Prisons Research Section of the Home Office Research, Development and Statistics Directorate

The varying staff:prisoner ratios displayed above can be partly explained, of course, by a realistic approach to target-setting that takes into account the likelihood of recruiting staff in an area with a low or high Black and minority ethnic population, such as the areas in which Prisons A and B are respectively situated. However, especially given that Black and minority ethnic staff are over-represented in administration posts, a Black and minority ethnic prisoner in Prison A is far less likely to come into contact with a member of staff from their own ethnic group, or any other Black and minority ethnic group, than a prisoner from Prison B. The target at Prison C means that, when it is achieved, just one of 120 staff members will be from a Black and minority ethnic community.

At the time this study was conducted, the ethnicity of prison drug service staff was not monitored centrally, but many study participants recognised that Black and minority ethnic prisoners were under-represented as drug service clients, and most commonly explained this as the lack of Black and minority ethnic staff (both in the Prison Service in general and in prison drug services specifically). For example:

*[There should be] more Black and minority ethnic women staff so that many of the women here have a chance to ask for help. (Civilian CARATS worker)*

*Yesterday there was a meeting at the Race Relations Board about ethnic minorities and why they don't use CARATS. Black and Asian staff would make a difference... (Indian, nic)*

*Very few Black women on my caseload...We definitely need to have Black and minority ethnic women delivering services. (Civilian CARATS worker)*

Ethnically diverse teams are not an end in themselves, however. Appointing a Black and minority ethnic member of staff is ineffective unless there is also a commitment to systematic organisational change, with Black and minority ethnic workers employed as generic workers, and all workers trained in diversity issues. In this way, meeting the needs of an ethnically diverse prison population becomes a collective responsibility rather than a specific role attached to one post (Fountain et al., 2003; Sangster et al., 2001; Wanigaratne et al., 2003).

Many prison officer and civilian drug workers thought that priority should be given to widening the ethnic diversity of CARATS teams. Suggestions included creative thinking about the process of recruitment, including where posts were advertised, and developing links with Black and minority ethnic community organisations:

*In advertising for the new posts, we have to see how we advertise and have to go to the communities more. It is very important to understand the context of drug use, so we need to build stronger links with the community groups.* (Civilian CARATS worker)

Some Area Drug Co-ordinators and external drug service providers added the issue of the gender of drug service workers as a barrier to drug service access:

*We are an all white, all female team and I have no doubt that this may be off-putting to some ethnic minority prisoners.* (External prison drug service provider)

*The majority of staff working in this field are white females. This may be a generalisation, but having a mixture of staff to reflect the ethnic breakdown of the client base would be a start. At present there are approximately 50% non-white prisoners at [prison] and no BME [Black and minority ethnic] staff working in the drug arena.* (Area Drug Co-ordinator)

### 6.8.2 'It's a white service for white people'

Previous research (Bentley and Hanton, 1997; Borrill et al., 2003a; Fountain et al., 2003; Sangster et al., 2001) has explored the implications of the under-representation of Black and minority ethnic drug workers in terms of the impact on accessibility of drug services to Black and minority ethnic drug users. Results show that members of Black and minority ethnic communities tend to see such services as run by, and for, white people. Although Black and minority ethnic prisoners do not necessarily want prison officers and drug workers from the same ethnic group as themselves, the presence of workers from different ethnic groups within drug service teams communicates an important message about who the service is for. This was specifically noted by many prison officers, drug workers, Black and minority ethnic prisoners, and some Black and minority ethnic community members:

*Also, all [drug service] staff here are white which sends a message... 'It's a white service for white people.' They need to be diverse to send the message that 'we are a service for a group of diverse people.'* (Afghan, ic)

*Many BME [Black and minority ethnic] prisoners often feel it is a white [drug] service run by white people for white prisoners...* (Prison officer - drug worker)

### 6.8.3 Cultural competence

Bentley and Hanton (1997) report that Black and minority ethnic drug users' reluctance to approach services is rooted in the perception their culture will be misunderstood. In the current study, many Black and minority ethnic prisoners stressed that ethnically diverse drug service teams would enable members

of their communities to relate better to drug workers; enable the workers to understand the context of these prisoners' drug use; would mean that services would be perceived as more accessible by Black and minority ethnic prisoners; and increase their trust in drug service staff:

*The worst thing [about prison drug services] is not using people delivering services who know what happens in our families. (Black British, ic)*

*Lots of Black [drug] users don't ask for help because they are ashamed to admit they have a problem [to a white drug worker]. If Black staff were delivering services, they might be able to talk to them. (Black Caribbean, nic)*

*If every time you want to talk about drugs, it is to a white person, then it is harder... There is a lack of trust in staff, especially for Black inmates. (Black British, nic)*

When asked to identify barriers to drug service access, several Area Drug Co-ordinators and their representatives cited Black and minority ethnic prisoners' lack of trust in drug service staff, particularly those who do not have culturally relevant skills. A representative of an organisation working with prisoners, ex-prisoners and their families succinctly summed up:

*Faced with a predominantly white staff, many Black prisoners do not feel safe to disclose drug use. They feel that the service providers will not understand the context of their drug use.*

In one of the prisons visited for this study, although the issue of diversity had not been considered at a strategic level, the CARATS team was ethnically diverse and reported that they had delivered improvements in terms of perceptions by prisoners of the accessibility of the service:

*We have a culturally and ethically diverse team which makes a difference in terms of accessibility. I have often had a client and if I can't connect with them, I will put my hands up and am able to pass them to someone else. Here, we don't get people saying, 'you don't understand my culture.' It does help having more Black staff. (White civilian CARATS worker)*

However, staff in this team thought that the improvements had been achieved by the professional characteristics and personal commitment of two of its workers. Although currently successful, the lack of a strategic approach left the improvements vulnerable if these two workers left their jobs.

A few study participants had not totally grasped the concept of cultural competence, some believing, for example, that prisoners' many different ethnic groups made the staffing issue difficult to resolve. In particular, apart from citing the existence of prisons' Race Relations Committees, IMB members were most likely to illustrate prisons' sensitivity to cultural diversity by the availability of various ethnic foods in the prison canteen. In addition, a few IMB members presented this as an inconvenience for the prison service:

*To actually give to that [Orthodox Jewish] girl what she should be getting in accordance with prison rules creates mayhem in the prison - Kosher food and so on... it is extremely difficult for the prison to manage it. And similarly with Muslim girls, dealing with Eid and so on...there are problems.*

#### 6.8.4 Diversity training

The Commission for Racial Equality (Biddle and Pavey, 1995) reports that prison officers highlight their own lack of cultural awareness, and emphasise this as a priority training need. In the majority of prisons visited for this study, some sort of diversity training was taking place. Most staff had received this either as an aspect of their initial training or as an annual event. It is clear, however, that diversity training tended to be handled as a discrete exercise, which diminished its relevance to day-to-day work. The result is that diversity issues impacting upon staff's work are neither actively nor specifically addressed.

Many prison officers thought that diversity training was too brief and several added that the Prison Service saw the issue of diversity as a '*paper exercise*':

*I do that [conduct diversity training] with the Training Officer. It's not brilliant. It's when we can release staff...More miss than hit. It needs to be improved quite badly.* (Prison officer)

*There is a lot of talk, a lot of lip service... because they have to have a diversity team. They have to train staff in diversity.* (Prison officer)

Those Black and minority ethnic prisoners who discussed diversity training for staff agreed:

*The other day, two officers who are CARATS workers called me 'coloured.' The CARATS staff do not have enough training...they do not know how to address you. If they took it seriously, they would train you before they gave you the job. They would not let you operate machinery without proper training, but their attitude is, 'we are only dealing with Black people, so you don't need the training.'* (Black British, nic)

In terms of diversity training in the context of drug services, Wanigaratne et al. (2003 p.49) stress that '*Instead of looking at race and culture as a separate issue in training, every topic in substance misuse should be looked at from a racial and cultural point of view.*' As Sangster et al. (2002) point out, white workers have an important part to play in culturally competent drug services. Many of the white drug workers interviewed for the present study recognised that their own understanding of diversity issues was limited and indicated they would be keen to access relevant training:

*I have no understanding of what it is like in Brixton [south London]: I do not know what services are available, what the social context of [drug] use is, so it is much harder to help, it is harder to provide effective advice for resettlement.* (White civilian CARATS worker, North of England)

When asked for suggestions for initiatives to ensure that the needs of all problematic drug-using prisoners can be effectively addressed, six (27%) of the 22 external drug service providers wanted more training and support in Black and minority ethnic issues, for prison officers and for civilian drug workers:

*Some prisons would like to have guest speakers at race relations meetings and also better distribution of data / information relating to Black and minority ethnic prison statistics.*

Despite some form of diversity training being conducted in all the establishments visited during this study, only one programme was reported by interviewees to have considered issues surrounding drug service planning and delivery. In this prison, diversity training and direction was delivered to the CARATS team



by their manager, and there had been a specific focus on the issues of accessibility to drug services by Black and minority ethnic prisoners, and increasing cultural competence to develop workers' skills and enhance their effectiveness. In other prisons, a number of white CARATS workers working within all-white teams supported the need for such leadership.

### 6.8.5 Racism and discrimination

Fountain et al. (2003) and Wanigaratne et al. (2003) highlight that many members of Black and minority ethnic communities are reticent about approaching drug services due to fears of experiencing not only a lack of cultural understanding, but overt and institutional racism. In the current study, although most interviewees who discussed racism commented on its indirect and institutional forms, several prison officers and prisoners spontaneously reported overtly racist attitudes and behaviour of prison officers, and that these were not adequately addressed:

*Bullying, harassment, inappropriate comments - it needs to be improved. Some staff are going to be like that, but they need to recognise now what they are saying is not acceptable. Are those things handled in a serious way here? No. (Prison officer)*

Several prison officers and drug workers commented on institutional racism in the Prison Service, seeing it as inward-looking and addressing the problem of racism only in a tokenistic and defensive manner, and most of the prisoners who discussed racism also commented on its indirect and institutional forms:

*The racism here is hidden, not like the eighties, when they called you 'Black bastard.' They find other ways of doing it. (Black British, nic)*

*It is not direct racism here anymore...It is to do with getting access to stuff. (Afghan, ic)*

*Issues for foreign nationals take a back seat even though there are equal opportunity signs everywhere. They treat us like we are invisible, illiterate, scum of the earth... (Black Caribbean, nic)*

Some prisoners felt that there was more racism and stereotyping of members of Black and minority ethnic communities in prisons outside London:

*They [prison staff] think when we [Jamaicans and Black British] are loud, we are being aggressive, but that's how we relate to each other. White guys get more help than Black guys...There's a lot of racism in all jails outside London. Less so in London because there are a lot more Black officers. (Black British, ic).*

The lack of Black and minority ethnic staff, in conjunction with fears of racism, has led to a distrust by Black and minority ethnic prisoners that they would receive an equitable and culturally-sensitive service:

*They're [Black and minority ethnic prisoners] not going to join [access drug services] if they are not seeing Black faces and are constantly hearing of racism and abuse going on. (Prison officer)*

Most interviewees representing organisations working with prisoners, ex-prisoners, and their families felt that recruiting more members of Black and minority ethnic communities would change perceptions about racism in prisons and prison services. One explained why this is problematic:

*Black people's own perceptions about the racism in the prison system is due to a predominantly white prison staff, and their reluctance to work in this setting.* (Representative of an organisation working with prisoners, ex-prisoners, and their families)

The absence of transparency in drug service application procedures and waiting lists for services (discussed in sections 6.4.1 and 6.4.2) were perceived by some Black and minority ethnic prisoners to be indicative of racism:

*I have tried to get on courses but I cannot. The therapeutic community does not have a lot of Black prisoners.* (Black British, nic)

*You see white people coming to the [drug-free] wing when Black people are there on the waiting list.* (Black Caribbean, ic)

Unlike other study participants, most IMB members participating in this study asserted that prisons took issues of racism seriously and cited the existence of a Race Relations Committee as proof of the commitment to racial equality, but some prisoners commented on what they saw as inadequacies in the prison's race relations strategy. In one case, a Black and minority ethnic prisoner appointed to the prison's Race Relations Committee said that the officer in charge had told him '*we are learning from you,*' because the officer had had no specific training to undertake this role.

A few Black and minority ethnic prisoners commented upon the inadequacies of complaints procedures following racist incidents, reporting that they had little confidence in either prison Race Relations Committees or IMBs. Some of these prisoners' concerns related to difficulties in explaining racist incidents to white staff, whilst others were related to fears that complaining would lead to negative repercussions from prison staff.

#### 6.8.6 Strategic consideration of ethnic diversity

The report of HM Chief Inspector of Prisons for England and Wales (2002) recommends that diversity issues should be at the heart of prisons' management and structures, but the findings of this study emphasise the lack of a strategic lead on diversity within prison drug services. For example:

Whilst many prison officers and drug workers stressed that drug services should consider more fully the needs of Black and minority ethnic prisoners, some felt overwhelmed by their current workload, and lacked the seniority to take ideas forward.

The data in section 5 of this report reveal that only three establishments of the 133 (2.25%) on which data were available have drug services that target Black and minority ethnic prisoners, and only 28 of these (21.1%) are planning such services (table 3, in the appendix).

Around half of the external drug service providers recommended that prison drug services give more consideration to cultural and religious diversity, including recognising that this may include different drug-using patterns.

Most IMB members did not recognise the need for the consideration of ethnic diversity in the planning and delivery of prison drug services. On the contrary, many thought that by not considering this issue, prisons were treating all prisoners equitably:

*I don't think there is a need to give consideration to needs of Black and minority ethnic prisoners. We are all humans and have the same need.*

External drug service providers, and Area Drug Co-ordinators and their representatives were asked if they could provide information pertaining to Black and minority ethnic prisoners in the form of literature, research reports, etcetera. Only a minority could do so: for example, 30 (65%) of the 46 questionnaires returned from Area Drug Co-ordinators or their representatives said they could not provide any relevant information. Thus, information about Black and minority ethnic prisoners is not reaching those whose work would benefit from the knowledge.

That said, this study did find isolated examples of good practice: in one prison, a needs assessment had been undertaken that identified major gaps in drug services for Black and minority ethnic prisoners, more of whom reported crack cocaine use than white prisoners. As a result, a specialist crack cocaine post had been created.

Where the diversity had been addressed, both in recruitment and training, benefits were reported by staff. In one prison, the CARATS manager had taken a strategic lead on issues of diversity, and so diversity issues were considered during staff meetings and training, and seen as a collective responsibility. Staff in this team recognised the value of this:

*At the time of recruiting, we were conscious that we wanted an appropriate mix of races in our team. It is about the ability to relate to and respond to the needs of a client group who often express feelings of racism faced by them in society. We need someone who has that life experience that training cannot quite provide. (Civilian CARATS worker)*

It can be reasonably expected that leads on Black and minority ethnic issues would greatly facilitate the extent to which prison drug services address ethnic diversity. Area Drug Co-ordinators reported that 116 prisons have such a lead, whilst the question was unanswered in the case of the remaining 17 establishments. Less than half (10 / 45%) of the external drug service providers have a Black and minority ethnic lead, however, although two reported that they were currently in the process of appointing to this post.

# 7

## Experiences and Perceptions of Specific Prison Drug Services

This section examines the experiences and perceptions of the study participants of a range of prison drug services: induction, detoxification, 1:1 counselling, groupwork, drug testing, services for users of drugs other than heroin, and throughcare.

In discussions on these services, it was clear that many prison officers and drug workers in all the establishments visited for this study held the same view on the overall approach of the Prison Service to the issue of drug service provision: that there is recognition of a significant drug problem amongst prisoners, but responses to it are inadequately resourced. Concern was expressed by many of these interviewees that the result is that the credibility, status, and success of prison drug services is limited.

### 7.1 Induction

Most prison officers and drug workers interviewed for this study emphasised that although there were a number of means of accessing prison drug services, a prisoner's induction session is an important forum for the provision of information on these services: in prisons where prisoners are screened on reception, as many as 80% report a serious drug problem (Lee, 2005). Many added that the presence of CARATS staff at induction sessions was becoming more routine, and in one of the prisons visited (a local prison with a high turnover of prisoners), the CARATS team was located in the induction wing and new prisoners were assessed by a CARATS worker on arrival. However, as now discussed, induction sessions were thought by many study participants to be an unsuitable occasion to recruit drug users to drug services.

#### 7.1.1 Too much information

The CARATS Interim Review (HM Prison Service, 2003b) reported prisoners' concerns over being bombarded with information on a variety of issues immediately on arrival at a prison. The prisoners, prison officers and drug workers interviewed for this study agreed, stressing that, whether or not they are currently using drugs, many prisoners are preoccupied with more immediate concerns, and it may not be the most opportune time to give detailed information:

*At induction I did not want to refer myself [to drug services] because I was getting my head around coming here, and made a referral later... (Black British, ic)*

#### 7.1.2 Peer influence

Collison (1996) and Cope (2000) report that, for young offenders, to be seen to be in control by their peers is the critical issue in relation to their drug use and status. In the present study, the powerful influence of peers at induction sessions was reported to operate as a barrier to drug service access for some, especially when the induction session is delivered to large groups:

*Embarrassment is a major factor that stops people from coming forward to receive services...when inductions are in a smaller group ...more people sign up [for drug services]. When it is in a large group,*

*young people are more embarrassed and if one or two people in their group say 'I'm not bothered with this crap,' then the others feel reluctant to sign up. (Prison officer - CARATS worker)*

*I've never seen a prisoner put his hand up at induction to ask for help. (Civilian CARATS worker)*

### 7.1.3 Suggested solutions

With the above concerns in mind, several prisoners, drug workers, and prison officers suggested that information about drug services should be proactively given throughout sentences:

*We should also get back to people who we met at induction and ask them if they have changed their mind about receiving help. (Senior prison officer)*

*CARATS workers should generally roam around talking to everyone, because for some people it is easier to be approached than to approach others. (White British, nic)*

This strategy is already employed in some prisons, and has the advantage of also reaching those who initiate or resume drug use whilst in prison, and, as some of the external drug service providers pointed out, those prisoners who wait until they have been transferred from a local prison before they access drug services.

### 7.1.4 Additional induction issues for Black and minority ethnic prisoners

Black and minority ethnic prisoners were less likely than white prisoners to view their drug use as problematic prior to imprisonment (also reported by Borrill et al., 2003a), which may partly reflect differing patterns of drug use. This may result in Black and minority ethnic prisoners being more likely to dismiss information on drug services at induction as irrelevant to them.

Prisoners from all ethnic groups felt that because the stigma and embarrassment surrounding drug use is a significant issue, induction should be conducted in smaller groups than at present. However, given the stigma attached to use of certain drugs, especially to the use and injection of heroin, by members of some Black and minority ethnic communities, this issue may have particular relevance for Black and minority ethnic prisoners (stigma is discussed in detail in section 6.7).

Those prisoners who had English language and literacy problems found it particularly difficult to recall information given at induction. Some Black and minority ethnic prisoners suggested the use of translators or peer educators to provide the information in these cases, and that those acting in this capacity are trained by drug service providers.

## 7.2 Detoxification

For drug-using prisoners who have just been incarcerated and are undergoing withdrawal symptoms, detoxification services will often be their first encounter with prison drug services. The quality of this experience may determine their future willingness to access the other drug services whilst in prison.

Prison Service policy is to offer detoxification - after consultation with the prison's medical officer - to prisoners who, on arrival, show signs of, or report, addiction. Table 1 (in the appendix) shows that 55% of all prisons offer detoxification; just under a quarter offer methadone maintenance; and the drugs offered during detoxification vary amongst different establishments. Detoxification services are not intended to be offered in all establishments and are mainly provided in remand centres and local prisons. In prisons, the detoxification process takes place over a shorter period than in the community.

Overall, prison officers and drug workers in prisons with detoxification provision reported that the service was working well:

*Detoxification - it's only just been set up but it is running very well. The Subutex [buprenorphine] does stop all of the rattle [withdrawal symptoms], all of the pain, so it is working. They [prisoners] are happy with the drug and the course works. (Prison officer in detoxification unit)*

However, some prison officers and drug workers reported problems with detoxification services in the prisons in which they worked. In particular, they reported communication difficulties with healthcare, who manage detoxification. They, and other study participants, also had concerns about the lack of detoxification provision in some prisons, inadequate medication, and the eligibility criteria for this service.

### 7.2.1 The healthcare - CARATS relationship

In most prisons in England and Wales, drug detoxification and the prescription of medication to ease withdrawal symptoms is managed by the healthcare department (it should be noted here that the term 'healthcare' was used interchangeably by the study participants to describe a staff team, a department, and the health services it provided).

PSO 3630 identifies the importance of close liaison and active interdisciplinary working between CARATS and the prison healthcare service. However, many prison officers and drug workers reported concerns about the lack of co-operative working between the two, and this was underlined by some IMB members and some Area Drug Co-ordinators and their representatives. A few expressed this in a neutral manner:

*What tends to happen is everybody - healthcare, drug services and probation - does their little bit and I think if we talked about this as a group of professionals then I think needs could be met better...We all want the same - we just have different roles. (Civilian CARATS worker)*

However, the majority were clear that the problems were rooted in the separate locations of healthcare and CARATS, and a poor approach to co-operative working by healthcare staff because of sensitivities about professional boundaries, also reported from some prisons by Mair and Barton (2000) and the

CARATS Interim Review (HM Prison Service, 2003b). For example, an Area Drug Co-ordinator wrote that there is a '*professionalism issue*' where healthcare staff perceived CARATS workers as '*just drugs workers*,' but themselves as the '*professionals*.' Other study participants said that the result of this was that:

*The healthcare does not take kindly to us referring someone...because they are meant to be making the diagnosis. (Civilian CARATS worker)*

*Healthcare did not often attend the drug strategy meeting - that is not good...They should be dedicated to the prison. (IMB member)*

### 7.2.2 Lack of detoxification provision

Some prisoners, prison officers, and drug workers in prisons with no detoxification provision reported that this situation causes serious problems for a small number of prisoners, and recommended that the provision be extended to all establishments. Some prisoners recounted positive experiences of detoxification services, but when asked for the main thing that could be done to improve drug services in the prison, several of those in establishments with no detoxification provision cited the addition of this service.

Female prisoners reported incidents of self-harm and depression amongst women who were withdrawing without a detoxification service:

*People have a problem rattling [withdrawing] from heroin and there is no methadone prescription. People on crack have lot of problems too. They should have a detox unit here. There is a lot of self-harm here because of the depression. Eighty percent of the women here are taking it out on their bodies. They need medication, and they need people to listen to them. (White British, ic)*

Not all prison officers agreed, however: two officers who were not directly involved in the delivery of drug services suggested that detoxification services should not be provided to any prisoner. Their rationale for this stance was that making the process of withdrawal more uncomfortable for prisoners '*would instil in their minds the idea that drug-taking is a bad idea*' and:

*If it was hard to withdraw from the drugs, maybe they'd think a little bit more about going back to them because of what they'd been through. (Prison officer)*

### 7.2.3 Medication

Some prisoners and drug workers were critical of the dosage of substitute medication given to prisoners undergoing detoxification, stressing that it was inadequate:

*The healthcare here is pretty dreadful. Someone had a £1,400 heroin habit a week but got 30 ml methadone [per day]. The healthcare should listen to us - they are pretty appalling here compared to the healthcare in the community. (Civilian CARATS worker)*

Despite an overall satisfaction with detoxification provision, some drug workers reported problems when it ended, and, like Malloch (2000), suggested that the provision of sleeping pills would particularly support prisoners during this period. The most frequently cited concern of prisoners who had undergone a detoxification was also the period immediately following it. As also reported by Mitchell and McCarthy (2001), they felt the process was too quick and post-detoxification medication was inadequate:

*At the end of detoxing, when your methadone is finished, is when you are really ill, when you get your backaches, your cramps and you can't sleep. But then you have to go about on your normal regime [without medication].* (White British, ic)

The few IMB members who discussed this issue agreed that, in some prisons, post-detoxification services were inadequate, and that this meant that newly-detoxified prisoners found it difficult to abstain from drug use.

#### 7.2.4 Eligibility for detoxification

Access to detoxification services is determined soon after arrival into prison. However, testing to determine drug use is not routine, and some drug workers and medical staff rely on prisoners' disclosure of drug use. As discussed in section 6.4.2, drug services are not always immediately available to prisoners who arrive at a prison late on a Friday, at the weekend, on a bank holiday, or who have used neither opiates nor cocaine for a few days and therefore return urine tests that are negative for these drugs. Some prisoners also reported excessive waiting times for medical approval for detoxification. Two prisoners summed up this situation as follows:

*If at first you say you don't use, if you come back and say 'I take drugs,' they will do a test to see if it is there in your system. If there are no drugs in your system, then you don't get help with medication, even if you are still feeling aches and pains [withdrawal symptoms]. So if you tell them that you were on drugs as soon as you come in, when it is still in your system, then it may be easier [to obtain detoxification services]. But many people are afraid to tell at that stage because they are worried of the consequences.* (White Irish, ic)

*The problem was I was in police custody for five days. During those five days, I wasn't using heroin...so when I hit the prison and I saw the doctor after a day, they said because the heroin had been out of my system for five days they couldn't put me on the drug treatment [detoxification], so I just had paracetamol and did it raw [detoxified without substitute medication].* (White British, ic)

### 7.3 1:1 counselling

Along with CARATS assessments, CARATS drug counselling sessions (generally known as 1:1s) are the most common drug service available to prisoners, and are provided in almost every prison (table 1 in the appendix). Prisoners' satisfaction with 1:1s was high, but dependent on drug workers' perceived skills and commitment, whether counselling sessions were held in a private location, their frequency and duration, and how easy they were to access.



### 7.3.1 Satisfaction with 1:1s

Many prisoners reported a high level of satisfaction with the 1:1s they were receiving. Some had experienced well-structured sessions with members of staff who could effectively address issues around drug use. For example:

*After I have seen the CARATS workers [for counselling], if I have an argument, I don't need a spliff [cannabis] to calm me down. I can manage that trigger. (Black African, ic)*

The emphasis of such positive comments, understandably in relation to 1:1s, was on the skills, characteristics, and approach of the drug worker conducting counselling sessions. Prisoners made clear distinctions between workers, highlighting those they saw as dedicated members of staff and those they saw as 'just here for the money':

*There are two workers that are brilliant. The rest of them can't be bothered. It really depends on which worker you get. (White British, ic)*

*This is the best CARATS worker I have ever had because she is on the level. I built up a bit of trust in her and that is all she needed for me to show her that I am motivated and she will go all out for me now. (White British, ic)*

A large proportion of prisoners receiving drug services placed a high value on personal experience of drug use amongst drug workers:

*[Prisoners] would prefer to get services from someone who has been through it - he [sic] will know what you are going through. (Black British, ic).*

*My worker does everything for me... She has been on drugs, so she knows what she is talking about. (White British, ic)*

### 7.3.2 Privacy

Prisoners who were anxious about discussing issues in group settings particularly appreciated 1:1 provision, emphasising the value of the opportunity to discuss their concerns in a private and confidential setting:

*A lot of people like to do 1:1s. It's more private - people don't like explaining their life in front of everybody. (White British, ic)*

*Even if you do not want to be in a group, you can see someone one-to-one. (Black British, ic)*

However, as discussed in section 6.6.2, in some prisons, the lack of private space in which to conduct 1:1 counselling sessions was reported by prisoners, prison officers, and drug workers. For some prisoners, this acted as a barrier to drug service access.

### 7.3.3 Frequency and duration of 1:1s

It was discussed in section 6.3.1 that the operational priorities of prison officers who are also drug workers leads to drug service staffing shortages. This means that appointments with prisoners can be cancelled at very short notice or last only a few minutes. Even some of those prisoners who reported being satisfied with 1:1s said that the frequency and duration of some sessions was not long enough to have a meaningful interaction and derive benefit from them:

*When they come to see you it's like 'Oh I can only talk for five minutes I've got to rush off.'* (Mixed race - Black Jamaican and white British, ic)

*You could have more time with them - you only get ten minutes a month.* (White British, ic)

*Sometimes I feel that I could do with more time, but I settle for what I can get... one meeting a month.* (Black African, ic)

Interviewer: *What's the worst thing about prison drug services?*

*When it [1:1s] gets cancelled, which happens about once a month, because they are short-staffed.* (Mixed race - Iraqi-Lebanese, ic)

Prisoners also said that CARATS workers did not always make prior appointments, and in many cases they did not know when their next session would be held, sometimes being told only the same day in order that they could be kept back from work or education sessions. This made prisoners' practical and mental preparations for the counselling session difficult:

*You don't know when CARATS are coming - at 11:40 you will be banged up and they come at 12:00 - you cannot prepare for sessions.* (White British, ic)

Such incidents caused prisoners upset, irritation and, in some cases, disengagement with 1:1s.

### 7.3.4 Access to 1:1s

In some cases, the wing on which a prisoner was placed impacted on their access to 1:1 sessions. Where prisoners were located on the wing where the CARATS team were based, for example, they could simply knock on the CARATS office door:

*If I need to, I could see them in a couple of hours, because my worker knows that if I want to talk, it must be important. I work in this wing, so I see them every day anyway.* (White English, ic)

For prisoners on other wings, getting access to 1:1s between appointments involved filling in an application form and waiting for a response, thereby, as discussed earlier, raising the issues of 'missing' applications (section 6.4.1), waiting times (section 6.4.2), and obstructive prison officers (sections 6.2 and 7.4.2).

### 7.3.5 Suggested solutions

Because of the length of time between appointments and the gap between making an application and seeing a worker if the need arose between appointments, many prisoners recommended a drop-in 1:1 service, to be used when they were going through a difficult time and were in danger of relapsing:

*It would be good if we can have someone to talk to whenever we have temptations.* (Black Caribbean, nic)

Some prisoners reported that they had tried, but failed, to make an emergency appointment at such times:

*In between [appointments] I have wanted to see them, but they have not been around.* (Black Jamaican, ic)

*Sometimes you need to see them more... Once I put in an application to see them and never heard from them.* (White British, ic)

*They're hard to get hold of... I don't always want to see them, sometimes I would just like to phone them and say I've had a shit day.* (Black British, ic)

Only a small number of IMB members commented on this issue, focussing on increasing the opportunities for prisoners to access 1:1 services through more 'roaming workers' and a drop-in facility.

### 7.3.6 Additional 1:1 counselling issues for Black and minority ethnic prisoners

Overall, Black and minority ethnic prisoners tended to report difficulties accessing 1:1s, whilst those who reported easy access were more likely to be white.

Fountain et al. (2003) report that some Black and minority ethnic communities are either not familiar with, or do not welcome counselling, and Abdulrahim (1998) suggests that counselling and general support is often based on Eurocentric assumptions and drug workers' lack understanding of cultural factors that impact on drug use and engagement with drug services (as discussed in sections 6.8.3 and 6.8.4). In the present study, many Black and minority ethnic prisoners identified the lack of diversity in teams delivering drug services as one of the main hindrances to establishing an effective working relationship with their drug counsellors. For some, counsellors who were familiar with the cultural and social context of their lives were crucial to establishing effective working relationships in a counselling context.

## 7.4 Groupwork

Groupwork - often referred to by interviewees as a 'course,' 'programme,' or 'rehab,' but meaning a group of prisoners working together in a therapeutic and/or educational setting, and therefore including peer support - is undertaken as an element of various types of prison drug services, especially intensive rehabilitation programmes.

#### 7.4.1 Selection criteria for groupwork

It was reported to this study that the selection criteria for participants for some types of groupwork, particularly accredited programmes, some of which involved writing life stories, requires certain levels of literacy, and, in one case, an IQ test. This was reported to exclude many prisoners from participation.

Some prisoners reported that access to groupwork was easier for heroin users, and that there is limited groupwork provision for stimulant users. To support this perception, table 1 in the appendix reveals that only 27 (20%) of 135 establishments provide crack cocaine-specific services. Several external drug service providers wanted more groupwork for crack cocaine users, which would also address the perception that prison drug services are for heroin users only.

Several external drug service providers deplored that long-term prisoners are not usually considered for rehabilitation programmes, in which much of the groupwork in prisons is conducted.

The issue of prisoners accessing drug services for reasons other than addressing their drug use (to enhance their parole chances, for instance) was a key concern in relation to groupwork in particular. As discussed in section 6.5.1, drug workers felt that those who were *'game playing'* caused problems in group settings and devalued the experience for those who were genuinely committed.

#### 7.4.2 Security concerns

In one prison visited as part of this study, civilian CARATS workers had attempted to develop groupwork, but reported difficulties created by prison officers. Clearly, bringing groups of prisoners together involves additional work for officers and raises a number of legitimate security concerns. The legitimacy or otherwise of these concerns in this case is unknown, but the views expressed by some of the CARATS workers in this prison were that, in some circumstances, security issues were cited by prison staff to avoid tasks that may result in additional work for them, and were not always valid (an observation supported by Mair and Barton, 2001):

*There is a huge scope for prisoner groupwork, but Security said no. We tested it out, but it fizzled out...officers kept creating obstacles. (Civilian CARATS worker)*

#### 7.4.3 Satisfaction with groupwork

Many prison officers and drug workers saw groupwork as a valuable element of drug services, providing an opportunity to share experiences and to challenge participants' thinking and behaviour. Many prisoners also commented positively on the benefits of groupwork with others in their situation, some adding that the sessions had helped them to reflect on issues around their drug use for the first time:

Interviewer: *What's the best thing about prison drug services?*

*Writing my life story [on a rehabilitation course] and reading it out to the others and hearing their comments and criticism. It is a big obstacle to tell others about your private life. (Black British, ic)*

*I'd rather talk to another user. I think that's why I got so much out of the 12-Step programme - they [other participants] are all ex-addicts. (White British, ic)*

Prisoners' negative experiences of groupwork focussed on waiting lists and the lack of follow-up, which meant the gains made during groupwork sessions were hard to sustain. Groupwork was also criticised by prisoners for a lack of structure within the sessions and low levels of training amongst staff conducting them.

#### 7.4.3.1 Waiting lists

Prisoners who had been able to gain quick access to groupwork reported that this contributed to their positive experience. Waiting lists for groupwork differ depending on the type of programme: the more structured, longer programmes have limited spaces and longer waiting times. Although some prisoners had accessed groupwork quickly, others reported waiting times of up to a year. Long waits were a major source of dissatisfaction, especially when it was believed that some prisoners had queue-jumped:

*There are those who cannot get it - there are only twelve places in the rehab course run every four months. (White British, ic)*

#### 7.4.3.2 Follow-up work

Ramsay (2003) highlights that good quality aftercare - both in prison and on release - is vital to the success of prison drug services, but Brookes, Mason and Mason (2003) report that aftercare and follow-up within the prison system is particularly poor. Most prisoners who had participated in groupwork reported that they had wanted follow-up support, but that little was available. This was especially the case if programmes such as rehabilitation courses and therapeutic communities were carried out on a separate wing. After completion, prisoners were moved back onto a general wing and some felt vulnerable to the pressures of using drugs:

*After that [rehabilitation programme] there is no aftercare - when you finish the rehab course, they chuck you back on the wing. (Black Caribbean, ic)*

*The drug course is only two days and I think you need a bit more... After the two days you are left with it all in your head and then you need someone to speak to. (White British, ic)*

#### 7.4.3.3 Groupwork staff's skills

Some prisoners reported poorly structured groupwork sessions, led by staff with limited training and experience (as discussed in detail in section 6.1.3):

*In the cannabis class, we talked about cannabis use, but it ended up with us all reminiscing about how great it was. (Black British, ic)*

*It's not looking at my drug use...they skip around things...I don't think it's in-depth enough. I think they should have a course running where you can sit and look at your triggers and things you can put into place and maybe look at other ways of life...If you're going to use [drugs], focus more on the safer ways to use.*  
(White British, ic)

#### 7.4.4 Continuity of group membership

In establishments where there is a high turnover of prisoners, it is obviously difficult to conduct groupwork with the same participants over a period of time. Prisoners from these prisons suggested that the solution is to have more frequent sessions and tailor the programme to fit shorter periods. This strategy had been successfully implemented in one local prison visited by the research team.

#### 7.4.5 Additional groupwork issues for Black and minority ethnic prisoners

Akhtar (2001) reports that 'Black' prisoners felt they would have had a more positive experience of groupwork if they had not been the only non-white person in a group. Powis and Walmsley (2002) also report that 'Black' and 'Asian' offenders on probation are concerned about engaging in groupwork where there are low numbers of Black and minority ethnic participants because of feelings of isolation and fears of discrimination, and Borrill et al. (2003a) concur in relation to prisoners. In the present study, only a small number of the Black and minority ethnic prisoner sample had been involved in groupwork, and although the sample was too small to draw strong conclusions, their experiences - and comments from a few Area Drug Co-ordinators - support the findings from previous research.

However, in one establishment, several Black and minority ethnic prisoners who had recently graduated from a twelve-week groupwork programme were interviewed, and reported positive experiences: in this case, equal numbers of white and Black and minority ethnic prisoners had been recruited to the programme.

One external drug service provider insisted that although '*all individuals [are] welcomed onto the programme regardless of their ethnicity,*' they added that groupwork participants need to be able to communicate in English, and '*whilst this may exclude a small number of individuals, it is difficult to see how this could be avoided.*' Another wrote that the problem for Black and minority ethnic prisoners was clear:

*The 12-Step programme is culturally biased and involves a lot of written homework. No choice for people with poor literacy skills and those whose English is not competent.*

Several external drug service providers stressed that the provision of groupwork sessions for crack cocaine users was especially important for Black and minority ethnic prisoners, who, they believed, '*are more likely to use crack*' than white prisoners.

## 7.5 Drug testing

Mandatory Drug Testing (MDT) was rolled out nationally in 1996. Since 1999, prisons with populations of less than 400 test 10% of prisoners, and those with over 400 test 5%. A positive result for an MDT is a disciplinary offence, which is generally punished by extra days on sentence or loss of privileges after, especially in the case of Class A drugs, referral to an independent adjudicator and (Gravett, 2000; PSO 3601; PSO 3620).

A larger proportion of male prisoners than females raised concerns about drug testing regimes, and focussed on its perceived orientation towards punishment only:

*You should be able to tell that you are using and still get full support from the staff. They have got to look at people who are failing the tests and work with them... They need to abolish testing - it is for their [prison staff] benefit, not ours. It is so that they can say 'we have had so many negative tests.'* (Indian, nic)

Some prisoners felt that the policy of transfer to or from a Voluntary Testing Unit (VTU) after testing was applied inequitably, dependent on the individual officer and the prisoner involved, and certainly, between prisons, there are different policies on action following positive drug tests (Brookes, Mason and Mason, 2003). As reported by Bullock (2003b), the present study also found that prisoners who expressed concern about potential loss of privileges due to drug testing were likely to be those serving longer sentences.

### 7.5.1 The relationship between drug testing and an increase in heroin use by prisoners

Whilst some prison officers and drug workers saw drug testing as a positive means of controlling drug use and a useful incentive to abstinence, others saw testing as contributing to a rise in heroin use in prison, because cannabis can be detected in the body for 28 days and heroin for only two or three days:

*Cannabis use has fallen and heroin use has increased inside prisons because of testing. A prisoner who has moved from injecting heroin to smoking it, to having cannabis, goes right back to heroin when put on the VTU [Voluntary Testing Unit].* (Civilian CARATS worker)

*Prisoners are switching from cannabis to heroin because of the testing regime. The tests push them to harder drugs and cause more problems later. Personally, I'd like it [testing regime] changed.* (Prison officer working on a VTU)

*Since it [drug testing] was introduced, I have seen lots of people taking heroin. The Prison Service has contributed to the growth of this problem.* (White British, nic)

*It [heroin] is in your system for three days so you can beat the MDT... I am smoking it like there's no tomorrow.* (Black Caribbean, ic)

The advantages of 'beating the test' by using heroin are not only to avoid punishment, but also to be moved to, or remain on a VTU. As discussed in section 6.5.2, the difference between conditions on these wings and general wings is so marked that it was believed to motivate prisoners to switch from cannabis to less detectible substances. Several prisoners commented that these tactics meant that they (and others) left prison with a bigger drug problem than when they arrived:

*Instead of soft drugs, people start using heroin to beat the system. So when you leave the prison, you leave with a bigger problem. (Black Caribbean, ic)*

*I am worried about it [heroin use] - when I get out I will have a larger problem... There should be smaller punishments if you're caught using cannabis, else there is more of an incentive to use heroin. (Black Caribbean, ic)*

It must be emphasised here that such study participants' experiences and their perceptions, whilst strongly held and regularly expressed, are not supported by the available evidence. Bullock (2003a) reports only 3% of drug-using prisoners switch to heroin to avoid returning positive drug tests, and Edgar and O'Donnel (1998), Farrell, Singleton and Strang (2000), and Hucklesby and Wilkinson (2001) found no evidence of cannabis-using prisoners switching to heroin for this reason. Edgar and O'Donnel suggest that expectations of switching may be based on an over-prediction of the power of testing, especially, as Cope (2000) reports, both staff and prisoners object to MDT because it damages officer-prisoner relationships and is seen to disproportionately punish cannabis use, which officers rarely see as harmful to the order and operation of prisons.

#### 7.5.2 Additional drug testing issues for Black and minority ethnic prisoners

The effect of the perceived switch to heroin from cannabis may impact upon the current stigma attached to the use of heroin by, particularly, some Black and minority ethnic prisoners (as discussed in section 6.7.4.1). It may be that heroin use will become less stigmatised amongst members of these communities if it is perceived to be used to avoid returning positive drug tests.

## 7.6 Services for users of drugs other than heroin

Drug workers (civilians and prison officers) reflected on the changes and progress that have occurred within prison drug services in the last few years. The general opinion was that the introduction of CARATS had achieved a significant and positive impact. However, staff shortages mean that CARATS teams found it difficult to satisfy the demand for their services, with the result that heroin users were reported to be prioritised because they are perceived as the most problematic drug users. The CARATS Interim Review (HM Prison Service, 2003b) raises some concern over this situation, and prison officers, drug workers and prisoners discussed the effect in terms of services for users of other substances. For example:

*Users of some drugs find it easier to get help. Heroin users get help more easily than crack users. (White British, nic)*

*If you're using heroin you get seen straight away. If not, you get pushed to the back of the queue. (Black British, nic).*



### 7.6.1 Cannabis users

Users of cannabis who felt that their drug use was problematic reported that CARATS workers did not always acknowledge their needs:

*I used cannabis daily and alcohol at weekends. When they asked me which drugs I took and I said cannabis, they were just not interested because it is not a class A drug. (White British, nic)*

*They should set up services for cannabis - it does not sound bad, but it is very hard to come off it. (White British, nic)*

Some prisoners whose drug-using repertoires included problematic cannabis use had accessed prison drug services, but because the focus of these interventions was not on cannabis, they felt that they had not benefited.

### 7.6.2 Stimulant users

Users of crack cocaine reported that this drug has not received the same attention as heroin from prison drug services:

*Only lately are they beginning to recognise that crack is a big problem, same as heroin. I have said that I take crack and have had no reaction [from prison drug services], but if I say crack and heroin then all the bells get ringing. (Black British, ic)*

Some prison officers and drug workers expressed concerns about the limited provision for stimulant users, particularly crack cocaine users, and indeed, table 1 (in the appendix) reveals that only 27 (20%) of 135 establishments provide crack cocaine-specific services:

*A lot will say 'I am a crack user - is there any point me putting [applying] to CARATS?' The perception is that there is nothing for them. (Civilian CARATS worker)*

Some prisoners reported that there were low levels of awareness amongst drug workers about the use of stimulants other than crack cocaine, and very little information on these drugs for prisoners:

*I was a stimulant user rather than using heroin. Most literature here is on heroin. I went to VTU wing. I did courses. I got adequate support, but it was not tailored to my needs. Both users and service providers don't see it [stimulant use] as a problem because it [prison] is not an environment that lends itself to stimulant use. (White British, ic)*

### 7.6.3 Prescription drug users

Problematic use of prescription drugs, mainly reported by female prisoners, was said by prisoners to be rarely addressed by prison drug services:

*I asked for help with prescription drug use, but was told that CARATS was not for that. (White British, nic)*

#### 7.6.4 Alcohol users

Several prisoners told the research team that they were problematic alcohol users. Services for them varied widely across the prisons visited for this study: whilst in some, prisoners reported that drug services also deal with alcohol users, other prisons were reported to have little or no provision for this group. Where alcohol use is linked to crime, and/or drugs are also used, services were reported to be more readily available.

Some prisons have Alcoholics Anonymous (AA) groups, but access to these groups is sporadic, and prisoners reported that lack of communication hinders awareness of AA visits to prisons. In one prison, AA meetings took place in the evenings, which meant that there were no drug workers present to facilitate prisoners' access to them. In another prison, several prisoners reported that wing officers did not always inform the prisoners of the time of the meeting, or failed to escort them to it.

#### 7.6.5 Services for users of drugs other than heroin: additional issues for Black and minority ethnic prisoners

The priority given to heroin users by prison drug services adds to the perception amongst Black and minority ethnic prisoners who use drugs other than heroin that, although they have been told that selection for these services is in chronological order, some prisoners are jumping the queue. Where these 'queue-jumpers' are perceived to be predominantly white, the opinion that drug services discriminate against Black and minority ethnic prisoners is reinforced. As pointed out by Borrill et al.(2003a p.61), even if a drug service has *'the highest standards in non-discrimination...if it caters mainly to heroin users, it will look like a "white" service.'*

## 7.7 Throughcare

The term 'throughcare' in the context of prison drug services is intended to be used to describe those services provided from an individual's first contact with the criminal justice system until after their release. However, it tended to be used by the participants of this study to describe only those services provided to a prisoner on their release, and frequently interchangeably with 'rehab(ilitation)' and 'aftercare.' PSO 3630, pertaining to CARATS, makes a clear commitment to throughcare.

There is more throughcare provision for prisoners aged 16-18 than for 18-21 year-olds, because there is no Duty of Care for the latter. For adults, there is more throughcare provision for sentenced prisoners than for those on remand. Provision varied widely across the prisons visited by the research team: some employed dedicated throughcare workers as part of the CARATS team whilst, in others, throughcare was part of the general CARATS workload and seen by some drug workers as a frustrating additional responsibility for those who were already overstretched.

The importance of throughcare in sustaining any achievements made by drug users in prisons was one of the most regularly raised issues by this study's participants. For example, in response to a question asking for recommendations for drug service development, external drug service providers and Area Drug Co-ordinators and their representatives raised the issue of throughcare more than any other, focussing on the development of better links between prisons and community drug agencies.

It is clear that prison drug services have found it extremely difficult to deliver on the commitment to post-release support in the community made in PSO 3630, and the CARATS Interim Review (HM Prison Service 2003b) describes active throughcare in the community as unachievable. The report of HM Chief Inspector of Prisons for England and Wales (2002) notes few drug workers actively supporting ex-prisoners in the community, and none of the drug workers interviewed for the present study had implemented the commitment to eight weeks of support post-release in cases where referral to community agencies had not been possible. Indeed, it is difficult to envisage how this could be implemented in many cases, because many prisoners had been incarcerated at great distances from their home communities.

### 7.7.1 Rehabilitation programmes

Prison officers and drug workers in all the establishments visited for this study commented upon the need to extend post-treatment drug rehabilitation services to incorporate a comprehensive throughcare component, both within prisons and in the community, so that prisoners can be referred on when they are released. These interviewees felt that rehabilitation programmes were critical to the long-term success of behaviour changes achieved in prison, and some suggested that residential rehabilitation programmes could operate in ‘halfway houses’ between custody and the community:

*There should be more rehab in prison, and there should be more of it near the end of their sentence, because the real fight starts when you are released. You should be able to go to rehab towards the end of your sentence, as a part of custody.* (Civilian CARATS worker)

*Lads here find it hard to maintain change and return here [prison]. I would like to see a halfway house.* (Civilian CARATS worker)

Prisoners who wanted to continue to address their drug use on release also pointed out that a residential rehabilitation place would increase their chances of staying drug-free:

*I have got a place in rehab on release, so hopefully it will work out...I am going to rehab straight from here, else I will bump into the same people and may start using [drugs]. It has been discussed with CARATS and I am in touch with the rehab now.* (White British, ic)

*If there was a CARATS worker to help route me into rehab, I'd be less likely to use.* (Black British, ic)

However, Borrill et al. (2003a) report that the application procedures for funding for community-based rehabilitation services are complex and lengthy. Several prisoners were concerned that they would not be able to access a place on a rehabilitation programme on release because of a lack of funding, and this was also an issue raised by other study participants:

*[Throughcare] drug services in general are not very successful. They [prison drug workers] try to get them [prisoners] into rehab, but it is horrific to get into. They are as successful as they can be, but a lot depends on what they get when they leave here.* (IMB member)

### 7.7.1.1 Lack of rehabilitation services for female prisoners

The report of HM Chief Inspector of Prisons for England and Wales (2002) notes specific gaps in the provision of drug rehabilitation services for women. Many prison officers and drug workers in the present study reported the lack of rehabilitation programmes in female prisons in the north of England, and saw this as an illustration of the Female Estate being the '*poor relation*' of the Prison Service. Although female prisoners can be transferred to a prison with a rehabilitation programme, this may be a great distance from their home community, and many turn down the opportunity of a place because it means losing contact with their families:

*If a woman wanted to go to rehab they would have to travel down to [prison] and if they are parents, they do not really want to go - they aren't going to get any visits. (Civilian CARATS worker)*

### 7.7.2 The vulnerability of newly-released prisoners

A large body of literature highlights the vulnerability of drug-related achievements made in prison in the immediate post-release period, and the importance of active throughcare to address this (Borrill et al., 2003a; Bullock, 2003b; Burrows et al., 2001; Field, 1998; Mair and Barton, 2001; Malloch, 2000; Mitchell and McCarthy 2001; Ramsay, 2003).

The potential value of throughcare that addresses issues around newly-released prisoners was also commented upon by both drug workers and by prison officers not directly involved in the delivery of drug services:

*The link to the outside is a big thing. Prisoners become dependent on a counsellor and all that bond and trust that's been built up, and then it's just gone and they're starting again. When they go out, the amount of pressure has just trebled. Do that throughcare bit from inside to out. (Prison officer)*

### 7.7.3 Post-release drug use

Bullock (2003a) report that ex-prisoners tend to revert to pre-release patterns of use, but, initially at least, at lower levels. Drug workers in the current study recognised that the period immediately post-release was critical for drug-using prisoners who had achieved abstinence whilst in prison, and especially risky for heroin users in terms of overdose. Few were optimistic that ex-prisoners would remain abstinent:

*If we have ten per cent who stay off drugs, I would say we are lucky. (Senior prison officer - Drug Services Manager)*

Drug-using prisoners - whether or not they were in contact with prison drug services - reported abstaining from, or limiting, drug use whilst inside prison, but some were more ambiguous about maintaining this after release. All the eight ex-prisoners interviewed for this study had started to use drugs immediately after release, with some using heroin and crack cocaine daily, and some of the current prisoners did not believe they would be able to resist temptation once out of prison:

*I don't want to use, but once I'm outside, it is very different...Last time...I saw the group I used to use drugs with and got back to it. (Black British, ic)*

Borrill et al. (2003a) report that post-release drug use is most regularly reported as a concern by stimulant users, and the lack of prison drug services for stimulant users, as discussed in section 7.6.2, means that these ex-prisoners have had fewer opportunities than heroin users to address their drug use whilst imprisoned.

#### 7.7.4 Post-release drug services

Like Mitchell and McCarthy (2001), drug workers stressed that prisoners were most vulnerable in the period between release and the first external drug service appointment:

*If someone gets out of here on a Friday and they are not seen for a week or so, we've lost them. (Civilian CARATS worker)*

Only one of the eight ex-prisoners interviewed for this study had accessed drug services when they left prison, and a drug worker estimated that:

*Only one in ten attend appointments on release. (Civilian CARATS worker)*

In interviews with prisoners and ex-prisoners, throughcare emerged as a crucial issue that determined their ability to derive long-term benefit from the drug services that they had accessed whilst in prison. Those prisoners who were about to be released and who had been referred to community agencies, or who had been consulted about their post-release plans, were eager to pursue the provision offered. However, a few were concerned about the temptation to use drugs they may encounter there:

*I am unsure about going to a drug service with lots of users. It's like putting cream in front of a cat and saying 'don't eat it'. There will be dealers near the drug service as well. (White British, ic)*

Others were worried that no services had been set up for them:

*What is going to happen when I get out on release? I would like to talk to someone, an ex-prisoners' support group, to release my stress. The Probation Service promised all sorts of help but never delivered. I will want to receive services but I'm not sure if I'll get what I really want. (Black British, ic)*

*I am being released in three weeks...I would like to receive services, but CARATS have not done anything. (Black Caribbean, ic)*

##### 7.7.4.1 Inter-agency co-operation

Mitchell and McCarthy (2001 p.212) identify two principal barriers in the development of effective throughcare: the 'tradition of prison service responsibilities ending at the gate' alongside an 'absence of co-terminosity between prisons and community services represented on DATS [Drug Action Teams].' In the present study, the issue of poor inter-agency co-operation in relation to throughcare was discussed by

many prison drug workers, external drug service providers, Area Drug Co-ordinators and their representatives, and IMB members:

*A prison may be quite successful, but when a person leaves the prison, their details are not passed on to outside agencies like the GP, and linked with outside services. (IMB member)*

It was reported that some community drug services worked closely with newly-released prisoners, but the majority of drug workers who discussed throughcare described poorly-developed relationships with them, and particularly stressed that prisoners should have contact with an external service before release (as recommended by, for example, Mitchell and McCarthy, 2001):

*There should be more interaction with outside agencies. Before release...they [prisoner] should have met...the worker beforehand. (Civilian CARATS worker)*

*If outside agencies come in to see them before they leave, there is more chance of them taking up services. (Civilian CARATS worker)*

Many of the prisoners interviewed for this study agreed. For some, contact with prison drug services represented their first contact with any drug service, and many of those who developed a positive relationship with their prison drug worker were concerned about starting again with a new worker on release:

*I want to continue getting help from the drug services, but may not be able to. I get on with my drug worker here. If I could get referred to someone and meet them before and could get to know them, maybe I would see them then [on release]. (Black African, ic)*

*I am going in it [drug service on release] blind. I would prefer to meet them first inside. (White British, ic)*

Some drug workers and Black and minority ethnic community members reported difficulties in inter-agency co-operation due to the distance between the prison and the location to which the prisoners would be returning upon release. Whilst this is an issue of concern regarding all prisoners, it particularly affects those from London: the majority of establishments in London are local prisons (for those on remand and serving short sentences), resulting in large numbers of Londoners serving sentences in other areas.

Some study participants, including representatives of organisations working with prisoners, ex-prisoners, and their families, stressed that a shortfall in community drug service provision and/or the attitudes of some external agencies to working with ex-prisoners, resulted in situations in which some prisoners released from custody could not be referred on to any community agency:

*There are not enough organisations for all of the girls that we get. So some of them are on their own when they get out. (Civilian CARATS worker)*

There were isolated examples of good practice in some of the prisons visited for this study. In one, for instance, a CARATS worker had been highly proactive in developing contacts with community rehabilitation centres, and had located funding streams for private centres. Several prisoners from the same prison made positive comments about the commitment, insight, and professionalism of this worker.

A few study participants were hopeful that the Criminal Justice Interventions Programme (CJIP) (HM Prison Service, 2003c) would address the issue of inter-agency co-operation:

*CJIP may solve a lot of that because you're gonna get outside agencies coming in for case conferences.*  
(Civilian CARATS worker)

*[CJIP] will ensure that clients are provided with seamless provision and provide effective throughcare for released prisoners. If this expands to additional areas it would provide a greater network of liaison and resources encompassing all groups. It will identify which services are required between the DAT [Drug Action Team], CARATS and the community and will enable more information to be shared and better links to specific services.* (External prison drug service provider)

As this study began, a framework for engaging and retaining drug-using offenders in treatment and continuity of care - the Drug Intervention Programme (DIP), formerly CJIP - was being set up. It lays the foundation for cohesive continuity of care between Criminal Justice Intervention Teams (CJITs), who deliver DIP in the community, and CARATS, who deliver drug services in prisons.

### 7.7.5 DTTOs (Drug Treatment and Testing Orders)

Some prisoners were happy to have DTTOs, now being replaced by Drug Rehabilitation Requirements (DRRs), on release:

*I'm OK with DTTO order - urine test, etcetera. That's for me...it gives me more incentive to get clean outside because it is not hard for me to be drugs-free inside.* (Black Caribbean, ic)

A few were not so sure:

*I'm not sure about DTTO. Alcohol makes me weak and may lead to other drugs, but cannabis is safe for me. But DTTO will catch me out on cannabis. Realistically, I will need some outlet, so it will be cannabis...* (White English, ic)

### 7.7.6 Poly-needs on release

The ex-prisoners who participated in this study attributed their return to pre-prison levels of drug use to the stress of being released from prison, boredom, unemployment, and having no income. A number of prison officers and drug workers also noted social and environmental pressures as key factors in prisoners returning to previous drug-using behaviour. In common with Borrill et al. (2003a) and Malloch (2000), they suggested that the multifaceted nature of the issues affecting prisoners on release warranted multi-agency responses, addressing a range of needs including housing, social skills, continued drug treatment, mental health, employment, and education or training:

*... most people involved with drugs have poly-needs. We cannot just isolate one need and look at it. Here [in the prison], we can do all this wonderful stuff, but when they go to a certain estate [home, on release], it does not work.* (Civilian CARATS worker)

Interviewer: *What's the main thing that could be done to improve prison drug services?*

*The throughcare. There are so many competing demands - they are using drugs and have been sexually abused, have mental health needs...these are complex needs and we stick them into a hostel [on release].*  
(Civilian CARATS worker)

Interviewer: *What's the worst thing about prison drug services?*

*Going out in the same circumstances that got them in...All this is linked to success with drug treatment.* (IMB member)

#### 7.7.6.1 Accommodation

Some prisoners reported that they had no arrangements for accommodation if their application for a residential rehabilitation place failed, and others were unsure if they could return to their families because relationships had broken down. Some were concerned about the high prevalence of drug use in hostels or other supported accommodation where they would be living on release:

*CARATS will organise a hostel for me but I am not happy with that because there are drugs there.*  
(White British, ic)

*Often, prisoners don't have a home to go to because the family has disowned them - especially difficult for the foreign nationals.* (IMB member)

#### 7.7.6.2 Education and employment

Most of the ex-prisoner interviewees had not had any work or education to go to on release and felt that this was a major reason for resuming previous lifestyles, including drug use:

*Basically you just get kicked out [of prison], or they tell you to go to Probation, but... they don't fix you up nothing straightaway, it may take a couple of months. By then it's too late, by that time you're back to the old routine.* (Ex-prisoner, Black Caribbean)

A current prisoner agreed that being unemployed was a risk factor for returning to drug use:

*Will need regular contact with services [after release] - NA [Narcotics Anonymous], outreach programme. I want the right services for when I am not working - the days will not be full and that will be the vulnerable period.* (White English, ic)

#### 7.7.6.3 Family support

Adfam (2002) report the initial post-release period as one of intense uncertainty for prisoners and their families, including fear about the future and often unrealistic expectations. Many prisoners in the present study reported reliance on the support of their families if they were to continue their engagement with drug services post-release, but also that maintaining family relationships whilst in prison was difficult,



especially for those imprisoned at great distances from home. These prisoners wanted their families to know about the progress they were making and the drug programmes they had followed:

*They should set up something to show the family that you are making progress. (White British, ic)*

Interviewer: *What's the main thing that would improve prison drug services?*

*Let families know of progress. (White British, ic)*

Many of the representatives of organisations working with prisoners, ex-prisoners, and their families noted that families, partners, and carers are undervalued and under-recognised in terms of preventing a prisoner relapsing into drug use on release. It was also pointed out that, where a prisoner's family has not been involved in (or even aware of) any aspect of the drug services provided to them, when the prisoner is released, *'the family has not been moving at the same pace as the prisoner and will have to readjust to the changes in them.'*

#### 7.7.7 Additional throughcare issues for Black and minority ethnic prisoners

The main throughcare issue reported to affect Black and minority ethnic prisoners specifically was the double stigma of having been in prison and of using drugs (stigma amongst Black and minority ethnic communities is discussed in detail in section 6.7.4).

Focus groups for adult Black and minority ethnic community members highlighted the problems experienced by ex-prisoners in re-establishing relationships with family, friends, and the wider community, and felt that reprisals and rejection made reintegration very difficult for ex-prisoners:

*It's very difficult to get back into society. Getting a job and acceptance in the community is really difficult. Even access to the mosque... If someone wants to change, society doesn't let them. (Indian)*

*It would be impossible to come back to a community here. The trust goes. (Pakistani)*

All the members of the focus group for young Black and minority ethnic community members people agreed that families would support a younger family member who had been in prison, but that shame and embarrassment would prevent such support extending to older family members:

*It's easy when you're our age - like my mum's supported me loads of times. But when you reach around twenty, you're out on your own then, because of the shame and you've let them [family] down. (Black Caribbean)*

The stigma of being discovered to be a drug user acting as a barrier hindering prison drug service access by Black and minority ethnic prisoners was discussed in section 6.7.4.1, and the same barrier operated when they were released:

*I have not approached drug services, in or out [of prison], because I did not want anyone to know I was a junkie. If I went to a clinic or a rehab, everyone would know and it would bring disrespect to my family and to me. That is why my parents still don't know about my drug use. (Pakistani, nic)*

*The thing that I found to be a barrier working with Black clients is that if I want to refer them to community drug teams in their home area, they don't want to go there... 'I've told you but nobody knows [I use drugs], I can't go there.' It is trying to get community drug teams to understand that... On a few occasions I have managed to do it by using mum's address [in another catchment area], but normally it does not work. (Civilian CARATS worker)*

Black and minority ethnic community members stressed that support was needed for the family and friends of released prisoners, to address their lack of drugs awareness, to develop their knowledge and confidence around drugs and drug services, and to restore relationships with the ex-prisoner in order that they did not re-establish contact with drug-using acquaintances.

## 8

# Recommendations for Prison Drug Service Development

## Update

In the time that elapsed during the fieldwork for this study, delivery of the research report to the funders, and preparation of this publication, there were several relevant organisational and procedural changes to prison drug services. These have not, however, adversely affected the validity of the research findings, nor of the recommendations. The changes have been indicated at appropriate points in the text, and include the following:

During the study, the Drug Strategy Unit (DSU), responsible for the Prison Service drug strategy, was part of the Prison Service. It is now part of the National Offender Management Service (NOMS) Health and Offender Partnerships Directorate, which links the Home Office and the Department of Health more closely, to co-ordinate not only drug services, but also general health services for the prison population.

At the time the research was conducted, the prisons in England and Wales were divided into 15 areas, three of which were not geographically-based. The establishments in one of these, the female estate, have since become part of the geographical areas in which they are located.

As this study began, a framework for engaging and retaining drug-using offenders in treatment and continuity of care - the Drug Intervention Programme (DIP), formerly the Criminal Justice Intervention Programme (CJIP) - was being set up. It lays the foundation for cohesive continuity of care between Criminal Justice Integrated Teams (CJITs), who deliver DIP in the community, and CARATS, who deliver drug services in prisons.

In 2003, the National Drug Programme Delivery Unit (NDPDU) was set up to deliver and monitor drug rehabilitation programmes. Since then, NDPDU have also taken over the delivery and monitoring of CARATS and the prison element of DIP.

The major aim of this study was to provide recommendations for areas of work requiring attention to ensure an ethnically diverse client group is reached by prison drug services, in keeping with the Race Relations (Amendment) Act 2000 / RR(A)A. The RR(A)A requirements are summarised in the box overleaf.

## Action by public authorities to meet the requirements of the Race Relations (Amendment) Act 2000

### Definition

Define all your functions - what you must do, and what you can do. Then identify - by ethnicity and other relevant criteria - the people for whom you should be providing various services.

### Consultation

Talk to your employees and to the people affected by your policies and practices, including people from ethnic minorities. Listen to their concerns and pay attention to their perceptions of your organisation's stand on racism and racial equality.

### Monitoring

Set up systems to monitor your workforce and the outcomes of your policies and practices.

### Assessment

Examine the impact of your policies and ask whether all ethnic groups are being treated fairly. Do they have equal opportunities and equal access to benefits, facilities and services? If not, why not?

### Change

Where the evidence from monitoring shows unequal outcomes between different ethnic groups, consider what changes are needed, and take action to prevent direct or indirect discrimination and to promote greater equality.

### Implementation

Where your organisation already has good policies on racial equality, make sure they are understood and put into practice at every level within the organisation. The policies should also be reinforced through staff performance appraisals and disciplinary procedures.

(CRE, 2000)

This report demonstrates that whilst there are aspects of prison drug services that require development for all their users and potential users, there are clearly differential impacts for Black and minority ethnic prisoners. In effect, the report constitutes a race equality impact assessment as required by the RR(A)A. After differential impacts are identified, the act requires that these are addressed through remedial actions. Rather than seek to do this at local levels by recommending actions for individual drug services or prisons, the authors recommend that the Drug Strategy Unit (DSU) adopt a whole systems approach to drug service development that will directly result in sustainable improvements for Black and minority ethnic prisoners. This approach is necessary because actions are required at national, area, and local levels, and, to be successful, they must be supported by a robust infrastructure for the performance management of race equality.

## Recommendation 1: Impact Assessments

**The DSU to establish an ongoing process by which race equality impact assessments can be carried out for all new and existing functions and policies.**

### Commentary

The evidence presented throughout this report highlights a number of issues and difficulties faced by Black and minority ethnic prisoners seeking help or treatment for drug problems. Having completed this initial race equality impact assessment, it is necessary for the DSU to establish procedures by which it can continue to assess policies and functions for differential impacts. The Home Office is required to do this for all of its functions and policies under the Specific Duties of the RR(A)A and has begun a review of all race equality schemes. By establishing its own procedures for undertaking a race equality impact assessment, the DSU will be able to ensure it can fulfil its obligations for the Home Office review. Detailed guidance on conducting a race equality impact assessment can be found on <<http://www.cre.gov.uk/duty/reia/index.html>>.

### Operational actions

- 1 Under the chairmanship of the head of the DSU, a group consisting of a cross-section of staff should be established to undertake the impact assessment of all existing and new policies and functions. This group will have lead responsibilities for subsequent RR(A)A reviews.
- 2 The race equality impact assessment group should prepare all the evidence gleaned from their assessments as DSU's contribution to the NOMS and the Home Office review of race equality schemes.
- 3 The DSU should ensure those responsible for conducting the impact assessment receive appropriate training and/or guidance and support.

## Recommendation 2: Area Drug Co-ordinators (ADCs)

**To address race equality, the DSU need to strengthen the management capability and confidence at Area Drug Co-ordinator level.**

### Commentary

The ADC role is essential for both service development and performance management and must therefore be the level at which performance management for race equality takes place.

HM Chief Inspector of Prisons for England and Wales (2002) recommends that diversity issues should be at the heart of prisons management and structures. However, evidence from this report suggests that there is a knowledge and skill deficit at ADC level in terms of understanding the requirements of the RR(A)A and the service development needs of Black and minority ethnic prisoners.

This study found some evidence of good practice in prisons where a lead on Black and minority ethnic issues has been identified (it was reported that 116 of the 137 prisons have such a lead), but these activities are not co-ordinated at area level. One prison had appointed a strategic lead on diversity issues within Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS): this service had consulted with the Black Drug Workers Forum and other relevant organisations and was clearly receptive to external expertise. The DSU and ADCs should ensure that such good practice is shared, so that the prison sector and external drug service providers are working together for race equality and have appropriate and effective models of service delivery.

## Operational actions

- 1 Each ADC to be given lead responsibility for race equality in drug services in their area.
- 2 All ADCs to undergo a comprehensive programme of training including, as a minimum:
  - the Race Relations (Amendment) Act 2000;
  - drug use amongst Black and minority ethnic communities;
  - and implementing organisational change for race equality.
- 3 Following the training, the ADCs should establish a common framework for an area race equality action plan (REAP) and related targets.
- 4 Each REAP should cover the major issues identified within this report and addressed within these recommendations: ethnic monitoring, procurement, workforce development, drug service access, drug service delivery, and community engagement. In doing so, REAPs should show how the impact of the current situation on Black and minority ethnic prisoners, highlighted throughout the report, will be tackled, particularly in terms of the barriers this population faces to drug service access.
- 5 The head of the DSU should establish a reporting structure by which ADCs report progress on their REAP on a six-monthly basis. This work will also contribute to the Home Office review of race equality schemes as part of their obligations under RR(A)A.
- 6 Individual ADCs should develop their REAP ensuring sensitivity to their areas' local issues, demographics, and characteristics.
- 7 ADCs should identify a race equality lead in every prison to act as a local race equality champion in implementing the area action plan.
- 8 CARATS teams should have a strategic lead on drugs and race equality.

- 9 The DSU should organise an annual race equality champions' conference where good practice can be shared, including discussion on how to remove barriers to drug services, and to ensure that a co-ordinated and consistent approach is being adopted.
- 10 Ongoing information on progress and training on the processes above should be made available for all Independent Monitoring Board members.

### Recommendation 3: Ethnic Monitoring Systems

**Ensure all internal and external drug service providers conduct effective ethnic monitoring of all prison drug service users, according to the 2001 census categories, and that these data are subsequently analysed.**

#### Commentary

REAPs and targets to be robust and meaningful, there needs to be systematic improvements in the collection and subsequent analysis of ethnic monitoring data on those referred to and using drug services. Effective monitoring must be based on a common framework for ethnic categories, and good practice would dictate that these are now based on those of the 2001 census. The Commission for Racial Equality website (<http://www.cre.gov.uk/gdpract/em.html>) has further guidance on ethnic monitoring.

#### Operational actions

- 1 Ensure those responsible for the collection of ethnic monitoring data are trained and provided with guidance on why the data are being collected, how to collect them, and how they will be used.
- 2 Ensure regular reporting and analysis of ethnic monitoring data takes place at area level, to determine any differential outputs or outcomes for different ethnic groups of drug service users. Data should be used to inform planning and development of each area REAP, and addressed in the six-monthly report provided to the head of the DSU.
- 3 Ensure ethnic monitoring data are able to inform planning and decisions about workforce development, and the targeting of specific Black and minority ethnic communities for employment.

## Recommendation 4: Procurement

**All Service Level Agreements with external drug service providers should ensure compliance with the Race Relations (Amendment) Act 2000.**

### Commentary

The majority of drug service delivery in prisons is through procurement. Therefore it is essential that procurement arrangements and Service Level Agreements (SLAs) reflect the need to provide an equitable service to all prisoners.

### Operational actions

- 1 Ensure all tender documents have a clear statement about how the provider will fulfil actions required by the RR(A)A and the ADCs' REAPs.
- 2 Ensure race equality is a key element of the interview and selection process in the award of contracts.
- 3 Set race quality targets in SLAs, such as completion of ethnic monitoring data and numbers of clients from diverse ethnic groups accessing services.
- 4 Ensure that performance management monitoring systems include reports to ADCs on external provider performance on race equality targets.
- 5 Monitor SLAs quarterly and review annually against a developed template.

## Recommendation 5: Workforce Development

**Ensure that the workforce for delivery of prison drug services more appropriately reflects the ethnic composition in the prison where the service is situated, and that all staff are trained and skilled in the delivery of drug services for Black and minority ethnic prisoners.**

### Commentary

This report highlights a number of issues in relation to the under-representation of Black and minority ethnic prison officers in general and of drug workers in particular. There is also evidence of lack of confidence amongst white staff when working with issues of diversity, and the requirement for further training and leadership.

Workforce development factors that affect the successful delivery of prison drug services include both representation of Black and minority ethnic staff, and development of all staff, regardless of ethnicity.



Within prisons where issues of diversity had been addressed, either through recruitment or strategically, staff had seen clear benefits in terms of credibility and positive changes in Black and minority ethnic prisoners accessing services.

In one prison visited for this study, issues of diversity had been considered in drug service planning and delivery. In this prison, members of the CARATS team reported that their manager delivered training and direction and that there had been a specific focus on issues of accessibility and representation. Team members reportedly gained wider cultural competencies to develop skills and enhance effectiveness. This example illustrates the importance of considering diversity issues at a strategic and managerial level. In another prison, civilian drug workers and officer drug workers had been able to access combined training provided by the external drug service providers, and this was felt to have broken down barriers between prison officers and civilian staff. In two prisons, diversity and representation had been actively considered within recruitment and selection of drug service staff.

Staffing is a complex issue, as its relevance operates both implicitly and explicitly. All workers, including those who are white, have an explicit role to play in the delivery of culturally competent services. However, ethnically diverse teams communicate an implicit message about who services are for.

## Operational actions

- 1 Review the targets for Black and minority ethnic staff recruitment at individual prison level in light of the ratio of Black and minority ethnic prisoners to staff.
- 2 Utilise specific workforce planning initiatives, such as the National Treatment Agency (NTA) apprentice scheme.
- 3 Provide all staff with a common induction level of training on drugs and diversity that covers legislative requirements, drug use, and the related service provision.
- 4 Provide intermediate and higher level training on drugs and diversity for those staff with more involvement in identifying and assisting prisoners with drug-related problems.

## Recommendation 6: Access to Drug Services

**The DSU to ensure that numbers of Black and minority ethnic prisoners accessing drug services increases in line with national targets.**

## Commentary

Black and minority ethnic prisoners should benefit from any increases in funding for drug services, and of initiatives aiming at increasing the numbers of prisoners accessing drug services. This is also clearly identified in the Prison Service requirements: PSO 3630 requires CARATS to acknowledge and respond in positive and practical ways to the diverse needs of the different elements of the prison population.

This report highlights that little specific work has been undertaken to address the needs of Black and minority ethnic prisoners within the establishments visited for the study. In addition, ADCs reported current drug services targeting Black and minority ethnic prisoners in only three (2.25%) of 133 establishments about which they provided information.

This report also raises a number of issues that negatively affect access to drug services in prison, including stigma, long waiting times, a lack of confidentiality and privacy, racism and discrimination, prison officers who are also drug workers, a lack of knowledge of drug services, and language and literacy problems. There is evidence of good practice in some establishments, especially in the use of proactive approaches that seek to increase user involvement in service development and delivery, which results in services that are more orientated to the needs of Black and minority ethnic prisoners. For example:

In one prison, a needs assessment had been undertaken which had identified major gaps in drug services for Black and minority ethnic prisoners. As a result, a specialist crack cocaine post had been created.

Prison drug services drawing on the expertise of prisoners are working well in some prisons: the study found some evidence that Black and minority ethnic prisoners rely on peers as sources of information on drugs services to a greater extent than white prisoners.

In some prisons, those involved in mandatory and voluntary drug testing of prisoners were in a separate team and a separate location to CARATS and other drug services. This communicated a very clear message about the separate nature of these roles and of those undertaking them.

Groupwork had been restructured successfully in one prison: frequent sessions over shorter time frames appeared to maintain group membership and better meet the needs of clients. In another establishment, several Black and minority ethnic prisoners who had recently graduated from a twelve-week groupwork programme reported positive experiences: in this case, equal numbers of white and Black and minority ethnic prisoners had been recruited to the programme.

## Operational actions

- 1 ADCs should ensure that every establishment has drug services that target interventions and activities in line with the demographics of the potential client population, including specific targets for Black and minority ethnic prisoners.
- 2 Ensure each prison establishes and implements a confidentiality policy for clients using drug services, including actions to ensure privacy in terms of the location of these services.
- 3 Encourage greater user involvement in the provision of drug services, particularly amongst Black and minority ethnic service users, as this will help break down barriers to access, including stigma.
- 4 Ensure all prison officer staff receive drug awareness training, including on drug use amongst Black and minority ethnic communities.
- 5 Specific actions to target foreign national prisoners should be implemented, such as the provision of information regarding drug service access in different languages and media.

- 6 The DSU should work with the NTA and the Home Office to establish key performance indicators (KPIs) for drug services in the prison sector.
- 7 ADCs should ensure that the prison sector conforms to the NTA waiting times criteria.
- 8 There should be clear demarcation of roles in respect of drug services and drug testing arrangements.
- 9 Ensure drug service provision reflects differential patterns of drug use amongst Black and minority ethnic prisoners.

## Recommendation 7: Aftercare and Community Engagement

**NOMS should improve aftercare for Black and minority ethnic prisoners by addressing poor access to community services, including the barriers due to stigma and the community's lack of information or understanding of drug use and the related service provision.**

### Commentary

Access to community drug services on release from prison is one of the most commonly raised issues by this study's participants and in the literature on prison drug services. Aftercare is reported to be particularly problematic for Black and minority ethnic ex-prisoners because of issues surrounding stigma; poorly-developed relationships by prison drug services with drug services in the communities into which prisoners are released; and poor understanding of the issues within communities themselves. These factors combine to create a situation for many Black and minority ethnic prisoners where they feel unable to access drug services in their community on release. This has implications not just for community services and CARATS, but also for the Drug Intervention Programme (DIP).

The University of Central Lancashire (UCLan) Community Engagement Programme has included five projects funded by the DSU to address the needs of Black and minority ethnic offenders, and has also conducted pilot community engagement projects in eleven DIP-intensive areas. These projects have provided the basis for the development of new ways of:

- engaging members of Black and minority ethnic communities in the local drug-related workforce and planning agenda;

- improving and sustaining the drug service engagement of offenders from Black and minority ethnic communities;

- enabling the development of drug services that are sensitive to, and meet the needs of, Black and minority ethnic communities;

- and producing drug service needs assessments that include consideration of families and carers, drug users and ex-users, and community members from local Black and minority ethnic communities.

Partnership with key agencies is crucial to the development of seamless aftercare provision. The ongoing work of Crime and Disorder Reduction Partnerships (CDRPs), Drug and Alcohol Action Teams (DAATs) and Criminal Justice Integrated Teams (CJITs) should be familiar to all ADCs and to each prison's race equality champion.

## Operational actions

- 1 Ensure that learning from the UCLan community engagement projects informs understanding about aftercare issues for Black and minority ethnic prisoners, including the needs of their families, carers, and communities.
- 2 Ensure that an outcome of the DIP-intensive area projects is to improve aftercare delivery for Black and minority ethnic prisoners and their families.
- 3 KPIs should ensure seamless transition of prisoners into community settings through the aftercare procedures.
- 4 There should be ring-fenced funding across all DIP national programmes to enhance the development of community engagement and to support the needs of Black and minority ethnic prisoners.
- 5 The DSU should establish partnerships with the NTA, CDRPs, DAATs and CJITs in order to adopt national KPIs for the uptake of aftercare services by Black and minority ethnic ex-prisoners.
- 6 DIP should ensure integration into the referral and care pathways set up by CARATS, to enhance community in-reach, engagement, and aftercare, and specifically address Black and minority ethnic prisoners / clients.
- 7 ADCs, together with prison race equality champions and regional NTA managers, should develop the waiting time criteria and guidelines for drug services in order to ensure that the needs of Black and minority ethnic prisoners are supported as appropriate.
- 8 Through partnership between the NTA, Home Office, and the DSU, all DAATs should evidence how they are effectively engaging and supporting Black and minority ethnic communities as part of throughcare and aftercare provision.
- 9 NOMS to ensure that all DAAT and DIP programmes take into account the needs of Black and minority ethnic prisoners, as part of the community engagement and aftercare priorities for targeting appropriate interventions.
- 10 Develop Black and minority ethnic mentoring schemes for prisoners in conjunction with CJITs.
- 11 Establish links between relevant community organisations and Black and minority ethnic prisoners, and develop peer visiting schemes for this population.

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# Appendix

**Table 1: Prison drug services: number of prisons by area.**

**Table 2: Ethnicity of prisoners and prison staff in England and Wales by area.**

**Table 3: Drug services targeting Black and minority ethnic prisoners: number of prisons by area.**

## Notes - Table 1

- [1] Including 2 Immigration Removal Centres, in which drug services are not provided.
- [2] Reports of crack cocaine-specific services overwhelmingly consist of 1:1 counselling (in 11 prisons) and/or groupwork (in 15 prisons), in which the crack cocaine-related component ranges from a one-off session of two hours to two sessions a week over a six-week period.
- [3] The main other complementary therapies are relaxation, massage, and drama and art. EST (Erhard Seminar Training), meditation, drumming and Tai Chi were reported by one prison each.
- [4] Prisons - Addressing Substance Related Offending (P-ASRO) is a highly structured cognitive behaviour programme aimed at reducing offending linked to substance use.
- [5] These intensive rehabilitation programmes consist of named programmes such as STAR (Substance, Treatment, Awareness, Rehabilitation), LEAP (Leyhill Enhanced Addiction Programme), MAD (Moving Away from Drugs), Penthouse, and Focus.
- [6] Reported harm reduction measures largely consist of information given on a 1:1 basis, via groupwork, and/or by written means such as leaflets. Issues covered by these methods include drugs education, safer injecting, tolerance levels / overdose awareness and prevention, information on communicable diseases / blood-borne viruses, and relapse prevention. This information is given at induction, and/or during the sentence, and/or on release. Two prisons supply condoms, and one supplies sterilising tablets for injecting equipment.
- [7] Fourteen prisons have specialist family workers, based in their visitor centres. ADFAM are reported to operate in ten prisons (six of them in London). The other main service for the families and carers of drug-using prisoners is the provision of information (usually leaflets) in visitor centres. Eight prisons involve families in end-of-rehabilitation programme reviews or case conferences, and three have links with prisoners' family support agencies based in the community.
- [8] The authors recognise that drug testing is not a service in the sense that the others in the table are. However, throughout this report, data on testing are included with data on services because the policy of testing and the consequences of test results impact considerably on perceptions and experiences of prison drug services.



Table 1

## Prison drug services: number of prisons by area

Source: results from questionnaire for Area Drug Co-ordinators, summer / autumn 2003

	West Midlands	East Midlands (South)	East Midlands (North)	North East	North West	Yorkshire & Humberside	Kent, Surrey, Sussex	Eastern	London	Wales	Thames Valley Hampshire, IOW	South West	Female Estate	High Security	Juvenile Operational Management Group	TOTAL
total number of establishments in area <sup>[1]</sup>	10	8	7	5	13	9	12	9	6	4	10	13	17	9	5	137
data received on	10	7	7	5	12	9	11	9	6	4	9	13	17	9	5	133
<b>detoxification</b>	<b>9</b>	<b>7</b>	<b>3</b>	<b>2</b>	<b>6</b>	<b>3</b>	<b>4</b>	<b>3</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>8</b>	<b>7</b>	<b>4</b>	<b>73</b>
with lofexidine (BritLofex)		7		1	2	2	3	3	2		2		1		1	24
with naltrexone														3		3
with dihydrocodeine (DF118)		7		1	2	1			2		3		1	1	2	20
with methadone	1			1					4				5	2		13
with benzodiazepines					2			2			3		3		2	12
with buprenorphine (Subutex)	2					1	3				3			2		11
with unspecified medication	9		3	2	1		4			4		4	2	2	1	32
<b>methadone maintenance</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>4</b>	<b>1</b>	<b>0</b>	<b>13</b>	<b>4</b>	<b>0</b>	<b>32</b>
<b>crack cocaine-specific services <sup>[2]</sup></b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>0</b>	<b>5</b>	<b>2</b>	<b>6</b>	<b>0</b>	<b>5</b>	<b>27</b>
<b>complementary treatment</b>	<b>10</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>4</b>	<b>9</b>	<b>1</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>7</b>	<b>13</b>	<b>10</b>	<b>9</b>	<b>2</b>	<b>94</b>
acupuncture	10	7	6	4	4			3	3	3	6		8	8	1	63
yoga							1		1	4	4		1	1		12
unspecified			1			9		1				13			1	25
other <sup>[3]</sup>					1				1	4	4		4	2		16
<b>intensive rehabilitation programme</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>3</b>	<b>5</b>	<b>7</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>8</b>	<b>7</b>	<b>5</b>	<b>2</b>	<b>62</b>
Cognitive Behavioural Therapy / P-ASRO <sup>[4]</sup>	2	3	3	2	3	2	3	4	3	1	1	3	5	5		40
therapeutic community				1	2						1	1				5
12-Step						1	2	3	1	1	1	2	1			12
unspecified					1										1	2
other <sup>[5]</sup>										1		4	1	1	1	8
<b>CARATS assessments</b>	<b>10</b>	<b>7</b>	<b>7</b>	<b>5</b>	<b>9</b>	<b>9</b>	<b>11</b>	<b>9</b>	<b>6</b>	<b>4</b>	<b>9</b>	<b>13</b>	<b>17</b>	<b>9</b>	<b>5</b>	<b>130</b>
<b>CARATS 1:1 counselling</b>	<b>10</b>	<b>7</b>	<b>7</b>	<b>5</b>	<b>9</b>	<b>9</b>	<b>11</b>	<b>9</b>	<b>6</b>	<b>4</b>	<b>9</b>	<b>13</b>	<b>17</b>	<b>9</b>	<b>5</b>	<b>130</b>
<b>CARATS groupwork</b>	<b>10</b>	<b>7</b>	<b>6</b>	<b>5</b>	<b>5</b>	<b>6</b>	<b>10</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>8</b>	<b>13</b>	<b>12</b>	<b>7</b>	<b>5</b>	<b>111</b>
<b>hepatitis B immunisation</b>	<b>7</b>	<b>7</b>	<b>2</b>	<b>5</b>	<b>8</b>	<b>4</b>	<b>11</b>	<b>7</b>	<b>6</b>	<b>4</b>	<b>9</b>	<b>0</b>	<b>15</b>	<b>8</b>	<b>4</b>	<b>97</b>
<b>harm reduction measures <sup>[6]</sup></b>	<b>9</b>	<b>7</b>	<b>3</b>	<b>5</b>	<b>8</b>	<b>3</b>	<b>11</b>	<b>8</b>	<b>6</b>	<b>4</b>	<b>9</b>	<b>0</b>	<b>14</b>	<b>8</b>	<b>4</b>	<b>99</b>
<b>services for families and carers of drug-using prisoners <sup>[7]</sup></b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>5</b>	<b>3</b>	<b>0</b>	<b>3</b>	<b>6</b>	<b>3</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>5</b>	<b>4</b>	<b>34</b>
<b>voluntary drug testing: wing based <sup>[8]</sup></b>	<b>10</b>	<b>7</b>	<b>5</b>	<b>3</b>	<b>7</b>	<b>9</b>	<b>11</b>	<b>8</b>	<b>4</b>	<b>4</b>	<b>8</b>	<b>13</b>	<b>16</b>	<b>9</b>	<b>2</b>	<b>116</b>
<b>voluntary drug testing: general location <sup>[8]</sup></b>	<b>10</b>	<b>7</b>	<b>6</b>	<b>5</b>	<b>6</b>	<b>9</b>	<b>11</b>	<b>9</b>	<b>6</b>	<b>0</b>	<b>2</b>	<b>13</b>	<b>11</b>	<b>8</b>	<b>3</b>	<b>106</b>

Table 2

## Ethnicity of prisoners and prison staff in England and Wales by area

Source: calculated from data received by the Prisons Research Section of the Home Office Research, Development and Statistics Directorate

	West Midlands	East Midlands (South)	East Midlands (North)	North East	North West	Yorkshire & Humberside	Kent, Surrey, Sussex	Eastern	London	Wales	Thames Valley, Hampshire, IOW	South West	Female Estate	High Security	Juvenile Operational Management Group	TOTAL
total number of establishments in area	10	8	7	5	13	9	12	9	6	4	10	13	17	9	5	137
% (range) Black and minority ethnic prisoners: February 2003 <sup>[1]</sup>	10-37%	14-34%	5-30%	4-8%	6-21%	4-25%	13-67%	17-57%	43%-62%	5-10%	7-67%	5-46%	7-65%	5-46%	10-34%	25%
% (range) Black and minority ethnic staff: December 2003	1.9-11.6%	0.7-6.9%	0.7-3.9%	0.6-2.1%	0.5-2.6%	0-4.4%	1.0-10.4%	1.3-7.5%	13.2-30.0%	1.6-2.8%	0.7-7.7%	0.6-4.3%	0.7-33.8%	0.5-7.6%	1.2-7.1%	5.3%
missing data (number of prisons) <sup>[2]</sup>	1	1	1	0	2	2	0	0	0	1	0	0	0	0	1	9

### Notes - Table 2

[1] The latest data available at the time of the research.

[2] Missing data are all from the 9 privately operated prisons.

**Table 3**

## Drug services targeting Black and minority ethnic prisoners: number of prisons by area

Sources: results from questionnaire for Area Drug Co-ordinators (summer / autumn 2003) / calculations from data received by the Prisons Research Section of the Home Office Research, Development and Statistics Directorate

	West Midlands	East Midlands (South)	East Midlands (North)	North East	North West	Yorkshire & Humberside	Kent, Surrey, Sussex	Eastern	London	Wales	Thames Valley, Hampshire, IOW	South West	Female Estate	High Security	Juvenile Operational Management Group	TOTAL
total number of establishments in area	10	8	7	5	13	9	12	9	6	4	10	13	17	9	5	137
data received on	10	7	7	5	12	9	11	9	6	4	9	13	17	9	5	133
current drug services targeting Black and minority ethnic prisoners	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	3 2.3%
planned drug service initiatives targeting Black and minority ethnic prisoners	0	0	0	0	1	area-wide N=9	area-wide N=11 [1]	0	no answer	area-wide N=4	0	no answer	3	0	0	28 21.1%
% (range) Black and minority ethnic prisoners [2]	10-37%	14-34%	5-30%	4-8%	6-21%	4-25%	13-67%	17-57%	43-62%	5-10%	7-67%	5-46%	7-65%	5-46%	10-34%	25%

### Notes - Table 3

[1] Excluding Dover Immigration Removal Centre, that does not provide drug services.

[2] These statistics are provided in this table in order that a comparison can be made between the proportion of Black and minority ethnic prisoners and the drug services that target them. The statistics are calculated from those supplied by the Prisons Research Section of the Home Office Research, Development and Statistics Directorate, and relate to February 2003 - the latest data on the ethnicity of prisoners that were available at the time of the research.

Centre for Ethnicity and Health  
Faculty of Health  
University of Central Lancashire  
Preston PR1 2HE  
UK  
Tel: +44 (0)1772 892 780

Email: [CentreEthnicityHealth@uclan.ac.uk](mailto:CentreEthnicityHealth@uclan.ac.uk)