Substance Abuse Treatment in Offenders: What works in the Prison Setting?

SSM5 Dr J O’Neill

Caroline Atherton 200423797
A society should be judged not by how it treats its outstanding citizens but by how it treats its criminals.

Fyodor Dostoevsky²⁹
**Contents Page**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>4</td>
</tr>
<tr>
<td>Definitions and Learning Objectives</td>
<td>5</td>
</tr>
<tr>
<td>Abstract</td>
<td>6</td>
</tr>
<tr>
<td>Introduction</td>
<td>7</td>
</tr>
<tr>
<td>Method</td>
<td>9</td>
</tr>
<tr>
<td>Results</td>
<td>11</td>
</tr>
<tr>
<td>Discussion</td>
<td>13</td>
</tr>
<tr>
<td>Reflection</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td>18</td>
</tr>
<tr>
<td>References</td>
<td>19</td>
</tr>
<tr>
<td>Appendix 1 – Case Studies</td>
<td>22</td>
</tr>
<tr>
<td>Appendix 2 – Journal club Presentation</td>
<td>24</td>
</tr>
<tr>
<td>Timetable</td>
<td>26</td>
</tr>
</tbody>
</table>
Acknowledgements

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I spent a day with the CARAT’s team in Risley prison, to see what work they do with offenders. I was also able to visit the voluntary drug’s testing unit and drug free wing, along with the Mandatory drug’s testing area, to see how these are both carried out. Further to this, I spent an afternoon in the Prison Workshops, which has a high proportional of foreign National Prisoners, and I was able to speak to some of the prisoners. I also spent time with the prison officer who oversees the management of foreign Nationals in Prison.

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I was able to speak to 4 clients at the Basement drop in centre, who had previously used drugs and spent time in prison. This is where I gathered my two case studies from.
**Definitions**

**Substance dependence:** An individual continues to use alcohol or other drugs despite problems related to use of the substance. Compulsive and repetitive use may result in tolerance and withdrawal symptoms when use is reduced or stopped. This is considered a Substance Use Disorder\(^1\).

**Drug Intervention Programme:** Key element of the Governments scheme, introduced in 2003. Involves drug treatment providers and the criminal justice system working together to stop the cycle of drug misuse and offending\(^2\).

**CARAT:** Counselling, Assessment, Referral, Advice and Through-care. Prison based tier two non-clinical drug treatment. Prison based delivery of the drugs intervention programme\(^3\).

**CJIT:** Criminal Justice Integrated Teams. These drug workers deliver the community element of the drugs intervention programme. They offer access to treatment, support and continuity of care through the criminal justice system and CARAT workers via the drugs intervention record - a document which monitors an individual’s progress through treatment and is transferable between organisations\(^3,4\).

**NOMS:** National Offender Management Service. A service that works to improve correctional facilities, with particular emphasis on the end to end management of offenders. It states to ensure the safety of the public from offenders, and the acceptable punishment of those who do offend\(^5\).

**Learning Objectives**

- To gain an insight into the relationship between drug use and offending behaviour.
- To look at Government initiatives set up to tackle offenders who use drugs
- To evaluate the drug services available to offenders in a prison setting
Abstract

**Introduction:** There is a long establish link between illicit drug use and criminal behaviour. The Government has set up numerous strategies within the justice system which target offenders on arrest and whilst in custody, to address these issues.

**Method:** A literature review was carried out, searching five databases for papers relevant to the management of drug using offenders in custody.

**Results:** Two articles were critically appraised. The first article, based on a questionnaire given to offenders in police custody, illustrates the patterns of drug use in London showing the particular prevalence of heroin use and also looks at previous convictions and use of prior based drug rehabilitation services. The second article is a three arm randomised controlled trial comparing various combinations of prison methadone, counselling and community referral. It concluded that methadone combined with counselling in prison and followed up with referral to a community drug team was the most effective method.

**Discussion:** The main drug services available in prisons in England consist of CARAT’s, rehabilitation courses including CBT, P-ARSO, therapeutic communities and methadone programmes. Evidence shows that combining drug services such as methadone, rehabilitation and referral to community drug workers has a significant effective of drug use and recidivism rates – this is the aim of the Government’s new Integrated Drug Treatment Strategy.

**Recommendations:** Further work is needed in the area of women and illicit drug use as there are predominantly other related issues such as prostitution which the rehabilitation needs to address.

**Conclusion:** Studies highlight the particular problems faced with short term offenders especially the high incidence of drug related crime and lack of engagement in rehabilitation programmes in this population of offenders.
**Introduction**

There is long established association between substance abuse and criminal behaviour, a survey reported by the National Offender Management Service states that 69% of those arrested in England and Wales tested positive for drugs. Further to this, 70% of offenders claim they had used illicit drugs in the year prior to imprisonment. The crime associated with drug use is also rising, in the period 2007-2008 drug crime had increased by 18%.

A study looking at the drug use of prisoners in England and Wales highlighted the particular problem of heroin and cocaine whilst incarcerated, with 26.4% of heroin users stating that they first used the drug while in prison and that prison itself was a factor that increased the risk of drug use.

The Government has set up many initiatives to combat the problem of drugs in prison. In 1995 Mandatory drug testing (MDT) was introduced which required all prisons to randomly test 5-10% of the population, depending on the size of the prison, each month. MDT gives data on the scale of the drug use and can help to identify those offenders who could benefit from rehabilitation services. Results for MDT from a northwest prison, between November 2008 and January 2009 give figures ranging from 7.3% -12.7% positive for the 5% population chosen at random. Officers can also request a “suspicion” drugs test, if they suspect an offender is using drugs, these figures are usually much higher, for example, in December 2008 60% of suspicion tests were positive for drugs in this prison. There were fears that MDT would cause a rise in heroin and cocaine use due to the shorter half life of these drugs, however, results from MDT’s and studies have not shown this.

In the past, the Government placed emphasis on reducing the amount and supply of drugs in prison, with improvements in CCTV cameras and sniffer dogs. However, with this failing to make an impact, more recently the government has shifted its focus onto services which offer treatment to drug using offenders.

Prior to an offender reaching prison, there are many stages of the judicial system were treatment and help for illicit drug use can be accessed.
The Drugs Interventions Programme, were criminal justice works alongside drug treatment agencies, is one of the major ways the government is tackling drug use through various initiatives.

The Arrest Referral scheme, set up in 1998, targets drug users on arrest, by making them aware of drugs workers who they can refer themselves to for help. Arrest referral schemes have shown promise in tackling the problems of drug use and criminal behaviour\textsuperscript{11}. The Drug testing programme, initiated in 2005 under the Drugs act, gave the police authority to test arrestees for drugs, currently only heroin and cocaine. This programme also allows testing of those who commit “trigger offenses” for example, burglary or theft as these are predominantly crimes committed to fund drug use\textsuperscript{11}.

Drug treatment and testing orders (DTTO’s) were brought in in 1998, in a further effort to break the link between crime and drugs. Added on to conditions of probation, a DTTO requires the offender to undergo regular drugs test, attend drug rehabilitation and regular court hearings to review their progress. The DTTO can be revoked, if not being adhered to, and the offender re-sentenced\textsuperscript{11}. A study looking at reconviction rates 2 years after DTTO implementation, show discouraging results, with high rates of reconviction and high numbers of revoked orders. Those who completed the order showed reduced reconviction rates – emphasising the need to keep offenders on the orders\textsuperscript{12}.

The most recent initiative from the Prison Drug strategy is the Integrated Drug Treatment Strategy (IDTS) which brings together all aspects of prison drug treatment under one umbrella, with the aim of improving the drug treatment available to offenders. This new strategy also places a greater emphasis on continuity of care beginning when an offender comes into custody and continuing once they are released\textsuperscript{3}.
**Method**

Five databases were searched for articles relating to the field of study: PubMed, Cochrane Library, Medline, EMBASE and Scopus.

Medline and EMBASE were searched using the NHS library for health.

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Results from search 8 – drug free unit gave no results and searches 10 and 7 – cognitive behavioural therapy gave results that were deemed not relevant to the study.

The abstracts of the 30 unique results were read and 3 articles were considered appropriate.

The Scopus database was searched using the following phrases, with Boolean operators AND/OR: Prison AND Drug rehabilitation AND Cognitive behavioural therapy OR Methadone OR Drug free Unit. The search was limited to articles or reviews, medicine or psychology, published between 2000-2009. The search gave 5 results, the abstracts were read, and 3 articles were deemed relevant.

PubMed database was searched using the terms: prison, drug rehabilitation, therapeutic community, methadone detoxification, cognitive behavioural therapy, CARAT workers, with the limits: Published in the last 10 years, Human, male, Clinical trial/meta analysis/RCT, English Language. 23 results were found; a review of the abstracts limited this to 6 relevant articles.

The Cochrane Library was searched using the terms: Prison AND drug rehabilitation AND methadone OR Drug free unit OR Cognitive behavioural therapy and limited to journals publish from 2000-2009. The search gave 7 results, 4 of which were appropriate to the current study.

The reference list of all the articles were searched for further studies or textbooks which would be useful.

The Department of health Website was also searched under Offender Health for published documents relating to drug treatment and rehabilitation in UK Prisons.
Results

Two articles, focusing on different methods of managing drug use in prison were chosen for critical appraisal.

The first article\textsuperscript{13} is a structured questionnaire survey carried out in London, to assess the current patterns of drug use and compare these with the results of a similar survey in 1992. The questionnaire was given to all self confessed drug users in police custody at the time of the study. In total 113 participants gave their consent to, with 95.4\% of these going on to complete the questionnaire.

The results show that heroin is the most widely used illicit drug, followed by crack cocaine, with 50\% of those questioned admitting to injecting both simultaneously. The health implications of drug use were also enquired about, with 6.4\% reporting that they were hepatitis B positive, 20.2\% hepatitis C positive and 3.6\% reporting being HIV positive. On a positive note, a large proportion of the study population were aware of hepatitis prophylaxis and the importance of harm reduction when injecting – indicating that messages about safer drug use are working.

The questionnaire asked about previous arrests, with the majority of the participants – 82\% having been in prison before and 38\% have been on drug rehabilitation courses previously. This study suggests that these treatment interventions for drug users are not working and need to be looked at.

This cross sectional study, conducted via a questionnaire, gives a snap shot of current drug use in the London area. The results are available immediately, there are no interventions so ethical issues are kept to a minimum, the study is also a low cost observational study from which hypothesises can be formed.

The primary limitation to this study is the reliance on self reported drug use, and although it is stated that self report can give a level of reliability, the results may show bias. As the questionnaire was carried out in custody, participants may under report their drug use. The questionnaire was completed predominantly by males – 82\%, which may under report issues with women and drug use.
The second article is a three-arm randomised controlled trial conducted in an American prison, comparing combinations of prison counselling and methadone maintenance treatment, evaluating results at 1 month after release from prison.

The study highlights the high relapse rate of heroin use following release from prison and the need for drug rehabilitation services in prison to extend into the community following release.

The participants were chosen from one Baltimore prison; eligibility and exclusion criteria were clearly stated. Baseline characteristics were assessed to ensure the participants were comparable. The 211 participants were then distributed by ‘block randomisation’ to one of the three groups:

1. Counselling only in prison with passive referral to community methadone programme
2. Counselling in prison and immediate referral to community methadone programme
3. Counselling and methadone in prison and continuation to a community methadone programme.

The hypothesis of the study was to show that group 3 would give better results with regards to heroin use, cocaine use, and uptake onto community programmes, by looking at:

- Admission to community treatment
- Urine opioid and cocaine test results
- Self reported heroin or cocaine use

Statistically significant results were identified for admission to community treatment, favouring group 3, urine opioid tests and self reported heroin favouring groups 2 and 3. This shows that early initiation of methadone and counselling has positive effects on heroin use. Cocaine use in all three treatment groups was high, and did not differ between treatment arms.

This study had a good follow up percentage of participants – 96.2%; it is a clinical trial which compares the intervention with a control group and used randomisation to allocate participants to treatment groups, thereby reducing bias.

Limitations of the study are that it only investigated male inmates, excluding issues surrounding females and drug use. The trial was not blinded, this may have affected results particularly with respect to group three – who received methadone – they may have reported more positive results knowing that they were receiving maintenance therapy. Furthermore, the intention to treat analysis may have skewed results as there were a large number of
participants lost to follow up – particularly in group 1. Eighteen of those randomised to group 1 left the study as they wished to receive methadone.

**Discussion**

There are many ways in which an offender can access drug treatment services in the Justice system, outlined in Fig 1, with this discussion focusing on those available in custody.

![Diagram showing drug treatment services in the Justice system](image-url)
The Counselling Assessment Referral Advice Through-care service (CARAT’s), plays the central role in prison drug treatment. CARAT’s was set up in 1999 and is available in all prisons in England and Wales\(^\text{11}\).

Substance using offenders can be referred to a CARAT worker either by a prison officer or other prison department, from prison health care, a community drug worker or via self referral.

CARAT’s is the main non-clinical drug rehabilitation service. It is mainly tier 2 services provision focusing on harm reduction, education, referral to rehabilitation courses and most importantly release planning and liaison with community drug workers\(^\text{15}\).

Initially, all offenders referred to CARAT’s are assessed, using the Substance Misuse Triage Assessment (STMA) or the Comprehensive Substance Misuse Assessment (CSMA) if the custodial sentence is long enough. Both methods aim to evaluate the level of substance abuse along with the medical complication of drug use\(^\text{11}\). All assessments are recorded on a Drugs intervention Record which allows information to be transferred with the offender on release.

CARAT’s are responsible for\(^{11,15}\):

- Referral to more intensive drug rehabilitation programmes – after a CSMA
- Referral to Voluntary drug testing programmes.
- Providing group therapy sessions to look at an offenders drug misuse, provide harm reduction and drug overdose information.
- Proving a care plan for the offender while in prison.
- Most importantly – release planning and communication with Community drug workers, to ensure drug rehabilitation continues after release.

Voluntary drug testing (VDT) programmes, available in all prisons and drug free units are in place to help offenders abstain from illegal drugs. VDT requires offenders to take regular drugs tests and consecutive negative results will be rewarded with certificates and recognition from the Governor – which an offender can use to show good behaviour to the parole board and also to their family. Drug free units can further help those offenders who have never used illicit drugs, to keep them away from pressures of drug use elsewhere in the prison\(^\text{16}\).

There are currently 114 drug rehabilitation programmes set up in England. Comprising Cognitive Behavioural Therapy, Therapeutic Communities’, 12 step approach and for shorter
duration sentences, there are short duration programmes lasting 4 weeks, Prison-Addressing Substance Related Offending 6 weeks and others\textsuperscript{17}.

An article, from 2001, looking at offenders views on prison drug treatment found that the CARATs service was the most accessed service, with 36\% of those with a pre-prison drug problem using it, compared with 28\% for detoxification and 10\% for Therapeutic communities or Cognitive behavioural therapy\textsuperscript{7}. The higher uptake of CARAT services maybe due the numerous routes of referral, and availability in all prisons. The figure of 36\% is still low, and even more discouraging is the fact that of those who accessed CARAT’s only 47\% of those found that the service helped them\textsuperscript{7}. With the introduction of IDTS – bringing together clinical and non clinical aspects of drug treatment, such as CARAT’s, future offenders may find the combined services more helpful.

Therapeutic communities (TC’s) are well established in America for the treatment of substance misuse, those used in drug rehabilitation are known as ‘concept TC’s’\textsuperscript{18}. Residents live in a community setting which has rules and a hierarchy system, were good social behaviour is rewarded. Substance abuse is seen as a disorder of the whole person therefore a TC aims to look at social and personal values including honesty, responsibility, respect, relationships and employment, along with abstinence from drugs\textsuperscript{19, 20}. There are several differences between community and prison based TC’s, primarily related to security and single gender prisons.

Trials in America, looking at TC’s have shown promising results. In New York, those offenders who completed the TC programme were three times less likely to be re-arrested then those who failed the programme. These results were mirrored in Texas with reductions in crime and drug use and an increase in employment rate in the TC group\textsuperscript{21}. A meta analysis looking a studies collected for the Correctional Drug Abuse Treatment Effectiveness project, concluded that TC have a positive outcome and do reduce recidivism rates, they are better than “group therapy” and an increased length of time spent in a TC further reduces the recidivism rates\textsuperscript{20}. Currently in the UK there are three prison Therapeutic communities specifically for drug rehabilitation at HMP Wymott and HMP Garth and HMP Grendon Underwood. There is also a Ley Prison Programme, set up in 2000 in HMP Bullingdon which has similar aims and methods to a TC, but also includes some cognitive behavioural strategies\textsuperscript{19}. 15
Cognitive behavioural therapy (CBT) is also an intensive form of rehabilitation therapy. In a similar vein to TC’s, CBT focuses on a “whole person” approach, aiming to make offenders aware of the consequences of their actions and to develop new ways to manage their behaviour. CBT for offenders includes the Programme for Reducing Individual Substance Misuse and P-ARSO which is a prison modified version of the Addressing Substance Related Offending. Referral to CBT is via the prison CARAT’s programme. Studies looking at CBT and its effects on recidivism rates show promising results. A study which looked at offenders with a known drug problem, found that of those who received CBT whilst incarcerated, only 27% reported that they would be “likely” to re-offend, compared with 48% who received no treatment for their substance dependence. Limitations with CBT were discussed and related largely to the high non-completion rate, possibly due to the length of the courses. In one study, only 10% of those with a substance abuse problem received CBT with a bias towards offenders sentenced for 4+ years, meaning those with shorter sentences missed out, despite a high prevalence of drug related offences in the shorter sentence offenders.

As noted earlier, heroin use is a particular problem in offenders, not only due to the health risks with taking the drug, but also the symptoms surrounding withdrawal. Following remand in custody, an offender often faces withdrawal from opiates. This can produce unpleasant symptoms such as abdominal pain, nausea, anxiety and lead to impaired mental capacity, unusual risk taking behaviour and an increased risk of suicide. The addiction to opiates is seen as a chronic medical condition, therefore, providing treatment, is an important ethical and legal duty.

All prisons in England and Wales provide detoxification to offenders who enter prison with an opiate addiction with either methadone, buprenorphine or lofexidine, along with detoxification programmes for alcohol and benzodiazepines. Once an offender enters prison the initial screening process is designed to identify immediate medical needs – including opiate dependence and withdrawal.

All opiate replacement programmes should begin with 5 days of stabilisation on the substitution drug, and then progress to either:

- Detoxification, minimum of 14 days.
• Extended Detoxification > 21 days.
• Opiate substitution maintenance, over 13 weeks or longer depending on the case\textsuperscript{26}.

Methadone and Buprenorphine maintenance therapy have only recently been introduced across England, and their provision is low. All offenders with a community maintenance prescription, should have this continued in prison; offenders with an opiate addiction serving a short sentence (<26 weeks) or with chronic opiate use should be offered maintenance therapy\textsuperscript{25, 26}. Substitution programmes have an important role to play in release planning particularly with risk of overdose in the first 2 weeks following release. All offenders should be offered continuing substitution treatment possibly at a higher dose or referral to community aftercare services\textsuperscript{24}.

Methadone has been shown to be effective in treating opiate dependence with initial improvements in recidivism rates and reductions in the incidence of hepatitis C\textsuperscript{27}. Further research has failed to show this effect of methadone on recidivism rates, however, many studies emphasise the significant public health benefits from methadone including reducing HIV, hepatitis B, hepatitis C and reducing suicide along with increased uptake of other rehabilitation services\textsuperscript{27, 28}.

There are many areas for improvement in pharmacological treatment of opiate addiction. Firstly, increasing the provision of substitution programmes, as evidence from one study showed that only 54\% of those using heroin on a daily or more than daily basis were offered detoxification. Furthermore, combining pharmacotherapy with other psychosocial therapies and counselling techniques improves overall treatment outcome, which is the objective of the new Integrated Drug Treatment Strategy\textsuperscript{14, 18, 28, 29}. Finally reducing the barriers to continuation of methadone treatment in the community which include lack of funding and staff shortages, long waiting lists and social issues, such as unstable housing and lack of transport\textsuperscript{29}.

**Recommendations**

An issue raised in several articles relates to women and drug abuse. Although not specifically addressed here, drug use in women can often be associated with prostitution, physical or sexual abuse and pregnancy. It is important that drug rehabilitation services address these issues.
Conclusion

The evidence reviewed in this report shows the significant problems of drug related crime and drug use whilst incarcerated. The current schemes in place for rehabilitating drug using offenders appear to have a more beneficial effect on longer term sentenced prisoners. However, studies report that the more significant drug related crimes and drug use is seen in shorter sentenced prisoners.

As highlighted in the two case studies, the period following release from prison is key to improving drug use amongst offenders. Referral to a community drug worker via CARAT’s, coupled with methadone treatment, ideally initiated in prison, has been shown to significantly reduce drug use – giving support to the new IDTS scheme bringing together the clinical and non-clinical aspects of drug rehabilitation.
References


25. HMP Prison Service Order 3550Clinical Services for Substance Misuser’s


Appendix 1

Case Study 1

A 35 year old male, who has served 9 sentences in prisons across the country, totalling 10 years in prison. His prison sentences have all been for car theft/shoplifting/burglary – to get money to pay for drugs.

He began using drugs at age 16 outside of prison. Has used crack cocaine and heroin both smoked and injected. Could not inject the heroin himself, so stopped. During prison sentences only smoked heroin.

At forest green Prison, he was on a drug free wing and detoxification from the heroin was with dihydrocodine tablets. This failed, and on release, he was back using heroin.

During other prison sentences, he has used the CARATS team for support and at the same time was prescribed methadone. Both of these helped and he was clean for 12 months after release from prison.

Two years ago was referred an intensive detoxification/rehabilitation programme – he feels this was very helpful and wishes to partake in similar rehabilitation programmes as soon as possible.

Following release from prison he feels he was abandoned with respect to his drug rehabilitation. Appointments were made for him to go to community drug centres, but he found these difficult to keep.

Currently he lives either on the streets or stays on friends sofas. He doesn’t sleep in hostels as his partner is banned from them, so he stays on the streets to make sure she is ok. He has used other services such as The Sister of Charity for food and found the Basement about 4 years ago and still goes there regularly.

He has been taking methadone for 3 months – not by prescription but “street” methadone. Started himself on 70mls and is now down to 5mls per day. During the interview, it was difficult to establish from him if he is still using heroin.
This case shows how the prison service could do more to help drug users. The attempt at “abstinence” on the drug free ward could have been combined with other rehabilitation services. After releasing offenders from prison, it is clear that their lives become chaotic and keeping appointments is difficult for them. This person suggested taking offenders straight to a drug rehabilitation centre or a community drug worker following release from prison, to reduce the temptation to use drugs again.

Case study 2

A 33 year old male who has served five prison sentences for burglary. His most recent sentence, of 2 years, ended in 2001 and following release, he described himself as having a “drug habit”.

He began using drugs aged 15 – mostly trying drugs such as magic mushrooms and smoking cannabis with friends. However, once in prison, drugs such as cannabis, heroin and crack cocaine were easily available and cheap, so he started using regularly.

In prison he was put on a methadone detoxification programme. This didn’t work and on release he continued using crack cocaine, heroin and cannabis and also tried other drugs such as amphetamines, speed and ecstasy. He has never heard of the CARATS team and was not put on any drug rehabilitation programmes while in prison.

About 6 months after release in 2001 – he realised his drug problem was out of control. He visited his GP and told him about his drug use, and he was put on a methadone programme. He currently takes 50mls of methadone a day and says that for the past 2 months he hasn’t taken any other drugs.

He has used community drug services such as the White Chapel centre – which helped to get him into a hostel, the Basement and the Lighthouse project – which offers counselling.

This case is a good example of a drug use that largely began in prison – due to drugs being readily available and cheap. It also highlights how some prisoners who abuse drugs are not helped in prison, and therefore, continue with their drug misuse outside of prison. Similar to the previous case study, this person was left to their own devices once they had been released; there was no evidence of referral to a community drugs team.
Appendix 2

Journal Club article:

**Introduction:**
This paper looks at 2 relationships: Drug users are more likely to spend time in prison and spending time in prison increases drug use.
The initiation of drug use in prison is a problem – shown in Scotland (6%) and Northern Ireland (20%) of injectors start in prison.
Psychiatric problems are significantly higher in prisoners than the general population.
This looks at characteristics of prisoners who use drugs, focusing on initiation in prison and related psychiatric problems.

**Methodology:**
A 90 minute Structred Clinical Interview conducted with trained ONS staff, categories were:
Demographic information, Social history, psychiatric diagnosis by DSM-IV, drug use and prison history.
Statistical analysis was by logistic regression (good for looking at one or more risk factors and a common outcome), with 4 sets of comparisons: 1. Ever users vs non users, 2. Those who used in prison vs those who only use outside, 3. Initiated use in prison vs those who initiated outside, 4. Initiators in prison vs those who use in prison but initiated outside.

**Results:**
Table 1: prevalence of drug use in prisons 4 categories above. Highlights heroin and cocaine use as a major problem in prisons, with 26.4% of prisoners who take heroin, started doing so while in prison.
Table 2: Characteristics of the sample used
Table 3: Uses social history and personal background as the variables to calculate odds ratios for use/initiation of heroin or cocaine in prison. Conduct disorder as a child/expelled from school/ homelessness/serious illness increase risk of using drugs.
Age group 21-39 are more at risk of using heroin in prison, and initiating heroin use in prison.
Table 4: Psychatric and prison history as variables. Previous prison sentence significantly increased the likelihood of initiation drug abuse while in prison for both heroin (up to 60 times more than those in prison for the first time) and cocaine (15 times). Antisocial behaviour disorder increased risk of having ever used heroin or cocaine. Paranoid personality disorder/neurosis decreased risk of using both drugs.

**Discussion:**

Drug use in prison is much higher than in the general population – especially heroin/cannabis. These drugs are more suited to the prison environment – whereas stimulants aren’t. Two reasons – either drug users are more likely to spend time in prison, or spending time in prison causes increase in drug use.

Emphasises that many prisoners were in the “vulnerable group” category for drug use prior to imprisonment – eg: excluded from school, local authority care.

Risk of drug use is heavily dependent on prison exposure.

**Limitations:** Interviews conducted in prison – therefore inmates may under report their drug use - may be worried about the consequences. Cross sectional study – cannot prove a cause. No randomisation, female population under represented.

On the other hand – prisoners may want to show how much of a negative impact prison has on their lives so may over report initiation of drug use.
<table>
<thead>
<tr>
<th>Month</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
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</table>
| January    | Introductory Talk
Liverpool Medical Institute 9am-3pm
Chose topic: prison and detention centres. | MRSN 10am
FADE library induction 1pm | Sahir House 9am
Journal club 1pm
Begin initial journal searches. | Asylum Link 9am
Journal club 1pm |
| February   | Journal Club 1.30pm – my Journal club presentation
STAR and MEDSIN talk | Formative Exam week
Visit to HMP Risley Prison | Journal Club 1.30pm
Shelter talk
Journal Searches | Visit to The Basement – 2 Case studies.
Journal searches |
| March      | Journal searches
Write up 2 case studies | Journal searches, write up acknowledgements and definitions | SSM meeting Everton road GP Practice 5.30PM | Journal Searches
Critically appraise 2 articles |
| April      | Easter
Write up Method and results section. | Easter
Write up Introduction | SSM meeting Everton Road GP Practice 5.30pm
Write up discussion | Write up discussion |
| May        | Write up conclusion + recommendations | SSM meeting Everton Road GP practice 5.30PM | Edit work + reference.
Send draft to convenor. | Submit SSM 5 |