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UNIVERSITY OF SOUTHAMPTON

HIV and hepatitis prevention in prisons

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Thesis submitted for Doctor of Philosophy

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ABSTRACT

Faculty of Social Sciences
Psychology

Doctor of Philosophy

HIV and hepatitis B and C prevention in prisons

by Shirley Ann Large

This thesis comprises three studies that explore the attitudes and beliefs of prison staff and prisoners towards HIV and hepatitis B and C prevention policy in prisons.

Analysis of the factors that influence the way prisoners and prison staff view prevention strategies highlighted some important issues from the perspective of the people most closely involved with implementation of prevention policy. The exploration of these issues was complex due to the security, legal, cultural and ethical issues that had to be considered.

A case study approach incorporating qualitative and quantitative methods was used to try to embrace the complexity of the research aim. A qualitative foundation for staff and prisoner interviews was used for two reasons; firstly, so that the views of the researcher were not imposed and secondly because there were few prior research studies to base the current study on. In addition, as prisons differ in security category and in the types of prisoners held, it was presumed that developing the research to give a wider representation of the issues would be valuable; this overview was achieved by questionnaire. Data were collected from ten prisons, there were forty-one in-depth staff interviews from three types of prisons; data from 182 questionnaires from 7 prisons and 18 in-depth interviews with prisoners from the three prisons where staff were interviewed.

The results show that the predominant concern of staff is that the prevention policies discussed in the study are to do with sex and drug misuse; activities considered illegal within the prison environment. Staff believed that some of the prevention measures concerned with reducing the risk associated with injecting drug use conflict with their discipline and security role and also conflict with the drug strategy policies that focus on eradicating drug use in prisons. Opiate detoxification programmes, abstinence based therapeutic programmes and drug-free areas were viewed most positively by staff and were portrayed as most closely aligned to their security and discipline role and the role of prisons in society. Most staff believed that providing condoms in prisons would also act against their discipline and security role. This is principally because of the potential to conceal or smuggle drugs using condoms and also because the stigma of same sex relationships in prisons may lead to aggression and bullying from other prisoners.

Prisoners described a hidden culture of same sex relationships in prisons and generally did not completely welcome policies concerned with improved access to condoms. However, some of the prisoners highlighted a moral imperative to distribute condoms in prisons.

Prisoners stated that they would view suspiciously any change in prevention policy concerned with injecting drug use, which ran counter to the current policies of intolerance to illicit drug use in prisons.

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DEDICATION

This thesis is dedicated with love to
my mother Jean Vaughan,
my husband Lawrence
and to my wonderful children Daniel and Louise

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CHAPTER 1

Literature review, general epidemiology and policy

1.1 CHAPTER OVERVIEW

The purpose of this chapter is to describe the general epidemiological picture of HIV and hepatitis B and C. The structure of the Prison Service will be described and the World Health Organisation Guidelines on HIV infection and AIDS in prisons (1993) will be outlined. Research of a more specific nature in relation to policy and prevention of HIV and hepatitis B and C infection in prisons will be considered in Chapter Two.

1.2 HIV AND HEPATITIS B AND C DEFINED

Human Immune Deficiency Virus (HIV) belongs to the retrovirus group and affects the body by infecting the T-lymphocyte population, which then gradually destroys the normal immune response mechanisms. It was first recognised in the early 1980s, although it has been acknowledged that spread occurred before this time (Donaldson and Donaldson 1993). During 1981, in the United States of America, increasing numbers of people developed opportunistic infections, particularly pneumocystis carinii pneumonia; additionally, unusual tumours were reported in previously healthy homosexual or bisexual men. The presenting symptoms are often general, such as weight loss, fever, malaise and lymphadenopathy. The diagnosis of Acquired Immune Deficiency Syndrome (AIDS) is dependent on certain indicator diseases being present, such as recurrent pneumonia within a twelve month period, which would suggest severe immunodeficiency. The national AIDS case definition enables surveillance of HIV and AIDS. Fully developed AIDS syndrome often involves opportunistic infections or patterns of malignancy infrequently seen in people with normally functioning immune systems, although any one of a wide range of infections or malignancies can occur. It is possible to have HIV infection and remain well and without symptoms for a long period. Previous longitudinal studies demonstrated that approximately 50 per cent of people would develop AIDS after 10 years of infection (Donaldson & Donaldson 1993). However, the prognosis has now changed considerably because of the development of combination therapy for HIV. New

treatments centre on multi-antiretroviral therapy, so that usually three distinct types of drug are used to prevent HIV replication (Howe 1998).

Principally the modes of HIV infection transmission are:

- sexual transmission through penetrative homosexual or heterosexual intercourse with an infected person
- from infected blood or blood products, through sharing infected injecting equipment, untreated blood transfusions prior to 1985 in the UK, and needlestick injuries
- vertical transmission between an infected mother and her baby; in the womb, during childbirth or from breast-milk
- iatrogenic transmission, which would occur as a result of an invasive medical or dental procedure.

The routes of transmission of HIV are similar to transmission routes of hepatitis B, D and C virus. Viruses transmitted in this way are referred to as blood-borne viruses.

1.2.1 HEPATITIS

The causes of hepatitis vary and may be attributable to; viral infections, be drug related, have a physical, genetic or unknown cause; however, the commonest aetiology is viral.

Viral hepatitis is caused by a group of viruses that predominantly affect the liver cells. The current known types of viral hepatitis are classified alphabetically A to G. They are unrelated in an immediate sense but have similar clinical manifestations rather than having the same causal agent (American Public Health Association 1995). The transmission of hepatitis B, and C is similar to the transmission route of HIV, contact with infected blood and body fluids such as vaginal fluids and semen.

Hepatitis A, B and C are responsible for almost all reported cases of viral hepatitis.

1.2.2 HEPATITIS A

Hepatitis A is the least serious virus of the hepatitis group. The virus is spread by contaminated food and water and is very infectious. It does not lead to liver disease in later years.

1.2.3 HEPATITIS B

Hepatitis B is a blood-borne virus. The virus has been found in almost all body secretions and excretions; however, only blood and serum derived fluids such as saliva, semen and vaginal fluids have been found to be infectious:

- percutaneous exposure to infected blood or blood products, sharing contaminated needles during injecting drug use, tattooing, needle stick injuries or other injuries from sharp instruments resulting in exposure to infective body fluids.
- saliva has been implicated as a source of infection from communally used toothbrushes.
- semen and vaginal fluid transmission of the virus usually occurs with homosexual or heterosexual sexual contact, from mucus membrane exposure to infectious blood and body fluid.
- perinatal transmission usually occurs through mucus membrane contact with infectious blood and body fluids during labour and childbirth. Breast milk is a minimal risk and does not prevent breast-feeding (American Public Health Association 1995).

Transmission may occur in the family or in institutions from the sharing of toothbrushes or razor blades or through sucking and chewing pencil/pen ends (Sira 1997).

Hepatitis B is 100 times more infectious than HIV. Up to 10% of those infected with hepatitis B virus will become a chronic carrier, posing a risk of infection to others. Approximately, 25% of chronic carriers develop cirrhosis of the liver with some of these going on to develop hepatocellular carcinoma (Sira 1997).

1.2.4 HEPATITIS C

Blood transfusion was an important route for transmission of hepatitis C in the UK before 1991 when testing the blood of donors was initiated. Injecting drug use is the predominant transmission route of hepatitis C and it has spread widely among intravenous drug injectors. The prevalence of hepatitis C amongst intravenous drug injectors approaches 60 – 80% in many countries.

Unlike hepatitis B and HIV, hepatitis C is not easily transmitted sexually and there remains uncertainty about the level of risk from sexual transmission. The transmission risk from mother to baby during childbirth is thought to be around 5% (Hughes 1998).

The worrying aspect of hepatitis C does not lie in its short-term effects, which are not usually severe, but in its ability to cause long-term mild hepatitis that can continue indefinitely. In 20 – 25% of people with hepatitis C there will be a progression to cirrhosis with possible hepatocellular carcinoma or liver failure (Hughes 1998).

People with continuing hepatitis C are highly infectious to anyone who shares a needle or injecting paraphernalia with them. They may look and feel entirely well and may be completely unaware that they are infected.

Interferon remains the mainstay of treatment however, the response rate to therapy is not high, and there are a number of unpleasant side effects. More recently, combination therapy has been looking more promising (Hughes 1998).

1.2.5 HEPATITIS D

Hepatitis D is always associated with a co-existent hepatitis B virus infection. Therefore, prevention of hepatitis B with hepatitis B vaccine will also have a concomitant effect on hepatitis D prevention. However, for a hepatitis B carrier the only effective prevention measure is avoidance of exposure to the virus. The routes of transmission of hepatitis D are the same as hepatitis B.

1.2.6 HEPATITIS E

The route of transmission for hepatitis E is via contaminated water and from person to person by the faecal-oral route. It is usually found in travellers to countries where

there is inadequate environmental sanitation. There is no evidence of chronic sequelae to this infection (American Public Health Association 1995).

1.3 RISK REDUCTION

‘Risk reduction’ and ‘harm minimisation’ are terms that are often used interchangeably. ‘Risk reduction’ strategies are more general measures implemented to reduce the risk of HIV transmission from risky behaviour, for example, safer drug use and safer sex. ‘Harm minimisation’ is specifically associated with measures implemented to reduce risk with drug use (AIDS Advisory Committee 1995).

The concept of harm minimisation in the UK is underpinned by the belief that HIV particularly, but also hepatitis B or C infection, are a greater danger to individual and public health than illicit drug use (Layzell 1993). Because of this re-conceptualisation, health and voluntary services have fostered the dual goal of minimising HIV and hepatitis risk behaviour as well as minimising illicit drug use. Discussing the policy response process to this shift in approach Rhodes stated:

“The immediacy of the health-related harms associated with HIV have demanded a reorientation and a re-conceptualisation of the drug problem and of the drug user” (Rhodes 1994a).

1.4 WORLD HEALTH ORGANISATION GUIDELINES

The World Health Organisation (WHO) Guidelines on HIV infection and AIDS in Prisons were produced in 1993 to provide international public health standards to enable development of policies for the prevention of transmission of HIV and for the care of those affected by HIV/AIDS. The guidelines comprise policy statements covering virus testing, education and information, access to condoms, bleach distribution and needle exchange. Three of the standards of central concern to this study are reproduced below:

- All prisoners have the right to receive health care including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.

- Preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release.
- It is important to recognise that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information and in avoiding discrimination (World Health Organisation 1993).

The principles, contained within the World Health Organisation Guidelines (1993), provide the foundation for many public health responses to prevention of HIV in prisons including campaigning organisations and some health authorities. The slight reduction in incidence generally of HIV in the UK has been partly attributed to the success of public health prevention measures employed in community settings (Howe 1998;The AIDS Control and Prevention (AIDSCAP) Project of Family Health International 1996).

1.5 NATIONAL HEALTH SERVICE POLICY

Intervention strategies for 'risk or harm reduction' incorporating 'harm minimisation' measures adopted and promoted by the National Health Service are centred on education, information and confidential counselling.

Safer sex advice identifies ways to change behaviour in order to reduce the risk of sexual transmission of blood borne virus infection and generally follows the kind of format outlined below:

- i. substituting penetrative sex with oral sex
- ii. using condoms and water based lubricants during sexual penetration. Anal sex requires the use of strong condoms
- iii. not assuming that a sexual partner is free from infection (Howe 1998)

Advice to injecting drug users accepts there may be a proportion of users that are unable or unwilling to stop injecting. Therefore, advice to injecting drug users generally follows hierarchical universally accepted guidelines;

- i. stop using and injecting drugs
- ii. enter and complete substance abuse treatment, including relapse prevention
- iii. take the following steps to reduce personal and public health risk, if continuing to take drugs:
 - a) never reuse or 'share' syringes, water, or drug preparation equipment
 - b) use only syringes obtained from a reliable source (e.g. pharmacies)
 - c) use a new sterile syringe and needle to prepare and inject drugs
 - d) if possible, use sterile water to prepare drugs; otherwise use clean water from a reliable source (fresh tap water)
 - e) use a new or disinfected container ('cooker') and a new filter ('cotton') to prepare drugs
 - f) clean the injection site prior to injection with a new alcohol swab
 - g) safely dispose of syringes and needles after one use (US Department of Health and Human Services 1997).

In addition to the educational strategies there are other statutory and voluntary community prevention measures:

- i. free confidential access to condoms
- ii. walk-in genitourinary clinics
- iii. needle and syringe exchange schemes
- iv. drug detoxification programmes
- v. drug maintenance programmes

- vi. drug abstinence programmes adopting a variety of treatment responses, for example narcotics anonymous.

Before consideration of the HIV and hepatitis B and C prison strategy response a brief description of the structure of the prison service will be given.

1.6 THE STRUCTURE OF THE PRISON SERVICE

The Prison Service became an executive agency of the Home Office in 1993; this change was accompanied by devolution of control to governors of establishments, who in turn report to Area Managers. Her Majesty's Inspectorate of Prisons is an independent body who reports on individual establishments about every three years. There has also been in recent years a small development of private sector prisons. Prison establishments are distinguished by function, age, gender and security category of the prisoners. The categories of prison are:

- Local prisons which serve the courts in their locality and therefore hold a large number of adult prisoners on remand. There will also be prisoners serving a short sentence.
- Young offender institutes can be open or closed establishments. Young offenders on remand are housed in specialist remand centres.
- Female prisons serve a much smaller inmate population than male prisons. They are not categorised in terms of security risk in the same way as male prisons, instead they will just be open or closed prisons.
- Males over 21 are outlined below they are categorised in terms of security risk :
 - i. dispersal prisons, these house category A prisoners who have the highest security status
 - ii. category B training prisons, these are all closed prisons and are a higher security category than C
 - iii. category C training prisons, these are closed establishments.
 - iv. category D prisons are open prisons (Criminal Justice Group 1995).

In 1995, the HM Inspector of prisons in his Annual Report stated that,

“At any one time, some 12,000 of those in our prison establishments are simply awaiting trial and are therefore presumed innocent, around half will not in the end serve a custodial sentence” (Tumim 1995).

The prison medical service was set up in 1878; it has remained a separate health care agency from the National Health Service (NHS) (Liverpool Public Health Observatory 1995). In 1992, the prison medical service became the Health Care Service for Prisoners. This change in name reflected a change in prison health care philosophy to provide prisoners with a health care service equivalent to that available in the community. The health centres in prisons in England and Wales provide health care based on the following classification:

- Type 1 provides a primary health care service from 8am to 5pm and has no in-patient beds.
- Type 2 provides a primary health care service from 8am to 8pm and has no in-patient beds.
- Type 3 provides primary and secondary health care 24 hours a day with in-patient beds.
- Type 4 will include type 3 provision but will extend its service to provide a speciality serving a whole area, or a whole directorate, or exceptionally the whole country (HM Prison Service Directorate of Health Care 1997)

Each prison has its own health care centre and provides care based on one of the types of provision above. There will be either a full time or part time medical officer.

1.7 PRISON POLICY AND GUIDELINES

An AIDS Advisory Committee was set up in 1986 for the purpose of advising the Director of Health Care for Prisons on all matters to do with HIV in prisons. The Committee published a comprehensive review of HIV and AIDS in prison in 1995 (AIDS Advisory Committee 1995). The Review described the particular responsibility that prisons have towards the prevention of spread of HIV; a responsibility that could be equally applied to the prevention of hepatitis B and C because they have similar transmission routes. The review also highlighted that within a prison there may be a concentration of the following groups of people:

- prisoners whose drug or sexual history outside prison has put them at risk of HIV infection
- prisoners with previously chaotic lifestyles
- prisoners who may not have traditionally accessed health care services
- prisoners in custody for sex crimes
- prisoners who continue to use illicit drugs.

The groups identified would be regarded in other community settings as difficult to reach and target with information about the spread and prevention of HIV and hepatitis B and C. The AIDS Advisory Committee identified that imprisonment may present an opportunity to target these groups with education and prevention messages. In addition, as prisoners tend to be young and therefore more sexually active, and because there is a concentration of previous injecting drug users and sex workers it can be assumed that a percentage will have HIV, hepatitis B or hepatitis C (AIDS Advisory Committee 1995).

There is concern about introducing policies such as needle exchange and bleach decontamination of needles and syringes into a prison, as this would mean acknowledging illicit and unauthorised possession of drugs and drug using equipment which is prohibited and punishable under prison law and criminal law. However, the AIDS Advisory Committee recommends a more enlightened use of discipline mechanisms so that help and treatment for the drug problem becomes the preferred response rather than a disciplinary proceeding (AIDS Advisory Committee 1995).

Issuing condoms to prisoners on release from custody has generally been permissible from around 1991. In 1995, The AIDS Advisory Committee recommended that all prison establishments should introduce condoms for use within male prisons and dental dams for use within female prisons (AIDS Advisory Committee 1995). However, the Home Secretary did not accept the recommendation relating to condoms in male prisons, consequently policy development was fragmented because there was not a general Prison Service policy guideline, although prison governors are not prevented from distributing condoms within their prisons. This fragmentation of policy led to concern about the potential legal liability of the prison medical staff in the event of a prisoner contracting a sexually transmitted

disease, particularly HIV, while in prison. Therefore, the then Director of Health Care issued a 'Dear Doctor' letter encouraging prison doctors to prescribe condoms and lubricants in the event of clinically assessing individuals as at risk of contracting HIV through sexual behaviour. The letter presented the possible legal risk to the individual doctor being in breach of a duty of care for not providing condoms in warranted circumstances. It went on to state that homosexual acts between consenting adult prisoners are not automatically unlawful as a prison cell is often capable of being deemed a 'private place' under the relevant law (Wool 95). Clinically prescribed condoms have generally become the Prison Service policy; and Home Office ministers now accept this policy. The BMA however, take the stance that condoms should be available in prisons without the need for health care staff to be directly involved (BMA Foundation for AIDS 1997). The 'Dear Doctor' letter arrived in prisons without an Instruction to Governors and this has reportedly caused some problems with the policy implementation; without guidance sent to both the health care and operational management of prison it may inhibit collaborative working between the two (Sexton 1997).

Research of young offenders suggests that the prevalence of risk behaviour is greater than amongst young people of equivalent age in the community outside a prison (AIDS Advisory Committee 1995).

Prisons are diverse institutions and therefore the type and impact of constraints that may influence the implementation of prevention measures could differ from establishment to establishment and indeed can change over time.

Prisons can function in very different ways because of the security category and diversity of prisoners. To overcome this the Prison Service have responded to the need for prevention measures at both a strategic and local level. The strategic response has been in terms of providing guidelines and support for education, counselling and abstinence based drug programmes. However, the day to day management of implementation of the full strategy has been devolved down to prison governors in individual prisons.

1.7.1 AIDS MANAGEMENT TEAMS

Underpinning the development of AIDS Management Teams (AMT) in prisons is the belief that HIV within prison is not only a medical issue, it also impacts on the whole

of prison life. Therefore, a multidisciplinary team approach towards prevention was developed. AIDS Management teams (AMTs) therefore, strategically consider how to respond to the relationship between HIV and security matters and to give feed back to the governor to inform operational decisions.

The HM Inspectorate of Prisons Report in 1995 recommended that all prisons should have an AMT and that the problems of hepatitis should be included in the terms of reference (Tumim 1995). Sexton (1997) described how the role of the AMTs had been extended in some establishments to encompass other functions, for example:

- to include other blood borne diseases, notably hepatitis B and C
- to include other communicable diseases particularly hepatitis B and C and tuberculosis
- to relate HIV management issues with those of the prisons drug strategies.

Current problems facing AMTs are that HIV prevention work is principally dependent on an interested and influential person in each prison, and there appears to be no consistency of practice between prisons. Furthermore, the cost of health promotion and disease prevention is high and HIV dedicated finance is becoming mainstreamed into general health budgets, therefore, prevention funds now have to compete against other health demands. Sexton (1997) reported that some prisons and health authorities expressed concern about maintaining the level of prevention work after the pump priming finance from health authorities and from the Prison Service Health Care Directorate runs out. Additionally, Sexton's report states that respondents were concerned about the provision and potentially enormous cost of HIV combination therapies, and the confusion about who should be the responsible agency to fund therapies of this cost and nature (Sexton 1997).

1.7.2 PRISON SERVICE STRATEGY FOR DRUG MISUSE

The Government's interdepartmental strategy to tackle drug misuse, Tackling Drugs Together (HM Government 1995) underpins the HM Prison Service response to the control of drug misuse in prison. Essentially the strategy calls for 'tough' control measures and the provision of access for drug users to appropriate services and treatment programmes (MacDonald 1997). The Nursing Advisor to the Directorate of

Health Care of HM Prison Service outlines the main parts of the prison drug strategy as being:

- reducing the level of drug misuse in prison
- zero tolerance of illicit drug use in prison establishments
- possession and trafficking of illicit drugs in prison are criminal offences and therefore, using drugs in prison is a disciplinary offence
- all reasonable measures to prevent drug misuse will be taken
- a stated commitment to providing help for prisoners who misuse drugs and to work with community services to provide continuing help on release from prison.

Individual prison governors are responsible for developing their own prison policy in response to this strategy (Willmot 1996).

A recent government white paper 'Tackling drugs to build a better Britain' (1998) has four main aims:

- to help young people resist drug use
- to protect communities from drug-related antisocial and criminal behaviour
- to enable people to overcome drug problems
- to stifle the availability of illegal drugs (Porter 1998).

The 10-year strategy outlined in the white paper will undoubtedly have an impact on the prison drug strategy at some time in the future.

1.7.3 MANDATORY DRUG TESTING

Mandatory Drug testing (MDT) was introduced into prisons in England and Wales in 1996 as part of the Prison Service drug misuse strategy. The target was to randomly test 5 – 10% of all prisoners in each prison every month to identify illicit drug use.

The purpose of the policy was threefold:

- to deter the use of drugs within a prison

- for identification of treatment and discipline requirements
- to provide information on the level and type of drugs used in each prison.

Refusal to provide a urine sample for testing or a positive illicit drug result culminates in a loss of remission on a sentence of up to 42 days (MacDonald 1997).

Gore et al., (1995) describes the results of the pilot study of MDT carried out in 1995, which demonstrates that the proportion of prisoners testing positive for opiates or benzodiazepines rose from 4.1% to 7.4% between the first and second phase of random urine testing. The authors call for an evaluation of this policy with regard to the public health consequences of prisoners switching drug use from cannabis to class A drugs. The apparent trend towards class A drugs like heroin is alleged to avoid the likelihood of detection, cannabis has a 14-21 day half-life whereas heroin has a three-day half-life (Gore, Bird, & Ross 1996). The combination of the relative infrequency of injecting drug use inside prison, and the short urinary half-life of heroin, may lead to MDT greatly underestimating the number of prisoners who are using opiates (Bird et al., 1997). Bird and colleagues (1997) assert that there should not be confusion between the need to tackle drugs within a prison and the need to collect accurate information on types of illicit drug used and the routes of administration (Bird et al., 1997). McDonald (1997) concluded in her study on MDT that resources and effort have been focused on testing and restricting the supply of drugs and there had been little effort directed at helping prisoners with their drug problems. MacDonald therefore, suggests there is little real attempt to tackle drug use in prison (MacDonald 1997).

1.8 IMPLEMENTATION OF HIV AND HEPATITIS PREVENTION GUIDELINES

A report on the implementation of the international guidelines on HIV/AIDS in prisons of the European Union reports an inequivalence of policy development. However, the report questions the appropriateness of directly implementing community policies and challenges that policies should be developed to meet the special circumstances and need of prisoners (O'Brien & Stevens 1997). In addition, a Canadian pilot study that looked at HIV prevention in prisons purely from a prisoner perspective, also calls for harm reduction to be specifically adapted to the unique prison environment because prisoner respondents reported concerns about personal safety if prevention measures were introduced (Calzavara et al., 1997).

Chapter One considered the general epidemiology and policy issues, Chapter Two will explore the empirical literature related to HIV and hepatitis in prisons.

CHAPTER 2

Literature review, HIV and hepatitis prevention in prisons

2.1 POLICY CONTEXT

HIV and hepatitis B and C prevention in prisons is complex, requiring additional levels of consideration than would be necessary for the prevention measures implemented by the National Health Service (NHS) in other non-hospital settings.

The legal, political, security and social constraints in a prison setting have complicated and delayed the implementation of equivalent NHS risk reduction measures, considered essential to prevent HIV and hepatitis B and C transmission. Some of the constraining factors are outlined below to illustrate the complexity involved in the development of policies in this area.

2.1.1 LEGAL CONSTRAINTS

Legal constraints include the difficulty of how prisons should respond to illicit drug use in prisons. The implications of introducing preventive measures such as needle exchanges and bleach for decontamination of needles has to be considered in this context.

Present law prohibits sex between men except that which occurs in a private place between consenting men aged 18 or over. In the recent past, there has been uncertainty about whether any part of a prison to which inmates have access constitutes a private place (AIDS Advisory Committee 1995). Pertinent for young offender institutions is the age of consent for homosexual sex; the age range of inmates in young offender institutes ranges from 15 to 21 years.

2.1.2 POLITICAL CONSTRAINTS

Prisons have to respond to political ideology and policy on punishment of crime. Implementing HIV and hepatitis prevention policy means acknowledging that there is same sex intercourse and drug taking in prisons which may be perceived to risk evoking a public response of 'being soft on crime and criminals'. Some crime has been linked to drug use and the need to have money to continue a very expensive

'habit', however, the vast majority of crime is against property; drugs themselves do not directly cause violent criminal behaviour (Power 1994).

The issues to be addressed when focussing on the political context is how can public health prevention measures integrate with the punishment and rehabilitation role of prisons.

2.1.3 SECURITY CONSTRAINTS

Security in a prison environment refers to the secure holding of inmates in custody.

The Report of Her Majesty's Chief Inspector of Prisons for April 1994 – March 1995 states,

"The first duty of the Prison Service is to keep in custody those whom the courts commit to prison and, within a safe environment, to operate purposeful regimes which challenge offending behaviour and prepare the prisoner for the time when liberty is regained. For the duration of a prison sentence, it provides the community with the assurance that it is 'safe' from any more wrong doing by the imprisoned criminal" (Tumim 1995)

Therefore, there is concern about introducing policies such as needle exchange schemes or bleach provision into prisons, which may appear to be complying with illicit drug use. The unauthorised possession of drugs and drug using equipment will remain prohibited and punishable under prison law and criminal law. However, the AIDS Advisory Committee recommends a more enlightened use of discipline mechanisms; help and treatment being the preferred response for a drug problem rather than a disciplinary proceeding (AIDS Advisory Committee 1995).

The security concerns associated with illicit drugs are possession of an illegal substance because of the legal implications and the potential psychoactive effect of the drug.

The security concerns associated with providing condoms are that they could be used to conceal drugs and that same-sex intercourse may involve coercion and abuse, and may additionally provoke a homophobic response from other prisoners.

2.1.4 SOCIAL CONSTRAINTS

As there are a disproportionate number of drug users in the criminal justice system, there is a potential for abuse of the systems set up to reduce harm from drug taking. There may be bullying in order to obtain drugs or because of debt from buying illicit drugs. Negative attitudes, such as hostility towards homosexual practice, may also affect the introduction of policies.

2.2 POLICY DEVELOPMENT

The Prison Service has adopted a strategic response to prevention of HIV and hepatitis B and C encompassing education, information, counselling and abstinence based drug programmes. The day to day management of implementation of the strategy has been devolved down to prison governors or a multidisciplinary AIDS management team (in some establishments because of a wider remit this team is called a communicable disease team). However, implementing the full-range of policies implemented by the NHS or recommended by the World Health Organisation (1993) for prisons has proved controversial for prisons. When deliberating any health issue for potential policy development, prisons have to consider the impact or conflict with the Prison Service primary concern of security. The fundamental principle underpinning the World Health Organisation guidelines is that all prisoners have the right to receive health care, including preventive measures, equivalent to those available in the community. This ethical principle has underpinned the public health pressure to implement the full range of NHS prevention policies in prisons. Prison policy fully endorsed the principle that prisoners should receive an equivalent standard of health care to that provided by the NHS (Joint Prison Service and National health Service Executive Working Group 1999). However, the difficult issues concerned with implementing HIV and hepatitis prevention remain unresolved.

The process of policy change can take years and problems can arise where different organisations are at different stages of the HIV prevention continuum. Sexton (1977) states that the lack of congruence between practice inside a prison and health practice outside a prison has led health authorities to become disillusioned with working with prisons. The consequence of the disillusionment is that there is ineffective communication between the two specialities (Sexton 1997).

2.3 EPIDEMIOLOGY OF HIV AND HEPATITIS B AND C IN PRISONS

2.3.1 EPIDEMIOLOGY

Epidemiology is an investigative technique that provides a population perspective on health, disease and health services. Key components of the approach are:

- examining the pattern of disease with and between populations
- searching for the causes of disease
- formulating health promotion and disease prevention strategies
- studying the natural history of the disease
- planning and evaluating health services (Donaldson & Donaldson 1993).

There has been debate in the prison literature with regard to the extent that prisons impact on the acceleration or suppression of the rate of HIV and hepatitis infection (AIDS Advisory Committee 1995; Gill, Noone, & Heptonstall 1995). The debate has arisen because of the problems identified in monitoring diseases that have a relatively long incubation period in a prison setting. Dolan et al., (1995) described the difficulties of accurately monitoring prevalence rates when acute infection with HIV or hepatitis B and C may be asymptomatic, and may only become evident after release from prison. Additional factors that could frustrate reporting are;

- if a person living with the virus is asymptomatic and unaware of their infection status, there is less likelihood of that person presenting for testing
- prisoners may have been advised in the past, that there was little advantage in being tested in prison for viral infections that have profound, emotional, psychological and social effects. However, because of the recent advances in treatments, such as, multi-antiretroviral therapy for HIV and the potential for interferon or multi-antiretroviral therapy for hepatitis C this perspective may be changing
- from the prisoner perspective, coming forward to be tested for HIV and hepatitis B and C, in an environment where illicit drugs and homosexual activity are not

accepted, may be a powerful deterrent against having viral investigations, or indeed, for declaring known HIV status

- prisoners may move around the prison system, from, say, a local prison to a category C training prison and this may conceal related cases.

Based on ethical principles, testing for HIV and hepatitis among the prison population is voluntary, therefore precise prevalence figures are not available (Conner 1995).

There has only been one prison based HIV and hepatitis B outbreak reported in the UK; this was in Scotland in 1993 (Gore et al., 1995). The circumstance of only one notified outbreak in the prison system in the United Kingdom has been used as 'evidence' to substantiate the claim that there is little to suggest a high prevalence of HIV in prisons. Conversely, however, it could be that reported rates under-represent the prevalence figures because of difficulties identified above. The official statistics available show that up to the end of April 1995, 449 HIV seropositive prisoners had been reported since 1985. In the same period 30 prisoners with an AIDS related diagnoses were notified and 12 prisoners have died of AIDS related illness whilst in custody, although only one, at his own request, remained in prison until he died (AIDS Advisory Committee 1995).

As part of the Prevalence of HIV in England and Wales 1997 survey a voluntary salivary study of HIV and hepatitis infection among prisoners in eight prisons was undertaken. The prevalence of HIV, hepatitis B and hepatitis C in 1997 is illustrated in table 2.1:

Table 2.1 Prevalence of blood-borne virus in prisons 1997

	ANTI-HIV	ANTI-HBC	ANTI-HCV
Males	0.32% - 9/2813	8.2% - 231/2807	8.7% - 243/2807
Females	1.2% - 5/410	12% - 50/410	11% - 46/410
Young Offenders	0.0% - 0/712	3.9% - 28/712	0.56% - 4/712

The prevalence rates for females was reported to be higher than for males and the prevalence rates of hepatitis B and C are, as expected, are higher than HIV. The prevalence rates for young offenders for the three viruses are much lower than the adult male or female rates. A limitation of the prevalence study for prisons is that the participation rate is not reported (Unlinked Anonymous Surveys Steering Group 1998). When these figures are compared to the pilot prevalence survey of three male London prisons undertaken in 1993 they show, that the prevalence of HIV infection at 0.3 percent (2 of 584) for males not to have markedly changed in that time. However, the prevalence of hepatitis B was 7.9 percent (46 of 584) in 1993, whereas the prevalence rate in 1997 had risen to 8.2 percent. In the 1993 pilot study it was reported that in those who reported injecting, the HIV infection rate was 1.2 percent (1 of 85) and 0.2 percentage (1 of 499) in those who did not inject. Amongst those who reported injecting in prison, the prevalence of hepatitis B was 16.1% (14 of 87) and 6.4% (32 of 497) among those who did not report injecting. The prevalence of hepatitis C was not reported in the pilot study. The results of the pilot study support the contention that intravenous drug users, who report sharing injecting equipment in prisons, are at greater risk of blood-borne infection. A major limitation of the pilot study acknowledged by the authors is the low participation rate, which should lead to a relatively cautious interpretation of the results. (Unlinked Anonymous HIV Surveys Steering Group 1995).

One of the conclusions of the 1997 prevalence survey of HIV in England and Wales was that in commissioning services priority should be given to prevention activity in sites of potentially increased risk and the report sites prisons as an example (Unlinked Anonymous Surveys Steering Group 1998).

2.3.2 RISK BEHAVIOUR IN PRISONS

Evidence to demonstrate behaviour in prisons that may facilitate the spread of hepatitis and HIV infection was shown in several studies. Dolan et al., (1995) reported that sharing injecting equipment with a number of users is far more common in prison than in community settings. Following the reported HIV and hepatitis outbreak in Scotland in 1993, a subsequent study one-year after the outbreak observed the level of risk behaviour was unchanged and did not differ from the risk behaviour in other prisons. The study also showed HIV positive prisoners injecting drugs and being sexually active (Gore et al., 1995). Dolan (1993) reported that many

countries have described a reduction of drug injecting risk behaviour in community settings but there was little evidence of similar risk reduction in prisons. A study of 421 prisoners at a Young Offenders Institute (YOI) in Scotland reported that 17% of the respondents reported having injected drugs while in prison and 3 respondents reported having anal intercourse while in prison (Bird et al., 1993). Gaughwin et al., (1991), reviewed 9 studies of ex-prisoners who were intravenous drug users; the study stated that 42% reported injecting drugs while in prison and 1 in 10 men reported having homosexual contact. In England and Wales in any year, between 1 in 3 and 1 in 7 prisoners will have a history of injecting drug use (Unlinked Anonymous HIV Surveys Steering Group 1995). A study of drug users in Scottish prisons suggested that the participants were less likely to use intravenous drugs when in prison. Thirty two percent had injected regularly in the community before sentencing, compared to 11% who were injecting during their current reported sentence. Only two people in a sample of 234 prisoners reported developing a regular habit. A finding of concern is that, of the number who reported injecting prior to their current sentence, 24% reported sharing at that time, whereas of those that reported still injecting in prison, 76% reported sharing equipment (Schewan, Gemmell, & Davies 1994). This finding supports the assertion that drug users generally appear less likely to inject in prison than in the community, but those who continue to inject in prison are more likely to share equipment. An interesting finding in this study was that prisoners who were being prescribed Methadone prior to their current sentence had demonstrated positive behavioural change in the community with regard to stopping or cutting down injecting and sharing of injecting equipment. This contrasted to the behaviour reported after imprisonment when high-risk behaviour tended to be reinstated.

A Home Office research study which examined the risk behaviour among males in 13 prisons in England and Wales shows that on imprisonment there was a sharp reduction in the use of amphetamines, cocaine and crack. However, the use of opiates fell less sharply. A 'sizeable' number of polydrug users decided to use only opiates whilst in prison, which suggests that opiate use forms a much higher proportion of the injectable drugs used in prison than it does outside prison. The survey also indicated the percentage of prisoners who reported using a drug for the first time in prison was; opiates 24 percent, crack 8 percent, amphetamines 7 percent (Strang et al., 1998).

A qualitative study conducted by Turnbull et al., (1994), asked 44 ex prisoners who were drug users, to describe their experience of drug use in prison. The respondents generally described prisons as places where drugs were readily available. All respondents had used drugs when they were last in prison, cannabis was used by all the respondents. Thirty-six had used heroin and or opiate substitutes over the same period, and 28 had used a variety of tranquillisers or anti-depressants, six had used crack or cocaine, two used amphetamines and two reported taking hallucinogens. However, the respondents who had been using non-prescribed drugs prior to imprisonment reported using less while in prison. Although the social nature of drug use in prison was described, the most common time reported for injecting drugs was in locked cells last thing at night. In an attempt to describe their drug taking behaviour some respondents spoke of drug use being fundamentally natural behaviour to them, therefore the notion of stopping drug use in prison was rejected by them. Some viewed drug use as unavoidable because they perceived withdrawal in prison as an additional punishment, described in the study by respondents as "doing double time".

In the study, prescribed medication for opiate withdrawal tended to be provided for a maximum of 14 days, with five days being described as more common, whereas respondents described the process of withdrawal as lasting two to four months. Some respondents described drug use as necessary for a variety of reasons; to assist sleep, and to relieve anxiety, depression, boredom and physical inactivity. Four people, two of whom were in prison for the first time, reported attempting to use the prison stay to help them stop drug use. However, their attempts were unsuccessful, with failure being attributed to the environment and general availability of drugs. All 44 respondents reported drug injecting prior to imprisonment whereas 16 had injected the last time they were in prison; of these, 9 reported sharing injecting equipment at some time. 'Sharing', however, appeared to be defined in this situation as "if needles and syringes were used immediately after, or prior to, their use by another person"; additionally, when injecting took place it was seen "as being dependent on the presence of others who were using the same needles and syringes". If there was a time lapse between shared use of the injecting equipment, the term "just using old works" was applied. This subtle use of terminology becomes important for monitoring the risk behaviour of sharing injecting equipment.

All of the respondents reported an attempt to clean needles, syringes and other drug paraphernalia. However, some respondents stated that although they knew how to clean equipment properly they were unable to do so effectively in prison. One respondent described the use of urine to supplement water to clean his syringe because of access difficulties to a regular water supply (Turnbull, Stimson, & Stillwell 1994). A multimethod study by McDonald (1997) showed that the staff perception of drug use in prisons was that there was a wide and substantial use of illicit drugs. Cannabis was believed to be the most heavily used drug, although the use of heroin and crack/cocaine was also reported to be fairly wide spread. Staff also believed that it was likely that some prisoners started a drug habit in prison as a consequence of boredom and peer pressure (MacDonald 1997).

In the UK, surveys of sexual activity in prison report unexpectedly lower rates of sexual activity than other international research has revealed (Curtis & Edwards 1995). In one study 10% of the sample reported that they were involved in sexual activity while in prison; most of the men in this study reported unprotected penetrative sex (Turnbull, Dolan, & Stimson 1991). Strang et al., (1998) in a survey of 13 prisons in England and Wales estimated the number of prisoners who were engaging in same sex sexual activity to be between 1.6 percent and 3.4 percent of the sample population. This figure was translated to give the number of male prisoners who would have sexual contact with another man to be between 900 to 1,900 of adult male prisoners who were serving a sentence at the time of the survey.

Due to the personal and social taboos regarding homosexuality, it is probably extremely difficult to obtain accurate information about the extent of same sex sexual activity. However, it may be that because of the social stigma and the lack of opportunity due to single locked cells in some prisons the amount of sexual activity is reduced (Power et al., 1991). Some of the men who have sex with men in prison may regard themselves as heterosexual, and may not have assimilated the gay cultural norm regarding safer sexual practices. Calzavara et al., (1997) reported that focus groups described sexual activity in female prisons as being commonplace, acceptable by staff and inmates and therefore open and visible. Whereas sexual activity in male prisons was described as stigmatised, discreet and not talked about (Calzavara et al., 1997). In the same report, the authors described male and female

respondents reporting the same level of sexual activity during imprisonment although, men were more likely to engage in higher-risk activity (Calzavara et al., 1997).

Coercive sex and prostitution have also been acknowledged as probably occurring in some prison systems, with the implication that those who coerce others into providing sex may not observe the 'rules of safer sex' (AIDS Advisory Committee 1995).

It is widely accepted that, although anal sex may contribute partially to the spread of HIV and hepatitis; the major risk factor for intravenous drug users, in a prison environment, is needle sharing whilst in prison. In a non-prison study undertaken in Berlin with 612 intravenous drug users, over half reported positive changes in risk behaviour related to injection behaviour, however a multifactorial risk factor analysis for HIV infection suggests that the most important risk factor in IVDU is needle sharing during a prison sentence. Furthermore, for those intravenous drug users who knew themselves to be HIV seropositive imprisonment was the only reason stated for sharing injecting equipment (Muller et al., 1995).

2.4 HEALTH NEEDS OF PRISONERS WITH HIV AND HEPATITIS B AND C

The AIDS Advisory Committee (1995) point out the centrality of medical care to prisoners with HIV infection; however, they affirm that prisoners also have needs that encompass a supportive environment and a positive knowledgeable attitude from staff (AIDS Advisory Committee 1995). The HM Inspectorate of Prisons Report in 1995 stated that staff and prisoners were now sufficiently educated about HIV to accept HIV positive inmates on the landings without undue anxiety (Tumim 1995). In the past prisoners with HIV or hepatitis B or C could be subjected to Viral Infectivity Restrictions (VIR) which meant that a prisoner with HIV or hepatitis B or C could be located in a single cell or prohibited from taking part in contact sports or unable to undertake certain kinds of work.

Hepatitis B vaccination should be available for all prisoners serving sentences of over six months.

2.5 CONDOM AVAILABILITY WITHIN PRISONS

Present law prohibits sex between men except that which occurs in a private place between consenting men aged 18 or over. In the recent past, there has been uncertainty about whether any part of a prison to which prisoners have access

constitutes a private place (AIDS Advisory Committee 1995) (see page 10 and 11 for explanation of prison policy). Pertinent for young offender institutions is the age of consent for homosexual sex; the age range of inmates in young offender institutes ranges from 15 to 21 years.

In 1996, the British Medical Association Foundation for AIDS developed a questionnaire survey to look at the availability of condoms within prisons. Questionnaires were sent to the senior medical officers in each of the 126 prison establishments in England and Wales, 76 were returned giving a 60% response rate. Most prison medical officers had taken steps to implement a condom policy of prescribing for prisoners at risk of HIV infection. 71 percent said the letter had been discussed with the AIDS management team or multidisciplinary HIV team in their establishment. However, although most prison medical officers reported progress on the policy, 28 percent volunteered the information that inmates had not requested any condoms. There were some prisons that had a local policy of freely available condoms. Two young offender institutes (YOIs) did not prescribe condoms because of the age of consent for male same sex intercourse, although respondents from other YOI establishments did not appear to have the same legal reservations. One of the young offender institutes was reported to state that condoms were not prescribed because of the high numbers of sex offenders and, secondly, that it may be viewed as condoning homosexuality; the latter concern was condemned by the authors as a moral judgement of no concern to the doctor. Some establishments had not implemented the policy because of the cost of implementation.

There was some reported concern about the legal aspects of male same sex intercourse in open plan prisons; in response, the BMA report states that the strict absence of privacy in a prison would not imply criminal liability on the part of the Prison Service because condoms would be prescribed on health grounds. However, the authors recommend a clear statement with regard to waiving disciplinary action if a prisoner is in possession of a condom. One respondent stated when outlining the policy implemented in their establishment that a condom exchange had been set up, so that subsequent issue of condoms would depend on the return of used condoms (BMA Foundation for AIDS 1997). The author of the BMA Report cautions the reader to be aware that the respondents of the questionnaire knew the British Medical

Association's policy position of confidential access to condoms without the need for the direct involvement of the health care staff (BMA Foundation for AIDS 1997).

It has been reported that prisoners may be reluctant to take up condom provision because fellow prisoners may label them as 'gay' or indeed, they may be suspected of concealing and smuggling drugs (Calzavara et al., 1997).

2.6 NEEDLE EXCHANGE PROGRAMMES

The WHO Guidelines states, 'that in countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this' (World Health Organisation 1993).

The considered advice of the AIDS Advisory Committee, to the Director of Health Care for Prisons, is not to adopt the policy of needle exchange schemes in prisons. Principally because it would present a significant conflict for the duty of prison authorities to detect drug smuggling into prisons and to prevent illicit drug use during detention (AIDS Advisory Committee 1995). The AIDS Advisory Committee acknowledges that it is an unrealistic expectation to eliminate injecting drug use in prison. Therefore, the basic tension between reducing the harms associated with injecting drug and adherence to the security requirement of the prison service remains unresolved.

Calzavara et al., (1997), in a pilot study looking at HIV prevention from the inmates perspective, reported that inmates were divided on the issue of needle exchange; 46 percent saw no problems whereas 54 percent identified various concerns:

- needles being used as weapons
- encouraging drug use
- encouraging fights
- spreading disease
- fear that people living with HIV could knowingly pass on the virus (Calzavara et al., 1997).

The first official prison based needle exchange in the world was initiated at Hindelbank Prison in Switzerland in 1994. The scheme used free access automatic dispensers to exchange one used syringe for one clean one. The evaluation of the pilot reported that:

- the numbers of prisoners who reported sharing significantly declined
- there was no shift in type of drug use or route of administration
- there were no new reported HIV or hepatitis infection
- only one person reported a continuation of the practice of sharing needles (Nelles & Furhrer 1995).

Before initiation of the pilot needle exchange programme staff expressed concerns about needles being used as weapons, a shift in the pattern of drug use to injection and spread of infection, these concerns were not found to be substantiated in the evaluation of the pilot. There are two factors to be taken into account when considering this positive evaluation, first is that Hindelbank is a relatively small prison for women so the applicability to all prisons should be examined further and second, that the ratio of staff against the installation of syringe distribution machines was one in five, this number remained stable during the pilot project.

2.7 CHEMICAL DISINFECTION FOR INJECTING EQUIPMENT

An important distinction needs to be drawn between sterilisation and disinfection; sterilisation is a process used to completely render an object free from all micro-organisms. Disinfection is a process used to reduce the number of micro-organisms to a level that is not harmful to health. Decontamination is a general term used to describe the action of removing microbial contamination to make an item safe.

There are several factors to be taken into consideration when considering the use of disinfectants including, the efficacy of the particular disinfectant, the type of item to be cleaned, the nature of the organism involved, the time available for decontamination and the possible risks to the people using the disinfectant (Ayliffe, Coates, & Hoffman 1993). Generally health care equipment used to pierce the skin would be sterilised and not disinfected. However where there is a comprehensive harm reduction policy chlorine-based agents (bleach) have been advised as a less safe substitute for sterilised needles and syringes for injecting drug users in an 'emergency'. The user

should be given proper information and advice about how to properly clean injecting equipment which would include a statement that bleach cannot offer full protection against HIV and hepatitis B and C infection and should not really be substituted for unused sterile injecting equipment.

Research has drawn attention to the limitations of bleach for inactivation of HIV and hepatitis virus. A laboratory based microbiological study designed to evaluate the efficacy of bleach for cleaning needles and syringes as a means of preventing HIV infection found no evidence in support of this prevention strategy. The authors therefore suggest that the focus of prevention should be on increasing access to sterile injecting equipment to reduce the frequency of sharing injecting equipment and preventing unprotected sexual exposure (Titus et al., 1994). The main finding of the study is also supported in a study by Vlahov et al., (1994).

A study designed to evaluate the inactivation of HIV, in needles and syringes containing infected blood, using household bleach, found that undiluted bleach was effective after 30 seconds of exposure time. However, in contrast a 10% dilution of household bleach was only effective after exposure of 2 minutes (Shapshak et al., 1994).

This would appear to negate the advice commonly given that a 1:10 dilution of thick household bleach is sufficient to inactivate HIV, this is clearly not effective in this situation. Flynn et al., (1994) concluded, in a study designed to observe the in vitro activity of household materials against HIV, that it is more difficult to disinfect needles and syringes shared by intravenous drug users than previously thought. Additionally, in this study, the authors point out a profound limitation to the use of bleach, in that very little is known about the effects of bleach or other disinfecting agents to inactivate hepatitis B and C.

Compliance with cleaning schedules can also prove a problem. A study by McCoy et al., (1994) showed that the compliance to taught cleaning schedules diminished over time. A high proportion of intravenous drug users used only water to clean their injecting equipment. For those that used disinfectant there was a discrepancy between self-reported contact time with disinfectant and observed contact time. The self-reported times were on average two times longer than observed times.

In an Australian study 58 syringes that were found in 3 prisons over a one-year period were examined. 95% syringes found were the 1ml volume syringe, 24% contained visible blood, 58% indicated repeated use, 26% had detachable needles allowing more blood to be trapped in the dead space between the syringe barrel and needle than with a fixed needle. The authors conclude the nature and condition of some syringes suggested a potential for transmission of contaminated blood. (Seamak, Gaughwin 1994).

A Canadian pilot study that focused on 39 prisoners, found that 11 reported injecting in prison, seven prisoners had shared needles and three of these had not cleaned their equipment (Calzavara, et al., 1997).

Much of the research presented with regard to bleach efficacy has focused on the risks of HIV transmission. This is because much of the current literature concentrates on HIV because there is currently no cure and treatments to suppress the virus can be very toxic and not suitable for all those infected. Hepatitis B and C are not infections of such profound consequence, nevertheless they have serious, sometimes chronic health implications. McBride., (1994) express concern that the debate about the risk of HIV transmission among intravenous drug users in prison has completely overshadowed any discussion of the threat of hepatitis C.

Bleach in the form of tablets was introduced in Scottish prisons in 1993, they are reported to be accessible and used by prisoners' (Bird, et al., 1997). The introduction of bleach tablets in prisons in England and Wales was abandoned because of a Health and Safety issue relating to the inflammable properties of the bleach tablets. There is currently a proposed pilot scheme to evaluate and facilitate the introduction of bleach into ten prisons in England and Wales.

The policy of introducing bleach into prisons is not a straightforward one. What would appear to be a clear public health policy becomes difficult in the absence of a clear comprehensive harm reduction policy. A community policy incorporating bleach would have a hierarchy of safer choices, providing sterile injecting equipment as the first and safest choice followed by a lower level choice of bleach for disinfection given with clear guidance and instructions about how it should be used. There should also be a clear statement about the uncertain efficacy of bleach against HIV and hepatitis B and C virus.

2.8 PREVENTION MEASURES FOR HIV AND HEPATITIS B AND C IN PRISONS

Although the empirical work presented in this chapter suggests an overall reduction in risk behaviour when individuals enter prison, there is still sufficient evidence of high risk behaviour to provide a clear imperative to implement appropriate and acceptable prevention strategies for the prevention of HIV and hepatitis B and C.

Research undertaken by Power et al., (1996) suggests that the level of knowledge about HIV prevention in the inmates of Scottish prisons was good. Knowledge was particularly good in prisoners who could be considered to have engaged in high-risk behaviour. Prisoners demonstrated good knowledge about sexual and drug risk behaviour and knowledge about methods of reducing transmission of HIV, however, the response was uncertain with regard to sharing some items of injecting equipment such as 'cooking up' spoons and the use of bleach for decontamination of injecting equipment. Therefore, the authors state that educational programmes on their own are unlikely to modify behaviour and call for more effort to identify the barriers that prevent individuals from adopting appropriate preventive behaviours (Power et al., 1996).

Policy will only be fully translated into practice if it is acceptable to the target group and to those charged with the responsibility of implementing the policy. HIV and hepatitis research has largely focused on risk behaviour and has not recognised the potential significance of the people within a given context responsible for prevention information and health campaigns. Guzzardi et al., (1997), suggest that the people responsible for prevention have remained largely invisible in research and it is assumed that the social organisation of the 'preventers' has little impact on the successful implementation of prevention programmes (Guzzardi, Stella, & Remy 1997). However, in a closed environment like a prison the beliefs and attitudes of the 'preventers' will affect how effectively the programmes are put into practice. Furthermore, the way prisoners view prevention policies will affect how successfully, or otherwise, a policy is accepted. It is often assumed that the target group will always take up such health policies. Calzavara et al., (1997), in a pilot study reported earlier in this Chapter, showed that 54 percent of the sample of inmates expressed concern about needle exchange programmes.

After exploring policy and previous research concerning HIV and hepatitis prevalence and prevention, models of health behaviour will be considered. The exploration of these models will identify the usefulness of using a particular theory-driven model to help organise and structure the research data of the current study.

2.9 HEALTH BELIEFS AND HIV AND HEPATITIS PREVENTIVE BEHAVIOUR

One theoretical model of health motivated behaviour on its own will probably not be able adequately to explain the complex and intricate problem that this study sets out to explore. However, despite the acknowledgement of this limitation, the utilisation of a model will give a core structure and focus to what could be an overwhelming array of concepts and information. This study is an attempt to explore the attitudes of the people most closely involved with policy, which may then have an impact on future policy development. The study will not explore behaviour change, this may well become the focus of a future study; rather, the imperative for this study is to explore the situated knowledge of risk behaviours and attitudes and beliefs about potential prevention strategies. The results will then provide a platform for the development of future prevention programmes in a way that is sensitive to staff and prisoner attitudes and beliefs.

Broadly, it is possible to identify two epistemological perspectives that have attempted to explain health behaviour and behaviour change. Firstly, sociological theory examines the impact of wider social factors affecting health such as culture, housing and poverty. Secondly, psychological theory which attempts to explain health behaviour and behaviour change and has focused on cognitive factors such as knowledge, attitudes and beliefs. Psychological theory attempts to identify the individual psychological determinants of health behaviour that appear more amenable to change than the far-reaching social factors identified in sociological models. Within a health context the health professionals who primarily have the practice responsibility for developing policy and encouraging change in health behaviour are health promotion practitioners and health visitors. Traditionally, the focus on individualistic behaviours that are amenable to change, described by psychological models, have influenced and underpinned attempts at preventive behaviour change campaigns in health promotion and public health.

Psychological models, referred to as Social Cognitive Models (SCMs), describe cognitive determinants of health behaviour that are also believed to mediate the effects of many other determinants such as social class (Conner & Norman 1996). The nature of the transmission routes of HIV and hepatitis B and C highlights the need to focus on behavioural change interventions. Therefore risk behaviours rather than environmental factors become the central issue of most of the research into HIV and hepatitis prevention. As there is not an effective vaccine and reliable proven treatment for HIV and hepatitis C, behavioural change is the most compelling means of prevention.

For the purpose of this study an SCM approach will be adopted to assist the illumination of key factors. The way prisoners and staff conceptualise hepatitis and HIV prevention polices will influence both the development of, and the acceptance of, any new policy. SCM theory proposes that health behaviours are the culmination of a rational decision-making process based upon 'deliberate systematic processing of the available information' (Conner & Norman 1996). The implication for health professionals, of applying the theoretical concepts from SCMs, is that the manipulation of cognitive variables demonstrated to be the determinants of a particular behaviour would potentially lead to effective interventions.

Generally, two types of SCMs are used in order to explain health-related behaviour and response to treatment. Firstly, attribution models focus on how individuals ascribe the causes of health related experiences; the application of attribution models in research has tended to focus on explaining causal factors in serious illnesses such as cancer and coronary heart disease (Conner & Norman 1996). The second type of SCM is concerned with preventive health behaviour; this clearly has more relevance for the study of HIV and hepatitis prevention in prisons. The most widely examined SCMs in respect of predicting future health related behaviours and their outcomes are;

- Health belief model (HBM)
- Protection motivation theory (PMT)
- Theory of reasoned action (TRA)
- Theory of planned behaviour (TPB)

Each model will be briefly examined in respect of their benefits and shortfalls both in general and specifically within a prison context.

2.9.1 HEALTH BELIEF MODEL (HBM):

The HBM emphasises key predictors of health behaviour; perceived susceptibility to illness, severity of a health threat, perceived costs and benefits associated with preventive action, the individual's general health motivation and environmental cues. Environmental cues could be internal cues such as physical symptoms or external cues such as mass media campaigns; either type of cue would prompt health related behaviour change (Abraham & Sheeran 1994). The HBM presumes that once an individual perceives the risks associated with an illness, and has the means to avoid them, they will realise the benefits of preventive action, and as a consequence take action to avoid risk (Schwarzer 1992). Conversely, if the individuals do not view themselves at risk there will be a lack of motivation to alter behaviour. In a review article, Abraham and Sheeran (1994) describe the cost benefit concept proposed by the HBM as persuasive and thereby providing an underpinning for health education (Abraham & Sheeran 1994).

The model has wide appeal both with researchers and professionals working in the field of prevention because the variables have a 'common-sense quality' (Conner & Norman 1996). However, weaknesses in the conceptual structure of the HBM have been identified, for example, there are some variables that are empirically reported to be predictive of health behaviour that are not incorporated in the HBM model. Intentions to perform a behaviour and social pressure are not featured in the theoretical framework of the HBM, however, both are prominent in the Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB). A perception of control over health behaviour is a prominent concept in the TPB and the Self-efficacy Theory and is not featured in the HBM. Lux and Petosa (1994), in a study to explore the safer sex intention of incarcerated youth, expanded the HBM to include self-efficacy, social norms and cues to action. The study supported the use of the expanded HBM, however, the authors caution that the practical significance of the expanded constructs require further research (Lux & Petosa 1994).

Finally, a major criticism of the model is the lack of differentiation between the motivational stage, characterised by cognitive variables, and a volitional stage where action is planned, performed and monitored (Schwarzer 1992).

The application of the HBM to a prison context has severe limitations, social pressure is potentially an important variable deserving of examination in a prison context. Additionally, behavioural intentions towards specific prevention strategies may prove a persuasive precursor to policy makers when considering the acceptability and applicability of particular prevention strategies. Control beliefs may illuminate important inhibitors for effective implementation of policy in a prison context. The concepts of social pressure, behavioural intentions and control beliefs may give valuable insights into preventive policy in a prison context however, these concepts are omitted from the HBM.

2.9.2 PROTECTION MOTIVATION THEORY (PMT)

PMT as proposed by Rogers (1975) was developed to provide conceptual clarity to the understanding of fear appeals. Essentially, a health message evokes fear in the receiver, who is then motivated to reduce the unpleasant emotional situation. If the message contains reassuring health advice, following the advice is a way to reduce threats (Boer & Seydel 1996). The model was further developed (Rogers 1983) to a theory of persuasive communication with an emphasis on cognitive processes mediating behavioural change (Boer & Seydel 1996).

PMT is most effective when:

- The threat to health is severe
- The individual feels vulnerable
- The adaptive response is believed to be effective in averting the threat
- The individual is confident in his or her ability to successfully complete the adaptive response
- The rewards associated with maladaptive behaviour are small
- The costs associated with the adaptive response are small (Power et al., 1994).

Critically for HIV and hepatitis prevention, if an individual does not perceive self-risk of blood-borne virus transmission then there would be a lack of motivation to adopt or accept the need for prevention strategies. An accurate assessment of risk is essential to provide the basis of rational decision making for behavioural risk reduction strategies. Power et al., (1994), in a study designed to compare inmates' lifestyle outside and inside prison, stated that prior to imprisonment, even though inmates were aware of their own level of HIV risk in relation to their sexual and IDU behaviour, it did not influence the adoption of safer behaviour. The authors suggested that the lack of condom use and lack of change in risks related to drug use implied a lack of consonance between self-awareness of risk factors and a willingness to adopt safer practices. They concluded that some individuals may enjoy risk-taking, for example, rock climbing and riding motorbikes; they suggest that there is no reason to believe that drug taking and sexual activity should be regarded any differently (Power, et al., 1994).

Behaviour change based on fear may not be sustainable over time, when individuals habituate to the threat, behaviour may revert to conform to more stable beliefs (Gallois, Terry, & Timmins 1994).

2.9.3 THEORY OF REASONED ACTION (TRA)

The Theory of Reasoned Action (TRA) was developed in response to the frustration resulting from the failure to predict behaviour from traditional measures of attitude. Attitude scales such as Thurstone, Likert, Guttman and Semantic Differential scales assumed beliefs were highly correlated with attitudes. Fishbein and Raven in 1961 found that the two constructs were relatively independent. An example quoted illustrating that beliefs have little influence on attitude was that whilst people may believe in ESP, some may judge it a good thing and some may judge it negatively (Fishbein 1993). Building on this in 1963, Fishbein developed and empirically demonstrated the validity of the expectancy-value model of attitude (Fishbein 1963). From this work he suggested that a person's attitude toward any object is a function of his or her beliefs about the object, and the evaluative aspects of those beliefs. So if it is believed that an object has 'good' characteristics, qualities and attributes, the more likely is a positive attitude toward the object (Fishbein 1993). Fishbein (1993), responsive to the growing discontent with the relationship of attitude scales and behaviours, stated that to really know whether someone would or would not perform

a given behaviour, the most appropriate thing to do was to ask about intention to perform that behaviour. He states that, as expected, people turned out to be very good predictors of their own behaviour. Thus, the emphasis shifts from predicting behaviour to understanding and predicting intentions. Predicting intentions is then the primary purpose of the TRA. The model assumes that behaviour can best be predicted from intention, and intention is underpinned by attitudes and norms held. The normative component is termed the subjective norm and is the person's perception of the expectation of 'significant others' to perform the behaviour and the strength of the motivation to conform to this expectation.

Fishbein describes a further assumption of the TRA:

"the factors underlying intentions to perform specific behaviours under one's volitional control were no different from those underlying intentions to perform behaviours that were not under one's volitional control" (Fishbein 1993).

However, Fishbein conceded that predictions of behaviour not under volitional control, as well as intentions to reach a given goal, such as intention to lose weight, often led to poor prediction. Further, the intention to engage in what he considered a class of behaviour, such as safer sex, also had poor predictive value (Fishbein 1993). Fishbein (1993) states that where behaviours are not under volitional control, Bandura's (1989) construct of self-efficacy may be an important determinant of intention and/or behaviour.

The TRA has received considerable empirical support from a number of researchers for health-related behaviours, such as smoking, injecting drug users and HIV preventive behaviour. An Australian study designed to test the TRA in the prediction of safe sex behaviour supported its use in certain groups, but stated it had little predictive value for homosexual men's safer sex intentions. The authors highlighted that for this group the importance of past behaviour was a better indicator of safe practice. The authors offer the suggestion that in this instance behaviour is the result of a threat-induced response to HIV rather than a change in beliefs. They believe this may mean that behaviour change in this group is less likely to be sustained over time and behaviour may revert into line with the attitudes and norms held (Gallois, Terry, & Timmins 1994).

Past behaviour will not be directly measured for two reasons, firstly, it is likely to be less predictive because prisoners are making health decisions outside their usual environments. Secondly, the focus of the study is potential policy development therefore staff and prisoners may not have had prior experience in this context.

2.9.4 THEORY OF PLANNED BEHAVIOUR (TPB)

The Theory of Planned Behaviour (TPB) extends the earlier Theory of Reasoned Action by the addition of a new factor, perceived behavioural control. Perceived behavioural control was conceptualised as a person's expectancy of the ease or difficulty of performing the intended behaviour. In common with other models described the TPB highlights the view that individuals make behavioural decisions based upon careful consideration of available information. The rationale for broadening the TRA was to enable incorporation of perceptions of control over performance of the behaviour. It was developed in this way because the TRA would only provide adequate predictions when examining volitional behaviours. Behaviours that require skills, resources or opportunities that are not freely available may be poorly predicted by the TRA (Conner & Sparks 1996).

In a study by Quine and Rubin (1997) it was suggested that attitude may be more important than normative beliefs where behaviour is being performed in private but that normative beliefs are more important where preventive health behaviour is performed publicly. In addition, perceived behavioural control was a more powerful predictor than attitudes supporting the claim that the addition of this construct increases the predictive power of the TRA (Quine & Rubin 1997).

One of the criticisms of the TPB is concerned with the research application of the model, if the researcher 'supplies the beliefs' in the measures designed to capture the beliefs and concepts of the model, such as in questionnaires, they may not be the most salient beliefs to the individuals or group studied. To counter the criticism it is suggested that research based on the TPB should allow the respondents to generate their own beliefs (Conners & Sparks 1996).

Despite the limitations in part described here, the TRA, and its extension the TPB, will provide a useful framework for this study, principally as an organisational device to guide the interpretation and organisation of the diverse and complex data. It will also prove useful, moreover, to enable relating this research to other theory based

research in the field of HIV and AIDS prevention that uses similar concepts and ideas, and will enhance its persuasiveness as a basis for the development of theory. Extensions to the theory such as the TPB attempt to deal with perceived inadequacies. Fishbein (1993) criticises the TPB in his introduction to a book on the application of the TRA to AIDS-preventive behaviour stating that “other variables are most likely to ‘work’ when inappropriate measures of the theory’s original constructs are obtained” (Fishbein 1993).

Thus, the use of other variables may lead to clouding of the fundamental issues concerning the components and relationships of the original theory (Lewis & Kashima 1993). Fishbein (1993) further criticises Ajzen’s TPB, stating that whereas in Ajzen’s original writing perceived behavioural control appeared to be closely aligned to self-efficacy, later discussions of this concept had reduced it to asking if the behaviour is ‘easy’ or ‘difficult’. Fishbein asserts that this basically equates with an affective measure of attitude of which there is empirical evidence of a high correlation of ‘easy/difficult’ with judgements such as ‘pleasant/unpleasant’ and ‘enjoyable/unenjoyable’. Therefore, he argues Perceived Behavioural Control (PBC) would not contribute to prediction of behaviour (Fishbein 1993).

Conner and Sparks (1996) state that PBC is a broad construct and consequently the measures used to try to assess the construct are diverse. Therefore, they stress the need to capture the nature of the construct and the nature of the control problems that people experience in particular contexts that give rise to perceived and actual control problems. To be of practical benefit though there needs to be an understanding about the meaning of the problems within a given context as well as the knowledge about what the problems are (Conner & Sparks 1996).

2.10 THEORETICAL FRAMEWORK FOR RESEARCH

Clearly, when policy makers move on to consider how to implement HIV and hepatitis B and C preventive policy the relationship between intention and actual behaviour will need to be addressed. Various models focus on the process of behavioural change. A stage model developed by Prochaska and DiClemente (1984), the Transtheoretical Model of Change, focuses on the how people change rather than why they change. The model identifies distinct stages to health behaviour change:

- Precontemplation: in this stage, there is no real awareness of the problem or interest in changing.
- Contemplation: when the individual becomes aware of potential lifestyle risks and the possible benefits of change, but there is not yet any commitment to change.
- Preparing to change: change seems possible and worthwhile. At this stage, support and help may be needed.
- Making the change: it is helpful in this stage to have clear goals, realistic plans and support.
- Maintenance of behaviour: in this stage change in health behaviour is maintained over a lengthy period (Strang, et al., 1998).

Consideration of the process of behavioural change is an essential aspect of policy development because of the complexities so far described. However, this will be the concern of the policy makers and will only be addressed in this study in relation to discussing the empirical findings.

As this study is seeking a framework for looking at attitudes and intention towards policy and not, at this stage, to measure the link between intention and behaviour then it would appear useful and empirically acceptable to adopt the theory of planned behaviour. This study explores the beliefs and attitudes that may be influential in the staff and prisoners intention to be involved in HIV and hepatitis B and C preventive policy and uptake of policies.

CHAPTER 3

Research Methodology

This chapter describes the general design of the study and the process of the study within the prison environment. Essentially, the methodology of the study comprised both qualitative and quantitative methods. The qualitative aspect sought to represent the reality of HIV and hepatitis B and C prevention in prisons from the perspective of the staff and prisoner participants whilst being sensitive to the complexities of behaviour and meaning within the context (Henwood & Pigeon 1994). The meanings and understandings gained from the in-depth interviews with staff were developed into a questionnaire and distributed to a wider population in a greater number of prisons. The Theory of Planned Behaviour was used as a framework to structure the mass of data gained from the staff interviews into a questionnaire design. The use of this Social Cognitive Model was not to test or develop the Theory of Planned Behaviour; rather, it provided a structure to explore the psychological and behavioural pre-determinants identified in the fieldwork towards current and potential HIV and hepatitis B and C prevention programmes. The Theory of Planned Behaviour and its application to this study was discussed in Chapter 2.

3.1 RESEARCH AIM AND OBJECTIVES

The aim of the study was to explore the beliefs and attitudes of prison staff and prisoners towards prevention of HIV and hepatitis B and C in prisons. In order to facilitate the aim the following objectives were developed:

- To outline the HIV and hepatitis B and C prevention policies currently employed in prisons
- To explore the perceptions of risk behaviours, such as sexual and needle sharing practices, in relation to HIV and hepatitis, held by prison discipline officers, health care staff and prisoners
- To measure the attitudes and beliefs of prison discipline officers and health care staff concerning risk behaviour among prisoners and to the further development of HIV and hepatitis B and C prevention measures.

- To consider the feasibility of developing further policy measures in line with the World Health Organisation Guidelines 1993.

3.2 METHOD

Following an extensive review of the relevant literature it was decided to explore the main issues from the perspective of those most affected by current and future policy. Therefore, the discipline staff, health care staff and prisoners were in the foreground of the study. Other staff whose contribution is also significant, such as, psychologists, probation officers and prison governors, were interviewed to elicit their viewpoint. However the design is essentially directed at those viewed most likely to be in the front line both in terms of implementing policy or being on the receiving end of the implementation of current or new policy.

Few studies were identified in the literature that specifically considered policy issues related to HIV and hepatitis B and C prevention. Therefore, it was decided to use semi-structured qualitative interviews which would allow the staff and prisoners to present their own accounts of the factors that facilitate or inhibit policy because the researcher did not want to impose too many preconceptions about the participant view of HIV and hepatitis B and C prevention, or even the acceptability of certain policies. A questionnaire was developed in an attempt to add further depth to the understanding of the issues over a greater number of prison sites. The use of a combination of qualitative and quantitative methods to explore the research questions across a wider perspective would allow the examination of the issues from different angles and possibly highlight some important commonalities and differences between different security categories of prison (Mason 1996).

3.2.1 TIME FRAME OF STUDY

The study took place over a three-year period from 1995 to 1998. In the pre-fieldwork phase of the study the researcher attempted to gain an insight into the social processes under investigation by attending as an observer a number of AIDS Management Team meetings in one of the prisons. The researcher was also able to spend time looking around the three prisons prior to the interviews with staff and to spend a number of hours talking to a wing officer and an education officer. During the period of the fieldwork the researcher became a member of the National AIDS in Prisons Forum.

The studies described in this thesis took place in three stages. The three stages were:

- Study one comprised qualitative interviews with staff at three different security categories of prison
- Study two was a questionnaire sent to a sample of prisons in England and Wales
- Study three involved qualitative interviews with prisoners at the three security categories of prisons from study one.

Piloting of the interview schedules and the questionnaire was undertaken to check the feasibility and appropriateness of the questions and assumptions. This phase of the research process has been described as less critical in a case study method that leans towards the more exploratory continuum of case study design (Robson 1998a).

3.2.2 DESIGN OF THE STUDY

The study was designed so that the themes that emerged from the analysis of the staff semi-structured interviews would form the basis of the staff questionnaire. This in turn was designed to explore the issues in a greater number of prisons. The interviews with prisoners explored the same issues identified in the staff interviews and questionnaire with additional exploration of the acceptability and uptake of current and potential policy for the prevention of HIV and hepatitis B and C from a prisoner perspective. The integration of the distinctive inquiry positions of qualitative methods and quantitative methods would offer a comprehensive exploration of the research question.

Following guidance from senior prison staff, data were gathered from three types of prison to ensure that there was a broad representation of staff and prisoner beliefs and attitudes towards the issues. Interviews were conducted and questionnaires were sent to the following categories of prison:

- Category B Local prisons
- Category C prisons
- Young Offender Institutions.

Prisons identified for staff and prisoner interviews were included in the study primarily because they fulfilled the inclusion criteria; however, as a secondary consideration, they had the benefit of being geographically close. Interviews with staff and prisoners took place in the same three prisons; the main benefit of this being that the researcher had developed a fairly good working knowledge about policy making in these particular prisons and had developed a good rapport with the facilitators. The questionnaires were distributed to seven prisons selected from a sampling frame of all the local category B prisons, young offender institutes and category C training prisons in England and Wales.

3.2.3 ACCESS

The process of gaining access to the prisons was an extremely time-consuming facet of the study, requiring the permission and approval of many levels of authority. For example, for each of the ten prisons some or all of the following were involved:

- The Health Care Directorate of the Prison Service
- The Prison Health Ethics Committee
- The Governor of each prison site
- The AIDS Management Team/Communicable Diseases Team at each site
- The health care staff at each site
- The Prison Officers Association representative at each site
- Security staff at each site
- HIV/AIDS co-ordinator at each site.

Therefore, access was sometimes subject to lengthy and sensitive negotiation with a number of staff members.

It was necessary in each prison to have a facilitator who would generally arrange access. For interview sessions, the facilitator arranged staff lists for a selection of participants and ensured private rooms and adequate staffing for the period of the interview. For questionnaires, the facilitators arranged access to staff lists or distributed questionnaires to the entire staff.

All the issues to do with planning, distribution, response rate and the reliability and validity of the questionnaire are discussed in Chapter 5.

3.2.4 ETHICAL CONSIDERATIONS

Ethical permission for the study was obtained from the Psychology Department of the University of Southampton and from the Prison Service Health Care Ethics Committee. Permission from the Prison Service Ethics Committee was staged so that phase one of the study had to be complete and a brief report submitted to the Ethics Committee before permission was given for phases two and three of the study.

The interviews in each prison were conducted in a way that ensured that conversations could not be overheard. Written and verbal consent was obtained and all interviews were tape-recorded. All participants were advised that if they objected to any question they were not obliged to answer and that they could withdraw from the study at any time. Participants were informed that all information would be stored securely and that all tape recordings would be erased when the interviews were transcribed. Participants were given assurance that no identifying information, of the individual or the institution, would be used in the thesis and research reports.

Staff respondents to the questionnaire were offered the chance to enter a prize draw. The intention of the prize draw was to offer a small incentive for completing the questionnaire and returning it in a stamped addressed envelope. The prize draw concept has been used in previous social science research with good effect in terms of improving the response rate; however, the benefits may be much reduced when the reward is not included with the questionnaire (Streiner & Norman 1995). The purpose of the incentive offered in this way was to demonstrate an acknowledgement of the time taken out of very busy schedules to complete the questionnaire. It was clearly stated in the covering questionnaire letter to the prison staff that the prize draw was a token of thanks. An assurance was given that the prize draw slip would be separated from the questionnaire immediately in order that anonymity would be maintained.

3.3 ANALYSIS

3.3.1 ETHNOGRAPHY

Ethnography and Case Study methods were influential in developing the research design of the study.

There was an initial preference for an ethnographic approach because it would enable a description of how the culture of a prison influences HIV and hepatitis prevention policy. The main features of ethnography that would apply to the study are:

- it promotes exploring, rather than testing a hypothesis, about the nature of a particular social phenomenon
- data are collected and processed without initially predetermined categories
- a small number of cases are explored in-depth
- the prominent form of analysis is verbal description rather than quantitative statistics.

(Atkinson & Hammersley 1994)

Characteristically, ethnography involves the researcher participating in the daily lives of the participants for a lengthy time period (Hammersley & Atkinson 1996). The required intensity of fieldwork was difficult to achieve because access was limited in view of the demands of security in the prisons. The researcher did not really gain sufficient access into what has been described as the 'real and everyday of the setting' (Banister et al., 1995a), even though the prisons were always welcoming and provided as much support as possible in the circumstance of providing a complex service.

Therefore, as a total adherence to the philosophical paradigm of ethnography was not possible, and as the research design would be enhanced from exploring the issues from the perspective of different research methods through the integration of qualitative and quantitative methods, a case study approach seemed more appropriate. However, the principles of ethnography remained influential in the study.

3.3.2 CASE STUDY

The case study method has similar basic principles to ethnography and is, in fact, broad enough to encompass an ethnographic approach into case study method.

The predominant concern of case study is an interest in the cases rather than the methods used. In common with ethnography the case study approach involves empirical investigation of a contemporary phenomenon within the real life context. However, where it differs from ethnography is an acceptance of using multiple research methods of investigation with data needing to converge in a triangulating fashion (Yin 1994). The case is defined by the researcher and can cover many situations such as a single person, a group, an institution, a neighbourhood, or a service (Robson 1998a). It has been stated that the case study method would be used when there is a need to cover contextual issues in the research, in the belief that they may be highly pertinent to the phenomenon of the study (Yin 1994). Case study method is useful where broad complex questions have to be addressed in complex circumstances and the researcher has no control over events. Case study method recognises that because of the complexity of the situation, no one method would sufficiently capture all pertinent aspects therefore, the use of multiple methods is typically favoured (Keen & Packwood 1995). Case study method also benefits from the prior development of theoretical propositions to guide data collection and analysis (Yin 1994). This enables the researcher to be explicit about how to select data and what the important features are. Cases are selected where either they are predicted to yield the same result or they are predicted to obtain a different result (Robson 1998a).

The selection strategies for sites of study in case study design is an essential consideration so that as far as possible misinterpretation of results is avoided; this is achieved by selecting cases or sites that are typical of the phenomenon being studied (Keen & Packwood 1995).

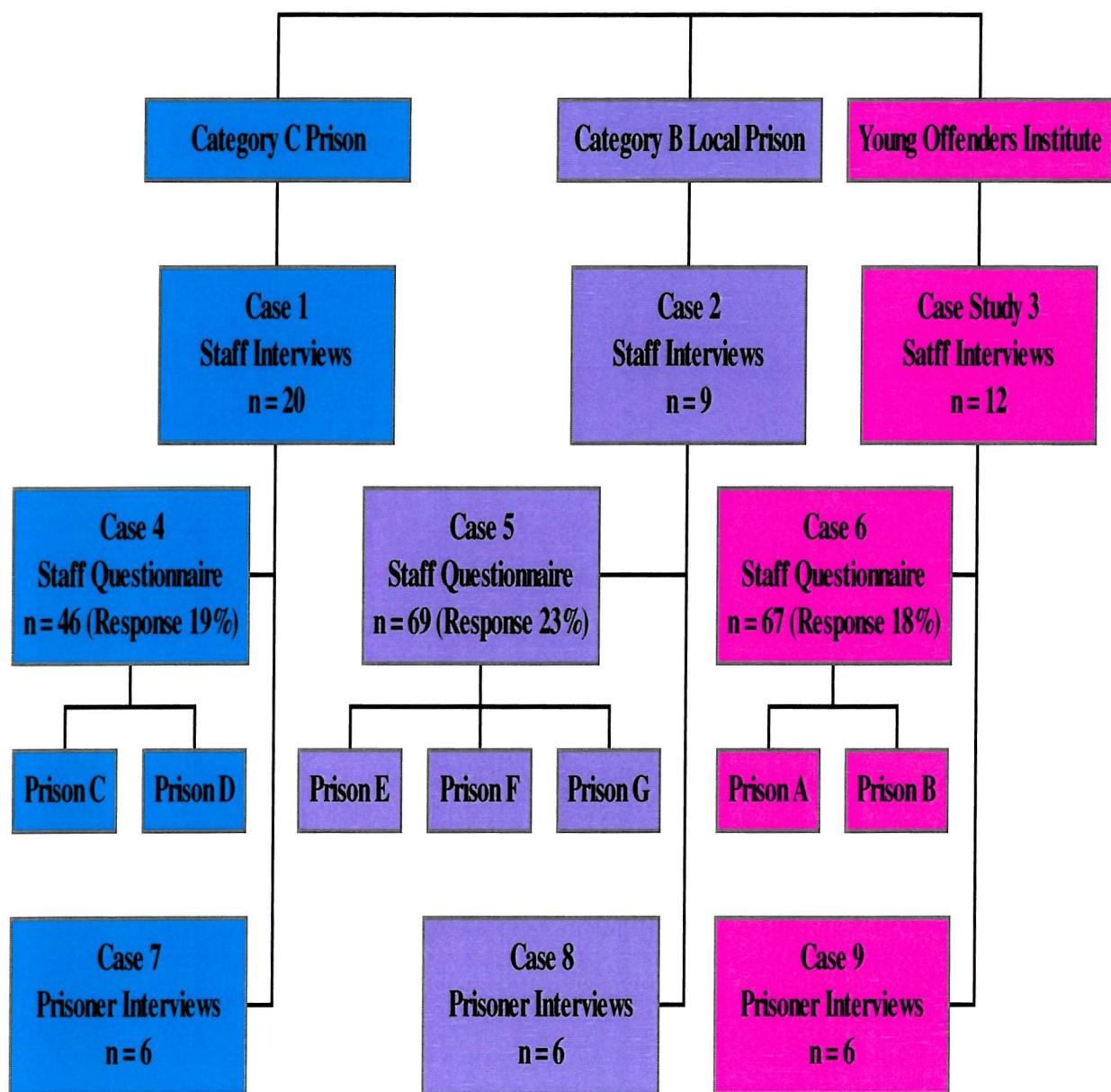
This study is designed as a multiple case study, the cases were selected in order that any important differences in the following areas were highlighted; security categories of prison, groups of people involved in policy and differences arising from different types of methods. Therefore the cases in this study were distinguished by these factors:

- Case 1 is the staff interviews in the category C prison
- Case 2 is the staff interviews in the category B prison
- Case 3 is the staff interviews in the young offender institute
- Case 4 is the questionnaire survey in the category C prison
- Case 5 is the questionnaire survey in the category B prison
- Case 6 is the questionnaire survey in the young offender institute
- Case 7 is the prisoner interviews in the category C prison
- Case 8 is the prisoner interviews in the category B prison
- Case 9 is the prisoner interviews in the young offender institute.

Cases are differentiated in this way because comparing cases may highlight important differences in attitudes and beliefs between environments, groups or methods.

A flow chart depicting the design of the case study is shown on the following page.

Table 3.1 Flow chart showing case study design



3.3.3 METHOD TRIANGULATION

A distinctive feature of case study method is the use of triangulation to increase confidence in the findings, so that data items are corroborated from at least one other source and more usually, by another method of data collection (Keen & Packwood 1995).

The particular combination of methods in this study was driven by the research questions. The need for a deep understanding of the prevention issues was gained from a qualitative perspective and the need to have an understanding of the commonalties and problems across a number of sites was gained from the quantitative questionnaire. Method triangulation allows richer and potentially more valid interpretations of one set of research questions and also contributes to the researcher's ability to achieve a complete understanding of the phenomenon being studied (Fu-Jin Shih 1998). Confidence in the research findings is increased because they are not viewed as an artefact of one particular research method (Banister et al., 1995b).

3.3.4 RESEARCH RIGOUR

Qualitative research has been criticised for lacking scientific rigour (Mays & Pope 1995). The qualitative aspect of the study is discussed here, and the reliability and validity of the quantitative method is addressed in Chapter 5.

This research report tries accurately to reflect the rigour applied to the study. To demonstrate the rigour, the thoroughness of data collection and the analysis has been written into the thesis. Ethnograph was used to fully transcribe the interviews and a codebook with definitions of terms (appendix 4) was used to identify categories from the staff and prisoner interviews. Extracts from interviews have been included in the write up of the analysis so that readers of the research can discern the patterns identified in the analysis (Yardley 1999). An attempt has been made to clearly describe the participants and settings.

Triangulation of methods in a study enables a check on the construct validity by examining data relating to the same construct from different research paradigms. Triangulation of the methods used increases the validity when evidence is actively

sought that rejects as well as confirms the results (Mays & Pope 1995). Additionally, the researcher searched for alternative ways to explain the data (Clarke 1999).

The purpose of describing the process and analysis of the study was to create an account that was transparent and able to explain reliably the issues under investigation (Mays & Pope 1995).

Wolcott (1994) describes a useful staged approach to transforming qualitative data from an 'unruly experience into an authoritative account'; this approach is described below:

- Description – This is where the data are organised and reported in a way that stays close to the original data. The final account may draw long excerpts from fieldnotes, or repeat informants' words so those informants themselves seem to tell their stories.
- Analysis – Data are organised and expanded beyond purely descriptive accounts. The analysis proceeds systematically to identify important factors and relationships.
- Interpretation – This is where the researcher attempts to attain understanding or explanation beyond the limits of the actual text.

There are not clear demarcation lines between these stages, nevertheless, thinking about data management within this kind of framework allowed the researcher to be aware of the way the data were organised and presented. Wolcott (1994) does however suggest that the novice researcher should focus more on the descriptive and analytic stages rather than on the interpretative level of analysis. However, he cautions against what he describes as descriptive 'heaped data' where the researcher is unable to sort out the data and passes the task on to the reader (Wolcott 1994).

This thesis was written as a descriptive account presenting extracts from transcripts to allow the participants 'to tell their story'.

The staff questionnaire was developed from the themes that emerged from the staff interviews in a format structured on the theory of planned behaviour. The questionnaire items assessed attitude, subjective norm, perceived behavioural

control and behavioural intention to implement HIV and hepatitis B and C prevention policies.

3.3.5 DATA PROCESSING

Ethnograph is one of a number of software packages specifically designed for supporting qualitative analysis. The strength of the package is for managing large data sets that would prove difficult to code and sort manually in a comprehensive manner. Ethnograph essentially automates the cut and paste task involved in qualitative analysis, the researcher still remains 'close to the data' to do the task of analysis. The core functions of ethnograph were used to code the transcripts, produce a codebook (see appendix 4) and produce compilations of all the codes so that each category could be viewed comprehensively. Analysis was continuous throughout the period of interviewing.

Categories were initially developed by reading and re-reading five transcripts to identify all concepts of importance. These concepts formed broad categories covering the most common salient points from the interviews. After seven transcripts were coded, one category, 'behaviour' was more clearly clarified and divided into smaller categories of behavioural intention, normative beliefs and behavioural control. All previously coded transcripts then had to be re-read and coded to reflect the additional categories. The codebook then had forty-six categories that were used to mark and identify interesting and relevant aspects of the data from all of the staff and prisoner interviews.

3.3.6 SENSITIVE RESEARCH

The study described in this thesis had two main areas of sensitivity of which the researcher had to be aware to respond to appropriately. The prison context was the first obvious area of sensitivity because of the requirement of security. Access, therefore, took a great deal of negotiation and patience; this was discussed earlier in this Chapter. The second sensitive area is the research topic; HIV and hepatitis B and C prevention are sensitive areas both for the prison authorities and for prisoners because prevention is about sexuality and illicit intravenous drug use in prisons. For the prison authorities and for the prisoners there was a need to give very clear descriptions of the steps taken to preserve anonymity and the measures taken to ensure confidentiality. To minimise these sensitivities, careful attention was paid to

assuring the organisations and the individuals about the trustworthiness of the researcher (Alty & Rodham 1998). The consent form contained both an explanation of the research and described the process of anonymity and confidentiality. The prisons were offered a research briefing on completion of the research report if one was requested. Clarification was sought for any terminology used to ensure that the participants and researcher were discussing the same things.

At the end of the interviews opportunity was given for the participants to make any comments or to clarify any concerns that had arisen during the interviews. Contact names for health care staff or HIV counsellors were given if required. On the questionnaires space was made available at the end of the questionnaire to make general or specific comments about the layout and content of the questionnaire.

3.3.7 THE ROLE OF THE RESEARCHER IN THE STUDY

Formulating a research question and organising and sorting the data are not conceptually neutral activities (Mason 1996). The influences on that process created as a result of the researcher's background and experience will be described.

This study originates from 1995 when the researcher was working in a community communicable disease control unit as a clinical nurse specialist. The communicable disease control team was called into a prison to help control a communicable disease incident. However, there were some tensions between the public health function of the communicable disease control team and the security function of the prison. The incident identified the need for a greater understanding of why these tensions arose. The area highlighted by the communicable disease team, as having the greatest potential for misunderstanding of role and function was HIV and hepatitis B and C prevention in prisons. Therefore, although the researcher was not entirely a novice in a prison setting there was a lack of understanding about the problems and barriers of HIV and hepatitis B and C prevention in this context.

3.4 SUMMARY

A case study approach seemed the most appropriate method to answer the research questions, however, ethnographic method was also influential in the approach to the fieldwork. The study was designed to explore from a staff and prisoner perspective the prevention of HIV and hepatitis B and C policies in prison. The benefits of the

particular research approach was that it involved studying the research question in the real life context. It values and promotes the use of multiple research methods in the study design. Case study method is useful when there are broad complex questions to be addressed in complex circumstances.

Specific access considerations were identified in a prison setting which had implications for the design of the study.

The next chapter describes the first phase of the research, the interview study with prison staff.

CHAPTER FOUR

Study one: Interviews with staff

4.1 CHAPTER OVERVIEW

This Chapter describes the findings from the first stage of the study, the staff interviews. The data are presented in terms of the common themes to emerge from the analysis. There are forty-one interviews with staff from three security categories of prison; a category C prison, a category B local prison and a young offenders institute.

A summary of the results at the end of the Chapter will identify the most important issues to take forward to the discussion of results in Chapter 7.

4.1.1 KEY AIM OF STUDY ONE

The aims of study one are:

- to explore staff perceptions of HIV and hepatitis B and C risk behaviours and related prevention policies
- to identify the facilitators and barriers to HIV and hepatitis prevention policy in prisons.

4.2 METHODS

Qualitative in-depth interviews were used to address the research questions in Study One of the research. A case study approach was used for the study; however, an ethnographic method also influenced the design of this particular phase of the study. The reason for choosing qualitative methods for this first phase is that there is so little prior research in this area therefore it was necessary to explore the issues from the perspective of those involved in current and in potential HIV and hepatitis B and C prevention in prisons. Exploring the issues in this way would provide the basis for study two, a quantitative analysis of the issues identified in a wider number of prisons by using a questionnaire.

4.2.1 DEVELOPMENT OF STAFF INTERVIEW SCHEDULE

Preparatory work for the study entailed a number of visits to each of the three types of security categorised prisons involved in the study. The purpose of these visits was to gather information about HIV and hepatitis B and C from informal discussion and observation. In one prison, the researcher was invited to attend the AIDS Management Team meetings as an observer. Furthermore, two in-depth exploratory interviews were undertaken with a prison-training officer and an HIV co-ordinator in the category C prison.

The aim of the preparatory work was to identify a series of appropriate open-ended probe questions that would give the staff participants of the study an opportunity to explore the relevant issues from their own perspectives.

4.2.2 INTERVIEW SCHEDULE

The interview schedule was designed to use probe questions to facilitate a general discussion about risk behaviour and the consequent policy issues (see appendix 1). The policy issues discussed reflected the prevention policy measures available in other community (non-hospital) settings. The discussion focused specifically on what enhances or presents barriers to policy in particular policy areas such as condom access, needle exchange, bleach for decontamination of needles and syringes and opiate detoxification programmes. However, the participants were encouraged to bring up and identify other policy and general issues that the researcher might have missed or not considered. There were also questions about grade and type of job, experience and length of service.

The in-depth interviews took place in the work environment in a private setting where the conversations could not be overheard. Permission was obtained to tape record the interview. The interviews lasted between 1 and 1½ hours. Participants were given the opportunity to describe important issues from their own perspective and also give their perception of how other staff and prisoners viewed the prevention issues.

4.2.3 GAINING ACCESS TO STAFF

In each of the three prisons, the governor of the prison helped to facilitate the research by identifying a member of staff. The researcher asked for an opportunity to

introduce the study to staff at staff meetings. In two prisons, the researcher was invited to attend two or three general staff meetings to cover all shifts in order to explain the study and how staff would be selected and invited for interview. In the third prison, this approach was considered difficult so, the staff were interviewed without an introductory explanatory session; however, staff did have a letter introducing the study and asking them to participate.

The selected staff from the three prisons were sent a letter by post explaining the research and asking if they would like to participate in the study. The 41 staff who agreed were asked to return a reply slip in a self-addressed envelope. All the staff approached for an interview agreed to participate. The interviews were then arranged and organised by the facilitator in each prison.

4.2.4 PARTICIPANTS

The sample were selected from three categories of prison:

- Category C training prison
- Young offenders institute
- Category B local prison

Quota sampling was used to identify staff for inclusion in the sample according to occupational rank in each type of security category prison. Staff were identified from payroll lists supplied by the individual prisons. The sample was stratified to build in some measure of representation of the proportions of all grades of discipline and health care staff. The number of interviews in each prison was a reflection of how much new information was forthcoming in terms of common themes for all of the prison environments, and for new themes particular to the category of prison.

There were 41 interviews, the breakdown into types of prison and staff is as follows:

Table 4.1 Staff grade and category of prison of interview participants

Staff grade	Category C	Category B	YOI
Basic Grade officers	10*	2	5
Governor Grade 5	1	1	0
Principal Officers	2	1	3
Senior Officer	1	1	2
Drug Advisor	1	0	0
Probation Officer	1	0	0
Senior Psychologist	1	0	0
Civilian Trade Worker	1	0	0
Medical Officer	1	1	1
Nurse	1	2	0
Health care officer (nurse)	0	0	1
Health care officer (non-nurse)	0	1	0
Total	20	9	12

* Includes one HIV counsellor

The category C prison was the first prison where staff were interviewed and therefore a greater number of staff were interviewed to ensure that all issues of concern had been identified. The category B Local prison had fewer staff interviews because it proved most difficult to access because of staff shortages and industrial disputes.

4.2.5 ETHICAL ISSUES

The Psychology Department of the University of Southampton examined the ethical issues and gave approval for the study. The Prison Health Research Committee gave staged approval for the study; approval was granted for the first phase with the requirement that a report was submitted outlining progress before stage two could proceed, and a report describing stage two and outlining progress was required before stage three could proceed. The Prison Health Research Committee permission also stated that approval should be obtained in writing from all the prisons involved in the study.

4.2.5.1 Confidentiality and anonymity

An assurance of confidentiality and anonymity was given at the beginning of each interview. The participants were told that only summaries of the commonly held beliefs would be used so that no one person could be identified. Participants were assured that all identifying text, such as names of people or prisons, would be removed from the transcripts; to reassure participants this information was also on the consent form. The participants signed a consent form and they were advised that they could withdraw from the interview at any time. Participants were asked for permission to audiotape the interviews and all participants gave their consent. The interviews lasted for between one and one and a half-hours. All interviews were fully transcribed and the tapes were wiped clean after transcription. Transcripts were stored in a secure locked cabinet.

The staff were given the opportunity at the end of the interview to ask any questions or clarify any points raised in the interview.

4.2.6 TRANSCRIBING THE INTERVIEWS

The interviews were transcribed verbatim as soon as possible after each interview and all transcripts were entered into Ethnograph V4.0. All identifying information was removed and transcripts were given coded identifiers. The coded identifiers evolved over the course of the study to enable an easier identification of the job discipline and type of prison, this proved invaluable during the analysis stage of the study. Each type of prison was assigned a range of numbers according to the type of prison, so for example an interview in the category C prison would be numbered in a numerical

range from 1 to 21 and later in the evolution of coding letters were given to describe the type of job, for example PO identifies a principal officer.

Relevant concepts and commonalities in the transcripts were identified as categories and a system of coding all the transcripts was developed into a codebook (see appendix 4). The process of this involved reading and re-reading the transcripts many times; the coding system was revised after five transcripts had been coded, making it necessary to re-code all of the previously coded transcripts. During the coding process forty-six categories were identified; following coding of all the transcripts, the categories were collapsed into a smaller more refined number of categories to facilitate the final analysis.

The data were analysed utilising a software package called Ethnograph. Ethnograph is one of a number of software packages specifically designed for supporting qualitative analysis. It is useful for large data sets that would prove difficult to code and sort manually in a comprehensive manner; however, it remains the task of the researcher to do the coding and analysis. The package automates the cut and paste task usually associated with qualitative analysis.

Ethnograph has the following primary functions:

- a sort function whereby Ethnograph allows blocks of text to be given a specific code
- a search function whereby Ethnograph finds allocated codes and pulls out every instance of a particular code. The blocks of text that have the same code can then appear together and this clustering of the coded segments help to identify the major themes in the data
- face sheets may be created and used to apply search filters. So for example, certain variables such as, age, gender or category of prison could be input into the face sheet of each transcript and used to filter out only those responses that apply to the particular variable (Seidel, Friese, & Leonard 1995).

4.2.7 THEMES IDENTIFIED FROM THE DATA

When the coding of all transcripts was complete the categories of data were aggregated into the following four major themes:

- 4.3.1 Education

- 4.3.2 Risk
- 4.3.3 Prevention policies
- 4.3.4 Barriers to policy development.

4.3 RESULTS OF STAFF INTERVIEWS

4.3.1 EDUCATION

In-service training and education in respect of HIV and hepatitis appeared to be available in recent years on induction programmes when staff initially joined the Prison Service. The amount of training for HIV and hepatitis subsequent to the induction period was variable and sometimes non-existent. Variations in the amount and quality of training was described by a number of participants. The consensus was, however, that more training and education in respect of HIV and hepatitis particularly would be beneficial.

The range, experience and beliefs about training are illustrated in the following extracts from the interviews.

4.3.1.1 Descriptions of training

A participant from the category C prison was critical of the amount of training he had received,

"I mean in eighteen years just to sort of have one short video shown you I don't think is a lot really. I know it's only maybe in the last five or six years it's become a major issue but I still think there should be more."

(S15)

A principal officer from the young offender institute responded to the question about training by saying,

"I'll be honest with you I can't remember, I'll be honest and say no umm, we didn't have anything at the prison college on initial training course umm, and I know the staff trained here on HIV on the wings about four or five years ago, but no, nothing, not what I can remember that sticks in my mind."

(PO39)

Another participant from the category C prison described his experience of training,

"Only from when I first came here, they give you like a brief sort of induction, you know, and a sort of rather large pack on information to read through."

(S4)

There were some accounts to counter the prevailing view of discipline staff that training was generally insufficient; one participant from the young offender institute said,

"Oh, for the HIV side of things, I've been trained by the Prison Department, they sent me away on a proper Prison Service course, so for the HIV part of it, I'm properly trained."

(TC38)

A number of participants were particularly concerned about a lack of education focusing on hepatitis.

One participant from the category C prison said,

"We've had quite a lot of training umm, with regards to HIV and AIDS but we've had, lets say hepatitis has been mentioned but it's not been gone into in the same way that HIV and AIDS has been covered, and there are a lot of blokes in here with hepatitis, variations of hepatitis, than there are HIV and it would be nice to have more information about the different kinds of hepatitis and what they mean, how they're transmitted."

(S8)

A senior officer from the young offender institute described his concern regarding hepatitis training,

"There needs to be more done of that [training], hepatitis especially. I think most adults I think have got the basics, a basic idea of HIV although it would be nice to get more training but I think hepatitis is the thing we need the training on if I'm honest with you cause we don't know anything about it, we get a jab every whatever it is,

and we don't know why we're having it, and that means, I mean that's down to personal safety and that type of thing. C [hepatitis] is the one we don't know anything about and if I'm honest we don't know really much about hepatitis B."

(PO39)

4.3.1.2 Why training is considered necessary

The need to keep updated because of rapid changes in knowledge and understanding of these viruses was described by some staff.

A non-discipline member of staff involved with one of the prisons said,

"Personally I make great efforts to stay up to date but, umm, yes I do think training is important in general because certainly my perception is things are changing so fast, that most training packages actually need to be updated pretty urgently."

(DC17)

A non-discipline member of staff from one of the prisons described concerns about keeping his knowledge current and up to date,

"I would never pretend that I know enough about it because medical research is demonstrating changes sort of within rapid rates and so the, I think there's always a need for ongoing training in this area."

(S20)

A number of participants talked about their concern at not understanding the transmission routes of the viruses.

A senior officer from the young offender institute said,

"I think that we should all be given some sort of training or update training as a matter of urgency because we are talking about people contracting, you know, a disease which isn't a very nice disease at all, there's no known cure and if there is a cure it's only something to slow it down and not actually cure it. Then you know with the Prison Service at the moment, the only thing that they actually do to help us, or to help allay any of our fears, is they make available rubber gloves, resuscitation aids,

and that's it, You might find the odd leaflet or notice around the institutions on wall, the hospital, etc."

(SO41)

4.3.1.3 Participant suggestions for improving training

Some participants volunteered suggestions as to how training could be specifically focused on the needs of staff in prisons.

One officer from the category C prison suggested,

They could probably do with sitting down and working out a policy where they spend a week on the issues rather than just saying at the moment you've got to spend a couple of hours, you could probably make it a week long or if they can't afford the week, two or three days where everyone has to attend for two or three days and they go through it basically dispelling the rumours umm, and then telling everyone the actual truth like how long the viruses can last in certain instances, when it would be safe, if for example you came across a room that was absolutely, and it's not beyond the realms of possibility, somebody's just slashed his wrists and there's blood all over the walls and such like, could you go in straight away and clear it up, how long would be safe before you can go in there and get rid of the blood products and things like that".

(S5)

One officer from the category C prison described how reducing the variability amongst prisons could improve training,

"I think some prisons do cover training better than others, I'm not saying [this prison] poor, I think [this prison] is quite good, but having worked at other establishments and listened to people at other establishments on what training they do, like they sort of shut down on Wednesday afternoons and do sort of full staff training and things like that, I've never actually been fortunate enough to work in an establishment that does that, it is obviously easier in some prisons than it is in others."

(S15)

4.3.2 RISK

Risk tended to be talked about in terms of the potential for occupational exposure to the virus and also in terms of the potential for a concentration of risk behaviour within a prison environment.

4.3.2.1 Occupational risk

There were a number of staff concerned about the occupational risk of transmission of HIV and hepatitis B and C in prisons.

How the occupational risk is perceived was explained by an officer from the young offender institute,

"I think there's a higher risk than in other jobs yeah. Umm, perhaps not as high as hospitals"

(TU33)

Some staff gave practical examples of occupational risk. An officer from the young offender institute said,

"Umm, I certainly think is that if you're maybe a lad who cuts himself or attempts self harm in any way, or you get involved in a scuffle maybe, I mean obviously lads get cut and officers get cut so there is, there is that danger yeah."

(YO35)

A senior officer from the local prison explained the occupational risk in this way,

"When we are actually dealing with prisoners in a violent situation umm, where situations arise spontaneously, there can be blood, urine, faeces all over the place and we're actually having to deal with it there and then. You may not be aware of cuts and slight scratches that you've got but you've got to respond and you're there, that is a major hazard from my point of view. Also I've seen the infection of HIV or AIDS in a prisoner being actually used as a weapon or at least shall I say as a threatened weapon where they threaten to throw urine over you, they threaten to spit in your face, they threaten to bite you, I've known of a case where somebody did attempt to bite somebody having threatened that they would infect them."

Staff expressed concern about searching both prisoners and the environment, a function that is part of the discipline and security role. The following extract from an officer from the category C prison illustrates this point,

"I suppose searching is my main concern regarding personal risk, whether it be searching an inmate, there's risk there, how great the risk obviously depends on the age of the blade and when it was last used and what it was used for, so that I suppose is my main concern, that and searching actually generally in the wing. There's a lot of areas that you can't actually physically see without the aid of mirrors and things. The number of implements you find is something that leaves me cold at times."

A further reflection from a category C officer describes his concern about finding hidden needles whilst searching,

"Not only do we come into contact through physical, you know, violence if you like, we also have a duty to search and obviously one of the concerns is needle prick injuries."

An officer from the category C prison described a situation where both staff and prisoners were concerned about the risk of virus transmission,

"If we know an inmate is a drug user, they tend to get singled out, in that way and therefore obviously they try and keep it as quiet as possible. The other inmates do tend to, we have, we've, I know of one instance where a guy had gone so far that he was injecting between his toes and he, the inmates on his particular spur were worried (a) because of their own health and cause he was wandering around probably with blood coming out of his feet and whatever, and (b) because what happens if he dies on that particular landing what happens if he overdoses accidentally is the way that they viewed it and I did have several people come down and we discovered that because of their worries."

(S5)

Some staff voiced fears that they may take home infections that would harm their families. The following extract from a senior officer at the young offender institute described his concern,

"When you've got an inmate who comes on to the wing, we aren't legally bound by the hospital to be told that this lad has got hepatitis B or C or HIV, which we can understand, but you know, myself included, I mean I've got four children, the last thing I want to do is be involved in bringing home a disease which would kill off my family."

(SO41)

An issue that was highlighted frequently during interviews was that some staff believed it would be beneficial to their occupational safety to be told medically confidential information about prisoners who were known to have HIV, AIDS or hepatitis B or C.

This belief was expressed by a senior officer at the young offender institute, he described the subsequent conflict this may cause,

"Today we've had eight receptions from [another prison], they come with hospital notes which are confidential, they go to the hospital, if we assume that one of them is HIV positive then the hospital will know and that's as far as it goes, we will not know that he's HIV positive. If for some reason one way or another we have a fight develop with him which we had to go in and separate and there's blood going and we get scratched as well, then we're vulnerable, very vulnerable but we don't know how. If we did know mind that could still cause problems because, well obviously staff would not go in to do anything about it if he was known to be HIV positive. Suicide, I mean we get a lot that don't actually attempt suicide they scratch their arms for one reason or another, they're depressed because they've got a long sentence, they're away from home they haven't heard from the girlfriend, again it's a thing we have to deal with but you have no knowledge if he's got any of these transmittable diseases."

(SO34)

Talking on the same subject an officer from the category C prison said,

"I'd rather know who is HIV positive on my wing, dealing with them, okay I've got a pair of latex gloves in my back pocket and if anything happens then I can whack them on and at least I've got a barrier if this particular guy gets assaulted.... It would be nice to know who is who, not for discriminatory purposes, just for pure own, I don't know, self."

(S8)

4.3.2.2 Beliefs about risk behaviour

A member of the health care staff described her perceptions of the prevalence rates of HIV and hepatitis B and C in the local prison,

"While I've been here [2 years] certainly, there's been very little HIV anyway. I think we've had two positives, that have been positive for quite some time. They were quite ill with it. There has been very little hepatitis B as well. They were intravenous drug users, yes both of them, yes, and still are. Well, the one might not be around any more, but the other one certainly is, yes. There's not a lot of hep B but there is quite a bit of hep C. So I haven't noticed it go up and down, it's just that there tends to be just a lot of hep C here."

(N60)

Most staff believed that the greatest risk behaviour in prison in terms of HIV and hepatitis B and C transmission is intravenous drug use and in this context talked about drug use and drug supply generally. The following extracts explain this perspective.

An officer from the category C prison described how he perceived the problems,

"I think in reality most prisons have got a lot of drugs inside them simply because it's not difficult to get drugs into a prison, they're thrown over the wall, they come in through visits. Unless all prisons in their visit rooms have a shield in front of the prisoner, and their visitors then you can't stop it. Whenever there is some form of body contact then drugs will come in, you physically can't stop it. What we are trying to do is to reduce it, that's as best you can do and drugs are a curse anywhere in

society, aren't they, and when you think of what you are doing is herding a large number of men together who, that's their very life for them, one thing they are going to try and do in prison is make life more comfortable for themselves and one way to do that is to alter the mood isn't it, because prison is not a girls' school it's a dark depressing place and there's one thing that prisoners will try and do is to alter their mood, is to make prison look a different kind of place when they're in there, that's what they're really trying to do isn't it, is to change their mood and make themselves different and they'll get drugs in to try and do that."

(S12)

A drug counsellor from the category C prison described the concerns voiced by many that the particular issue of concern with regard to transmission of HIV and hepatitis B and C in prison is sharing intravenous drug equipment, and the concentration of a high number of drug users in a prison situation,

"It isn't actually being in prison as such that is dangerous but the number of, or the percentage of, drug users in prison compared to in the general population is much, much higher, there is a lot of needle sharing in prisons there's general sort of knowledge of transmission of HIV but the knowledge of transmission of other blood borne viruses varies from scanty to downright ignorant or wrong and I see particular risks in that area. Also, tattooing in prisons and general sort of hygiene stuff like disposal of razors and so on, I don't think people are probably too careful with that in prison, but as I said that all comes down to behaviour rather than actual place."

(DC17)

A member of the health care team from the category C prison said,

"Because of the clients we get which in drug abuse is probably 75/80 percent of the clients we have here, are here because of drug related crimes and problems. So you have a sort of focalising of a group of people with that particular social problem. Whereas outside they're probably dissipated a bit more, but here we get a collection of them."

(FN11)

A participant from the category C prison said,

"We have a problem, we have a drugs problem in prison. Full stop. A lot of inmates will tell you that it's easier to get hold of hard drugs in prison than it is outside. The truth of that nobody knows, but that's what, you know, what people will tell you. Umm, there's you know, in a closed environment like a prison you have therefore got the actual equipment, the needles whatever are less freely available and therefore they are shared by a greater number."

(S6)

As far as sexual transmission of viruses is concerned, there were differences of opinion regarding whether there were sexual relationships in prisons. Some staff did not feel that prisoners formed sexual relationships. Some staff felt that sexual relationships were more likely to be formed in long term adult prisoners rather than in short term prisoners or young offender institutes. These kinds of beliefs would have an impact on beliefs about the prevention of sexual transmission and the necessity of providing condoms.

The following extract is from an officer from the category C prison explaining his belief that the length of sentence would be an issue in forming a same sex relationship,

"And then you've got, how long have some of these people been in for, we've got lifers in here who've been in for twenty plus years as straight as a dye. I'm a lifer case officer, he's been in thirty-one years, he's fifty-one now and he's quite open about it, he's done the umm, course to look at their sexual orientation, umm, for sex offenders, he's been on that course and quite successfully, he's been classed normal, but while he's been in he's quite happily admitted to the fact that, he came in at twenty-one, he's had quite a few relationships, he's dying to have a relationship with a woman, he's married twice, I mean never consummated it and he's been divorced twice, you know that's the kind of bloke he is, but while he's been inside he's had a number of homosexual relationships, purely because he's grown up, he's spent his whole life inside. Some of these people do grow up inside from their formative years. I mean from early, mid teen if you like, they've come through from the YOI [young offender institute] system into prison here and they either come in as little hard nuts or they come in as something you can sort of wipe the floor with and some of these guys do get, if you like, easily used."

(S8)

Another extract to illustrate this view is from a principal officer from the local prison,

Having worked with long termers, they confide in you quite a lot and when they come in to the system and I've actually talked to inmates that have said this to me, they come in to the system, and they think to themselves there is no way that I'm going to take part in anything like that. But over the years, they confess that they do. They've resorted to it."

(PO66)

A non-discipline member of staff from the category C prison said in response to the question about identifying particular issues regarding the transmission of HIV and hepatitis B and C in a prison setting,

"Well, yes, if you start looking at in terms of a prison environment there's, there is the potential for sexually transmitted, being sexually transmitted because there is homosexual activity umm, you know anal intercourse takes place within a prison, I don't think, I think it would be foolish to pretend it didn't happen. The extent to which it happens is variable because the research shows, seems to be sort of fairly inconclusive as to it, but it certainly I think happens more than a lot of prison staff would like to believe it happens.

(S20)

Some staff, particularly from the young offender institute, expressed the belief that same sex sexual activity in a young offender institute would be less likely than in an adult prison.

An extract from a principal officer from the young offender institute explains a view that was also expressed by a number of the staff from the young offender institute,

"I would say, I've never known, although we've had rent boys [sex industry workers] in here and whatever else, I've never known of any homosexuality in here and I don't, I'm not saying it wouldn't happen, but I'd be very surprised if it did, because again the age they're at I mean with even though these lads might be more liberal minded than maybe what I was when I was a kid, I think still think gay sex, that sort of thing, is

taboo with them because it's the age they're at, they're naïve and it's the old, you know, I don't like nonses [sex offenders] for arguments sake and it covers the whole spectrum of sex offences, gays I don't think it would happen with these lads umm, although they are at the age where they are impressionable you know that sort of, go that way or that way, umm, I've never known of it and I, I'm not saying I won't ever hear of it but I think with these lads it would be quite a taboo thing."

(PO39)

How this belief may impact on prevention is illustrated in this next extract from a senior officer from the young offenders institute,

"Again, [this prison] by and large doesn't suffer from the problem, umm, obviously we get the occasional homosexual in but we have singular cell accommodation for ninety percent of the lads and anybody that is either a known homosexual or a suspected homosexual then you wouldn't put in a multiple cell. Umm, therefore, condoms as far as this prison is concerned I can't see any point of issuing them not during their actual incarceration. Umm, they are available when they go out in any case."

(SO34)

4.3.2.3 Reflections on drug use in prison

The response to the issue of drug availability in all prisons was overwhelmingly that drugs were easily obtained in prison and that there were a high percentage of prisoners using drugs. Although most said that the use of intravenous drugs was infrequent it was also felt that where needles were used they were shared by a greater number in an adult prison situation.

There were variable reports on the nature and use of drugs between different prisons. Staff from the young offender institute reported that the majority of prisoners used cannabis and that intravenous drug use was infrequent whereas, in the local prison drug use was seen as much more prevalent than in a category C prison or a young offender institute. The following extracts describe these observations.

A member of the health care team from the local prison described the level of illicit drug use,

"About seventy percent of people here take drugs, they actually tell us because they want detox" [detoxification].

When asked what percentage of those were intravenous drug users she replied,

"Of the seventy percent about eighty to ninety percent. They come in mainly taking one drug, having been a polydrug user in the past. But there are some that come in polydrug users, yes. But most of them come in only using one drug at the moment, but having used lots in the past, different ones.....We know that they've got needles up on the wings and they're sharing, cause you'll actually get some men saying well we've had to use a needle but I know that at least ten others have used it before me. When I've been counselling somebody on a one to one, and they'll say something like that because they know they're not gonna get nicked for it basically. But yes, so I know that."

To explain some of the prevalence of illicit drug use she said,

"They've got so much time to think and if, as happens here a lot, their girlfriend rings up and says I'm dumping you over the phone which is much, much easier than saying face to face of course, then they have great problems in dealing with that. Because it's hard for a bloke to cry in front of their cell mate for a start and how do you deal with it. You can't do anything about it, she's on the out, whatever, so. So it's difficult. But I think that's one of the bigger issues that comes up on a regular basis and comes up in counselling as well. She's dumped me what am I supposed to do about it. The first thing a lot of them think about is I need something to calm me down, ie, medication. I want some Valium I can't get through this without it, that kind of thing."

(N60)

A member of the health care team from the local prison said in response to a question about the percentage of people going into prison having previously used intravenous drugs,

"Thirty-seven percent, but much fewer would share injecting equipment, probably 5%, between 5 and 10%, I think Scottish prisons would probably say between 6 and 12%."

He went on to describe intravenous use,

"It depends from week to week the clientele that you've got in, I mean I can tell you exactly in this prison who are sharing needles, now the only people who want to share needles with those are people who have done so from day one, the chances of a new smoker if you like going up and borrowing or using a needle off one of these people is very, very small, but that's the same percentage in all honesty as would be on the outside. Why should someone who is smoking opiates suddenly decide to go and use a needle from a long term IV user. They're not going to do it outside and they're not going to do it in here, I mean it's just the same and so we find the same people smuggle needles in all the time, we know they're doing it, we can't stop them it's the nature of visits but it'll be those people all the time and it won't be others unless others are doing it for some sort of pecuniary reason but it's very doubtful, the risks are too high."

(MO64)

One of the health care staff from the local prison described an outbreak of hepatitis B and C and the possible related sharing of intravenous drug equipment,

"We had an outbreak of hepatitis B and C, and one of them had obviously got hepatitis C and B and we had a spate of people all coming asking for tests, so they obviously shared works and used them, the same works, and then realised they were at risk and then after the incident came and asked for help and tests and so on. So they obviously are sharing."

(HCM61)

A senior discipline officer at the local prison described how difficult it was to gauge the level of intravenous drug use,

"There are other ways of taking heroin, other than actually injecting it, so therefore, one knows that heroin and cannabis is used here, I would think that the number of needles on the wings at the moment, I would think is not very high. I wouldn't think there's a great deal of needles, hypodermic syringes up on the wings at the moment. No I would think probably not. But you know, who knows, I mean, it's so difficult. It's a very difficult thing to actually prove or disprove isn't it."

(GO65)

A principal officer at the local prison reflecting on needle use in the prison said,

"We find needles all the time. In all sorts of areas. Thrown out of windows, in toothpaste tubes, all sorts of places, so yes it is going on."

(PO66)

Evidence of intravenous drug use was also described at the category C prison. The following extract from an officer from the category C prison illustrates the problem,

"We actually find evidence, we find needles and some of them are in a right mess. You know, bent and rusty and, and absolutely disgusting and they still, still they use them, like you know. I think that's the biggest, one of the biggest issues in the prison service is the needles."

(S3)

A senior discipline officer from the category C prison described how drug use had grown over time,

"In my view there's been a huge increase from, I mean taking alcohol out of the situation and actually talking about drugs, from very, very little use from those people who are actually going out actively to find an escape to actually, if you like, cultivate a drug, umm, dependence and habit and I think people probably did do that, were actually going out there looking, umm, I think the situation now is the vast majority have either got a dependency or certainly got a willingness to use, I would say from very, very few to you know the vast majority. I think prisons very often mirror what is happening outside."

(G19)

Drug use in the young offender institute was described by staff very differently to the picture given in the local or the category C prison.

A member of the health care team from the young offender institute described drug use,

"I've never known a syringe or needle found here, I've known this place for four years, I've actually been in post here for two years but I've never heard my predecessor or staff talking about finds for intravenous use and at the MDT [mandatory drug testing] it's 99% finds are cannabis. The lads have been into hard drugs of course on the out but it seems as if it's the cannabis they want and I've done a survey, a retrospective survey, that was based on 550 odd notes and I know from their statements that cannabis is the main drug."

(MO37)

A senior officer from the young offender institute expressed a view that it was the discipline regime in that particular prison that thwarted drug use, this view was echoed by a number of staff from that establishment,

"The problem is still here. It's, the youngsters still haven't devised ways of getting the stuff in. A lot of them still haven't the resources, but if they had the resources the problem would be rife. I mean, I'm only talking on the experience of this YOI [young offender institute]. You go to other YOIs where their regime isn't as strict as [this prison] and they've got a larger problem."

(SO41)

An officer from the young offender institute described how stricter discipline in terms of visits would impinge on the human rights of prisoners; this view was shared a substantial number of the participants,

"At the end of the day prison is just a reflection of society on the whole isn't it. I talk to people at home and whatever and they say well you shouldn't get drugs into gaol how do they get them in and I say well we could certainly cut drugs down by having closed visits for a start but umm, there would be an outcry if you had closed visits. If you kept them locked in their cell for twenty four hours a day you'd get no problems would we at all, they couldn't fight they couldn't do anything but do you want that type of regime so you've got to try and balance it haven't you. Umm, but yeah we certainly, well I think we have, we are finding lots and lots more drugs on visitors coming in now than there were."

(TU33)

A non-discipline member of staff from the category C prison described why it would be difficult to obtain a clear view of the extent of intravenous drug use in that particular prison,

"Not many inmates will confess to using drugs intravenously in prison so I don't feel able to come up with an answer in that way, but a lot of inmates complain about other inmates doing it, umm, and I certainly hear a lot of very angry inmates because they've gone into the washroom areas or the toilets and found syringes, etc, etc. I won't say 'a lot' but I will say a substantial minority and I don't really think that you can come up with figures based on the number of syringes because there is work that's been done I believe up in Scotland that shows up to twelve inmates can be using one syringe umm, so it's awfully hard to quantify and even though people are quite happy talking to me about their drug use, I think most of them don't actually want to be seen as being stupid enough to use needles in prisons so it's something that other people do but not me, guv."

(DC17)

Some staff described beliefs regarding the progression from soft to hard drugs and the social pressures in a prison to take drugs as contributing to drug problems in prison. The following extracts describe these views, an officer from the category C prison said,

"Once people kind of start taking cannabis it's a slippery slope in some ways though isn't it. I mean they take one then, I think the actual, I suppose once they've actually taken one sort of drug I suppose the temptation's always there to try something else. I mean I don't think a lot of people would do that but I think there's bound to be certain weaker willed people that will do that."

(S13)

A further view describing this belief was from an officer from the category C prison,

"There are those people that come in and quite honestly they're easily led, peer group pressure etc, etc, will mean that they will go out and they will have tried something, they might not go out with a habit, but certainly they'll have tried something and they might go out and carrying on trying it on the out and certainly I think yeah there are guys who leave here with a habit, with a drug habit, where they

didn't have one before and that's only through weakness of character and peer group pressure. We get a lot of young blokes in here who are immature even for the age that they come in, I mean we're talking twenties and they're still very immature even in their early twenties and they're easily led."

(S8)

Some staff were frustrated and saddened by the situation described. The following comment was from a principal officer from the local prison,

"I was talking to two [heroin users] yesterday on the landings, two youngsters and they picked it up when they came in, smack [heroin] and it's so sad and we have let them down, it's not themselves, they're only kids they're only babies, the prison service has let them down because of this lax, umm this lax security if you like that no one's got the balls to say right there will be closed visits for these people who we know from the past convictions and the time they spent with us will attempt to bring drugs in, but when they come in they're all given a clean slate even to the fact that they become cleaners and you know that on their last sentence there were intelligence reports on them that thick that they were running drugs around the landings because they were cleaners and were able to do so, and yet when they come in they're still given these jobs. Now that should never happen."

(PO68)

Echoing this view a principal officer from the local prison said,

"I've been here what, eight years now, and I've seen the increase in the heroin addicts coming into [this prison] when I first came here it was, it was hardly anything and now I've even had inmates come back in a right state and I've said how have you got like that, when I was in here last time. So they have actually got the addiction from here."

(PO67)

Many staff talked about the need to provide a much broader framework of support to help people with their drug problems; the following extracts illustrate this belief.

A principal officer from the young offender institute said,

"Lots of people have said getting off the drug is not the problem it's staying off, so that's the problem."

(SO32)

A member of the health care team from the category C prison said,

"I tend to see the drug taking as not the primary problem for most drug users, and that drug rehabilitation is not just a question of detoxing and keeping people off drugs and giving them information, it's also about dealing with the reasons why they are using drugs in the first place or feel that need and if you start from that premise then, I mean I do think it probably is in fact if you really wanted to a closed environment like a prison should be a place where you could ring people dry whether they want it or not but because I don't see that as, and if I thought that it was just the drug taking that was the problem then probably that would be a good idea and maybe it is, maybe if you do dry out all these people some of them will stay dry when you go out but it just seems to me there's a good chance that just because you can do it in prison doesn't necessarily mean they'll stay off it when they get out unless you address all their other problems."

(MD18)

4.3.2.4 Reflections on same sex relationships in prison

The prevailing belief was that there was not many same sex relationships in prison establishments except for those prisoners that were long term prisoners or had homosexual relationships outside prison.

An officer from the category C prison expressed a belief similar to a number of the participants when he said,

"I'm not aware of it [same sex relationships] I'm certainly not aware of that happening. Umm, I'd probably be a little surprised if that was the case but that's, it's hard to detach that from your own feelings isn't it, to try and put yourself there and think well how would you deal with three years of you know that sort of situation. No, I would say not it doesn't and if it did it would be such a tiny percentage it would be unaccountable if you like."

(S9)

Another officer from the category C prison explained his belief that the number of same sex relationships in prison were overestimated,

"Umm, I don't think there's as much [same sex relationships] as what people make out and let the public know there is, but I think because there is some that it's made into a bigger issue than what it actually, no it is a big issue but it's shown up larger than what it actually is."

(S15)

Some staff interviewed described the Prison Service as being reluctant to accept sexual relationships in prison. The following extract from an officer from the category C prison describes this belief,

"The prison service is a funny old service in that it won't recognise, it will not recognise it has a drug problem and it's trying to deal with that with MDT, well my personal feeling is, well the MDT scheme as far as the prison service is concerned is the be all and end all and will put an end to drugs in prison, it won't, it can't, it never will, yeah, unless there's a complete sort of screen between the prison and the outside world and there'll never, they'll never achieve it. The other side is umm, is homosexuality in prisons as well. I mean there's sort of two areas that they don't recognise, they recognise there's an AIDS problem in prison umm, we know homosexuality is practised but they won't recognise it."

(S8)

There were a number of officers who felt strongly opposed to same sex relationships in prisons. An example of this belief is illustrated in the following extract from a senior officer from the young offender institute,

"In my personal opinion we should be one hundred percent against them having any sexual relationship, because if they are allowed to have a sexual relationship in prison then there is no incentive to go back on the straight and narrow when they get out."

(SO41)

4.3.2.5 Reflections on tattooing in prison

It was reported that tattooing was not as prevalent as it once had been in the prisons, it appears that there has been positive changes in behaviour. The behaviour change was attributed to increased understanding by prisoners of the risk involved.

However, the following extracts show that some risk behaviour still occurred although less frequently.

An officer from the category C prison described his belief about how and why tattooing occurs in prisons,

"We try to stop tattoos being done but they have access to umm, motors off cassette recorders and things like that so they make their own. Again, umm, they probably do sterilise them in bleach if they can get hold of it but then our bleach is probably so watered down it makes no difference. So it is swings and roundabouts. They probably have, they know the risk those that have already got tattooed and they're probably prepared to carry on getting tattoos anyhow, those that do the tattooing umm, whether they practice on themselves I don't know, umm, but it's a way of earning extra tobacco or cannabis or whatever else they're into."

(S5)

Another officer from the category C prison described the risk behaviour associated with tattooing,

"A lot of it, almost always from my experience it's going to be a shared needle. Some of the tattooing machines that we've found are made from dismantled electric razors, pieces from radios usually using something along the lines of a Bic biro as the actual pen part of it, with sewing needles, hypodermic type needles, anything like that they can get to actually puncture the skin and those that I've found, probably about two dozen since I've worked here, almost always the needles are (a) very blunted, and (b) bent suggesting lots of use."

(S7)

There was one officer from the category C prison who described transmission of hepatitis C related to tattooing in another prison,

"We've got one guy on the wing at the moment who is very well tattooed and actually displays his tattoos at shows and he's got a half complete one on his back at the moment, you see it's quite impressive when you see it but umm, when he was having some work done on it at [another prison] he caught hepatitis C and I've actually taken him down to the local hospital for blood tests and what have you. It was definitely established that's where it [hepatitis C] came from, and he's still being tattooed here, right, and what more can I say. I mean they're cleaning needles with vinegar, umm, you know and seem to think that's going to do the, honestly they seem to think that's going to do the job."

(S8)

Another officer from the category C prison explained the intermittent nature of tattooing in prison,

"Well tattooing machines come and go. Sometimes if there's one around it gets used a lot. If there's not one around then nobody makes one. You may go two years and not hear about one and then all of a sudden there's one around. The last one we found, we understood had been in use for about three months but how often it was used I don't know."

(S10)

The view from the young offender institute and the local prison was tattooing only occurred very infrequently. A senior officer from the young offender institute described a change in tattooing behaviour over time,

"It's a dying art. When I first came here and of course a lot more things were allowed in them days, I've seen some quite ingenious tattoo machines made of Biro's, with a needle down the end and a model makers umm, little engine on the end, powered by a battery, oh very clever and with boot polish yeah, they can, its quite surprising but it's a dying art in prison or at least in the young offenders where it used to be very prevalent at one time, don't do too much tattooing nowadays."

(SO34)

However, just to show that it does still occur a principal officer from the young offender institute said,

"I caught two lads in here tattooing themselves a few weeks back, the first time I've actually caught them actually, and they were putting a tattoo on their, they were putting umm, they nicked a bottle of ink out of the education and a needle which we issue them with. Umm, he was putting something on his wrist and I must admit I mean I, I suppose it really didn't bother me umm, but I did say, funny enough I did say to him, I said haven't you thought about the needle he said oh, I've boiled it in water, all right fine, I haven't got a problem with that.

(PO39)

4.3.3 PREVENTION POLICY

It was generally felt by discipline staff that HIV and AIDS had gradually slipped into the policy background. One participant described it as not a 'hot issue' for prison policy makers. There was some feeling that this is because the pandemic had not reached the earlier public health estimates of prevalence rates. Therefore, other organisational issues, such as the drug strategy and suicide awareness policies, were given a higher priority.

An officer from the category C prison said,

"It's like everything else within the Prison Service it's time, money and what is the key word this week, and AIDS was a key thing two years ago, last year it was suicide, this year it's security. So it depends on the 'in' thing."

(S1)

A principal officer from the category C prison described how HIV policy 'had drifted into the background',

"It is fair to say that because of everything else that's come down um, that's prioritised, HIV and AIDS has gradually drifted into the background and so it's a, not a dead issue, but it's one of those things that get caught up in the maelstrom and coming from number one priority in a service had gradually slipped down the priorities really."

(S2)

4.3.3.1 Provision of condoms

The majority of staff interviewed are in favour of issuing condoms for use within prisons. However, when broken down by types of prison, in the category C prison the majority were in favour, in the local prison opinion was divided down the middle and the staff from the young offender institute were in the majority against condoms being issued. The picture was even more complicated by the majority of staff having concerns about condoms compromising security in the form of concealing illicit drugs and perhaps precipitating violent attacks because of homophobic attitudes. Most staff believed confidential access to condoms through the health care staff was important. This is, of course, the current policy position in prisons; however, there are clearly some issues about take up by prisoners of the condoms presently available. This complex situation is described in the following extracts that were chosen to identify the common themes that emerged from the interviews.

A member of the health care team explained condom provision in the category C prison,

"We actually provide condoms, I mean we're happy to provide condoms and advise as to safe sex and there hasn't been, there's been one case in the nine months since I've been here, the issue of condoms is almost exclusively for heterosexuals going out on home leaves and I think we literally have had one perhaps two people who've actually asked for condoms cause they intended to practice here, so if there is any significant amount of penetrative intercourse going on in the prison they do not feel the need or desire to discuss that with us, so we don't know really and I've no idea what, how often, that is a risk factor in prisons."

(MO18)

The member of the health care team from the local prison explained their policy position,

"The problem is you are talking about umm, prison systems which are different from the outside, I mean I was never approached as a general practitioner to prescribe condoms by a male, never, umm, and I know of very few GPs as peers of my own who have been, umm, but they are freely available outside, inside if they were freely available they would be used for other things and that is the problem that you face in

prisons is the level of abuse of systems, not just use. I would think the level of use of condoms in this sort of prison would be extremely small but the level of abuse or potential abuse of these things would be vast."

In terms of providing condoms he went on to say,

"Well it's there [condom policy] if you so wish to prescribe umm, it is not a major house concern as far as I'm concerned in this prison umm, it pales into insignificance compared to the other health problems there are here and umm, I have never in my time here been approached by any inmate to ask for condoms."

(MO64)

To explain the current policy position a member of the health care team from the young offender institute said,

"My understanding is that if the age is right, it's eighteen now, isn't it, it's brought down from twenty one, whether parliament decides to go to sixteen that doesn't matter for the moment, umm, but if I was still a [member of the health care team] here and my understanding is umm, that I should respond to the situation and they were two consenting males umm, I think the courts have rules that the prison cell is a private place and therefore I would umm, I would provide condoms out of stock so I haven't still answered your question here because the occasions never occurred, the difficulty is that because it hasn't been discussed with the governor so you've planted a seed for taking forwards."

(MO37)

The following extracts represent the responses from staff that were positive about condoms in prison; however, many of these responses were supplemented with concerns for the potential conflict condoms may cause.

A principal officer from the category C prison expressing a positive response said,

"I mean it's a known problem, it goes on, and if we can do something to actually slow down the transmission rate completely then marvellous."

(S8)

A principal officer from the young offender institute said,

"I've got no great thoughts on, you know, inter-sex relationships, if people like each other, it don't really matter what sex they are, but no I don't think there's any objection to it, I don't know whether it would induce more people to be involved or not, by the suggestion."

(PO40)

The following extracts represent the various responses concerning the perceived difficulties and conflicts surrounding issuing condoms in prison.

An officer from the category C prison expressed his concern in relation to how the general public perceive condom distribution within a prison,

"I think, I think if you asked the man in the street I think they would expect us to consider alternative ways of stopping this behaviour, rather than almost encourage it."

(S12)

A senior discipline officer from the category C prison described the conflict that condoms presented for discipline staff particularly in terms of their discipline role,

"Whilst you've actually got a rule that says people shouldn't be doing this, you're actually contributing to the situation by saying by the way if you do want to break these rules, this is something maybe you should use you know. I don't think it is a huge problem with it but I think there is a bit of an issue there."

(G19)

A senior officer from the local prison also described the security issue of potentially hiding illicit drugs in condoms as well as the conflict for staff in terms of their discipline role,

"That's not without problems umm, for a start the condoms in the cells are a useful hiding place for drugs umm, for swallowing drugs and letting them pass through the system round and round until they're used, umm, I personally don't see it in this light but I do know that some staff say that the giving of condoms as at least an

acknowledgement that sexual intercourse does take place and that basically it's okay, umm, but in a sense it's seeming to appear to condone it."

(SO69)

A senior officer from the young offender institute explained that he believed the issuing of condoms is morally wrong,

"Personally it disgusts me, On a second note, I think that morally it's wrong.

(SO41)

A senior discipline officer from the local prison said,

"I have a problem with that [condom distribution in prisons] because I have a problem with homosexuality. I do have a problem coming to terms with homosexuality. It's just, I don't know whether it's my upbringing."

(GO65)

An officer from the young offender institute also describe the issuing of condoms as encouraging same sex relationships,

"Umm, again I think it would be frowned upon by staff, I think the staff would see that they were actually encouraging homosexual activity I mean speaking personally that's how I would perceive it and I think maybe a lot of the staff would as well."

(YO35)

A member of the health care team from the local prison described her belief that issuing condoms resulted in staff appearing to condone same sex relationships,

"We know things happen on the wing. If we issued condoms, they would be using them for all sorts of things anyway, you know. I don't think, I think a lot of them would be like kids playing with them, wouldn't they. My own personal view now I wouldn't issue them because I feel we are actually condoning what they are doing."

(N63)

There was concern expressed by a substantial number of discipline staff that condom distribution would pose a security threat in terms of concealment and smuggling of drugs into and out of the prison.

An officer from the category C prison explained her concern about concealment of illicit drugs in prison which, would pose a conflict in terms of her security role,

"They cause us problems with the importation of drugs on visits. They go in with their condom, get the drugs from the visits, please miss can I go to the loo, please boss can I go to the loo, you never find them again and that is a major, obviously stopping drugs coming in to the prison is a major problem for us and that again the condoms fall into the wrong hands and we're back to square one again. I mean I, I agree with them for home leaves for on discharge etc, etc, but not for issue within the establishment no."

(S6)

An officer from the category C prison said,

"I'm sorry I don't think that they should, I really don't. If they want to get up to whatever they want to get up to, then that's entirely up to them, but I certainly don't think you should issue condoms, Again if you issue condoms that is one hell of a way of saying okay you can get drugs in and out of the prison cause all they'll do is to put the drugs in there and insert up their anus and then they've got an easy way of hiding goods that we can never detect."

(S14)

To counter the view that condoms would aid concealment of drugs a number of staff said that concealment of drugs would occur with or without condoms.

A member of the health care team from the local prison said,

"The trouble with condoms is that they can use them for storing drugs as well. That's a known route of drugs smuggling. But then they can do that with just cling film and that sort of thing anyway, so I don't see it as that much of a problem to have condoms."

(HCM61)

A drug counsellor from the category C prison commented on the potential for concealment of drugs in things other than condoms,

"Well I mean yes, drugs can be smuggled using condoms and whatever but I mean if you're going to smuggle the drugs you can get the condoms anyway so I can understand them saying that but I don't see you know that that's a reason. If you're going to do that then you've got to ban plastic bags from the prison as well because you can equally well use a corner of a plastic bag and I assume in terms of security risk that's what they're talking about."

(DC17)

A view expressed by a number of the Young Offender Institute (YOI) discipline staff was that condom provision might lead to sexual abuse and bullying particularly in a younger age range. Many of the prisoners would be below the age of legal homosexual consent. Some of the YOI staff believed that condom provision would not be taken-up because in a YOI environment one of the survival tactics was to be 'one of the boys'.

An officer from the young offender institute said,

"I, no I, we certainly shouldn't issue them, not in a YOI umm, because you could get into the ball game of having illegal sex, because we have them from fifteen upwards you know and it would very easy for the more mature ones, the stronger ones, to influence the youngsters, I mean they do it enough now, umm, and if you gave them condoms which is basically what you're saying to them is well there's your condom and if you want to go out and rape somebody make sure you put it on lad before you do it, you know, to me it's totally wrong we shouldn't do it."

(YO36)

The age of consent was raised again in this extract from an officer on the therapeutic community at the young offender institute,

"The consenting age is eighteen isn't it. Umm, well obviously up to eighteen if we issued them here then we'd be encouraging them to break the law again, umm, I think I'd be more acceptable to that than issuing needles umm, but I wouldn't be really happy with it."

(TU33)

A principal officer from the young offender institute described his concern that a large percentage of the prisoners in that establishment were under the age of consent,

"First of all we are dealing with young offenders, I would say as many as one-third of them are under age anyway so you're giving permission in effect by issuing those things [condoms] for people to abuse children which is just not on, it's a non starter here I think anyway. We can't allow inmates to bugger children which is what we would be doing."

(PO31)

A principal officer from the young offender institute described the potential that issuing condoms would have for young offenders who are often under pressure to conform socially to their peer group and therefore, not to stand out as sexually 'different',

"I think all the pressure would be peer pressure. Umm, what form that threat would take I don't know, it certainly would have an affect on the bullying I think."

He went on to explain how this may occur,

"Well people would be identified and put into this you know group, he's gay or he's a queer or whatever and we've enough problems with he's Welsh or he's black or he's English or whatever so I could see a potential problem there because he'd immediately identify somebody as being different from somebody else. And, the ethos in, especially in young offenders places is to be one of the boys, to be part of the group and that's really a good survival tactic is to be one of the group."

(PO32)

On a couple of occasions, discipline staff mentioned the need for a condom exchange. This would potentially operate in a way that a new condom would be exchanged when a used condom was returned for safe disposal. This was mentioned in the context of the security issue of needing to control the inappropriate use of condoms and also in terms of a used condom posing a risk of infection.

An officer from the category C prison said,

"They should have them [condoms] free of charge, yes they probably should but on an exchange system. I mean it's something, a condom, what was I going, I'll say what I was going to say it's not a health risk, possibly it is a health risk once it's been used and left lying around, but it's you know ultimately a condom on its own is no risk to anyone, I mean it could be used for all kinds of things but for what we are anticipating it's going to be used for, yeah umm, it's against prison rules."

(S9)

An officer from the category C prison explained his belief about policy and his concern with disposal of condoms,

"I personally don't think we should [issue condoms] because once we do it would become more wide-spread. It would put a seal of approval on it and the, the disposal would cause a problem because what would happen, they'd just be thrown out of windows and thrown down toilets which I understand the water board aren't happy about and my own personal view is that we shouldn't. We should keep it against the rules."

(S10)

A member of the health care team from one prison said,

"The thing is how do they dispose of them [condoms] and we can but we'd have to have designated areas and designated bags and things for that, They can't dispose of them very easily on the wings so it would be reasonable that it was on an exchange basis but again how do we actually cope with that here."

(FN11)

A member of the health care team from one prison discussed the issue of condom exchange,

"Well I'm told that in some places you have an exchange, and they have to bring back one condom or two condoms in order to replace them but I can't really see that as a major health issue. I mean if we really don't believe they know what to do with a condom then, then we're all in trouble really."

(MO18)

There was wide approval for the current method of distributing condoms through the health care staff. However, a few responses saw some potential problems with the operation of this policy.

A non-discipline staff member from the category C prison observed,

"I mean they're available through the health care centre, maybe that could be made more widely known umm, but I mean if you go to the health care centre, you know it's open at certain times and there is a queue of people there and I don't actually believe that an inmate is actually going to walk up to the window or whatever and say in front of eight or nine other inmates you know can I have some condoms please, it just isn't going to happen. The alternative is to actually go in sick and get to see the doctor but I mean that, you know doctor's time is a limited resource."

(DC17)

A member of the health care team from one prison described the benefit of initially distributing condoms from the health care centre so that they become more accepted in the system,

"I think it is medical in the wider sense of the word, umm, in a sense it's everyone's issue as well but things like that it's more likely to gather pace and reward if it umm, if it progresses the umm, at the roof of the health care team. It's more neutral as well in health care and more anonymous."

(MO37)

A principal officer from the young offender institute endorsed the view that condoms should be issued from the health care centre,

"I would personally think they should, if perhaps be issued the same way that they do any medical item, you know, and if it's confidential relationship between the hospital staff and the inmate over anything else, I should they should be in a position where they can say that they've got some sort of relationship with somebody."

(PO40)

A principal officer from the local prison said in response to a question on how condoms should be distributed,

"I think it would be detrimental yeah, other people seeing inmates go in to collect Durex's, condoms out of a box, I mean it's going to cause problems isn't it so I think the way that we do it here is they approach the hospital and it's all done confidentially, I think that's a better way of doing it to be quite honest with you."

(PO67)

There was little support for distributing condoms on the landings or wings but a few did think this would be the best way to enable distribution.

A member of the health care team from the local prison said,

"I think they should just be on the landing and when they give out the razors they give out condoms, you know. That's just a personal view on it. Because why draw the line that it's got to be a medical thing, it's not a medical thing really."

(HCM61)

4.3.3.2 Needle exchange

The majority of prison staff were against implementing needle exchange schemes in prisons. A number of reasons were given for this belief and these were focused on the following:

- it would not be taken up because prisoners would be suspicious of the motives of issuing needles when there was a policy emphasis on a drug strategy which concentrated effort on stamping out drugs
- it was perceived that there is a conflict with the drug strategy of searching for and eliminating drugs in prisons
- it was perceived that there is a conflict with security in terms of needles being used as weapons.

Of those that were in favour of a needle exchange scheme, most believed that it could only operate from the health care centre because of the security implications. Some believed that it could only be implemented in a unit segregated from the rest of the prison.

Extracts from the interviews that illustrate these points are set out below.

The following extracts explain some of the complexities of operating a needle exchange in prison.

A member of the health care team from one prison said,

"Needle exchanges on the outside work fine, I mean the HIV drop will show that but needle exchanges in prisons are open to considerable abuse and pressure and it is difficult to work out whether it would be useful or not because it isn't just a single functioning system, this is, there is so much input into the systems in prison that it is impossible to work out the ramifications."

(MO64)

A drug counsellor from the category C prison explained why he felt prisoners would be reluctant to take up a needle exchange and he also highlighted a potential pitfall of creating an illusion of safety if correct harm minimisation messages were not given,

"I very much doubt whether there'd be much uptake while the current drug strategy is in place. I mean I really believe inmates would see it as a trap, I really don't believe that they'd trust it and again even with a needle exchange, unless you're giving clear messages, don't share spoons, don't share water, umm, again you could be creating a false impression of safety. I really think that the only real message in a prison setting is if you're going to inject, don't share anything at all with anybody, that has to be the message and part measures I can see as potentially more harmful than good."

(DC17)

A member of the health care team from the category C prison talked about the potential conflict of providing needles and syringes and then prisoners obtaining their drug supply illicitly in the prison,

"You can give needle exchanges etc, etc, but if you're not prescribing the drug then MDT [mandatory drug testing] will get them so in that sense you're just setting them up to be penalised because you are saying we will support your drug taking. Now assuming that one of the decisions that is taken by a prisoner when they're going to use drugs is, can I actually do it, are there the practicalities available such as needles, such as syringes, then yeah you will be promoting that, you will be saying

look it isn't impossible to shoot up in prison, in fact we will give you a significant part of the gear you're going to need, umm, to offer that without then offering a safe supply of drugs and then say but you've got to get the drugs yourself seems to me ultimately untenable."

(MO18)

A member of the health care team from the local prison also commented on the difficulties that may be perceived by prisoners in exchanging their needles and syringes,

"Well that really is like condoning it, isn't it. Condoning that they use works and then they see the element of well, you know, we're bringing our needle for exchange, then I'm using drugs, so will they come and exchange because they'll know that we'll know that they're using, so from their point of view there wouldn't be any confidentiality there, unless there was a place where they could pick them up unobtrusively, sort of thing."

(HCM61)

Some participants were in favour of a needle exchange but most still voiced concern about the conflict of prisoners using illicit drugs with their needles and syringes.

A principal officer from the young offender institute said,

"I would say it's a good idea, I haven't got a problem with the idea at all to be honest with you, it's common sense but then you've got the other side of, well, you're giving them needles, where's the drugs coming from. I think there'd be such a public outcry and maybe from within prisons as well that you give them needles, umm, obviously they've got drugs, you know to some extent it's legalising drugs. Yeah from my point of view although it is a good idea but I think it is, it would be one hell of a conflict."

(PO39)

Some staff were not in favour of a needle exchange but felt that it would be a good occupational policy that would provide some degree of protection for staff.

An officer from the category C prison explained this perspective,

"I've got no time for people who deal in drugs or take drugs to be honest but if it was, for my own safety if there was a needle exchange I'd feel happier because I know there wouldn't be needles stuck under beds or behind doors and everything else, I'd know there's no chance they're going to get stuck into my finger."

(S1)

Some staff were totally against a needle exchange believing it to be condoning illicit use of drugs in prisons.

A member of the health care team from the local prison described her belief,

"In a needle exchange really your condoning them, saying oh, yeah, bring as many drugs in as you like because they shouldn't be bringing drugs in, we're in a prison and I don't like drugs full stop, I really don't. No I think it's saying to somebody yeah it is all right to bring your drugs in, you know, we'll give you needle exchange and everything, I don't agree with it, not in the prison."

(N63)

A principal officer from the young offender institute said,

"The theory being I suppose that they're saying that if you're going to inject anyway so do it with a clean needle. I think they've got hold of the wrong end of the stick, yeah I think get rid of the drugs is the answer not get rid of the dirty needles."

(PO32)

Some staff believed that a needle exchange would lead to bullying as the following extract from a principal officer at the young offender institute explains,

"You mustn't allow needles in because the people who are issued with them wouldn't have them very long, they would either be stolen from them or strong armed off them or they would be just abused by others."

(PO31)

Some staff described uncertainty about the value of a needle exchange scheme in a prison.

An officer from the category C prison said,

"As far as prevention it would probably be better but maybe you'd be encouraging it. I don't know. You know, again it's a catch 22 isn't it."

(S4)

Some staff expressed a view that prisoners knew the risks of sharing injecting equipment and therefore, due to the scarcity of needles, were unlikely to inject in prison. A senior discipline officer from the category C prison explained this viewpoint,

"I don't believe that they do want to share, that is my view, I think the dangers, they're aware of the dangers umm, and I don't think prisoners are stupid, they don't want to take any unnecessary risk, I don't believe that, I don't think that, I think, if we were to make them available, if we were to make needles available there probably would be quite a big uptake because then people could inject safely but I don't think they're stupid and they know the dangers. If they are forced to do it then they probably would do it but because we make it so difficult you know, umm, then it's not an easy option for them and generally people, human nature generally takes the easy option. So we assume that heroin is readily available here umm, and you can get a similar buzz from smoking it rather than injecting and there aren't a lot of needles around, I am told there are no needles around right now, that wasn't the case sometime back, but we went you know, we went looking and at the end of the day, even if you don't find it, if you chase it hard enough there's a chance that they won't ever get caught with it but they will destroy it and that's what I'm told happened."

(G19)

Other staff talked of their concern that it would encourage the use of intravenous drugs. A principal officer from the local prison said,

"umm, only for the fact that I think if we start supplying people with needles on the wings it's going to encourage other people to use."

(PO67)

A senior officer from the young offender also believed that a needle exchange would have the potential to encourage drug use,

"I think that a needle exchange would encourage drug misuse, I would think that more emphasis should be done on depriving the inmates the use of drugs rather than a needle exchanging."

(SO41)

Some staff were concerned about the conflict between the drug strategy and a needle exchange policy. A principal officer from the local prison described his concern,

"The way the prison service runs, if you were on a detox programme or a separate wing that is umm, trying to help guys beat the habit then you cannot say, here's a needle, we will look after that and you sign documentation to the effect that you trust us, it's going to be hard for you, you know that, yes we all know that, umm, but yeah, we'll give it a go and the minute they're caught with cannabis or injecting anything or inhaling anything umm, then it's this other thing where it's all or nothing and it should be all or nothing cause it's an all or nothing thing to begin with, if you don't give it up then you're going to die, that's the way it is, all or nothing, umm, so you've got to hit it with an all or nothing thing and there are some good lads here but before they came in weren't on any drugs, hard drugs at all, they're now addicts."

(PO68)

A principal officer from the young offender institute described the conflict between the drug strategy and a needle exchange scheme,

"One minute somebody is saying to you there should be no drugs in the place and then they turn round and say will you accept the fact that somebody's going to go and exchange needles on a regular basis, then you've accepted the fact that there's drugs in the place haven't you. Our aim is not to have any. I mean that's the whole point of the searching systems and that [the searching function of the drug strategy]."

(PO40)

Some staff expressed concern about the public reaction to a needle exchange in prisons. One participant, an officer from the category C prison, described the reaction he believed the public would have,

"Shock, horror. The same way I think as they received the information that drugs are freely available in prison."

(S5)

Another officer from the category C prison said,

"The majority of the public would disapprove, umm, certainly I believe there's organisations that would argue that it's a good thing, but I do think the vast majority would find it distasteful to say the least. Obviously you've got the various organisations that work with people with AIDS, with HIV umm, the organisations that deal solely with drug abuse, I'm sure all those organisations would say good idea let's push it forward and bring it in, but they would still be the vast minority compared with the general public."

(S7)

Some of the participants were concerned that potentially needles could be used as a weapon. This fear was expressed in a number of ways; the following extracts are representative of the range of responses.

A senior discipline officer from the local prison described his concern,

"You have to be careful what you give inmates because they use them against one another, and use them against staff, and I would see a hypodermic syringe in the wrong hands as a very dangerous weapon indeed to give an inmate and I don't think you could allow that in his possession, and say to your staff, we're protecting you, you're okay, he's a junkie, he needs this, but he changes it at the hospital every day or whenever he needs new needles, so in a way we're ensuring that the hepatitis side of it is reduced but what you're actually increasing is the other side of things, and if he is diseased, he does have hepatitis, there's nothing stopping him then from doing a fluid transfer to a member of staff as a deliberate act."

(GO65)

An officer from the category C prison described his feelings about a needle exchange in terms of needles being dangerous,

"I wouldn't condone a needle exchange because it's a, a needle can be used, it is a dangerous object and is a threat to myself and I wouldn't condone them using, issuing them."

(S5)

A member of the health care team from the local prison said,

"The weapon thing would be difficult to overcome I think because you can't contain people that, only those people that are going to be using IV [intravenously] on one wing, and say to the prison officers, well here you are more at risk. You know you can't it's impossible."

(N60)

Some officers described the impact of a needle stick injury on both themselves and their family. The following extract shows the way one senior officer described it,

"I can't think of a worse weapon than a hypodermic if you don't know what the risks are. It's not just the, the injury itself would be minor, it's the psychological effect, the effect on your family etc, for the months whilst you're waiting and unsure whether you are a time bomb waiting to affect your family [referring to waiting for the period of time it would take for the infection to show up in a blood sample]."

(S7)

Some staff described their response to statements about needles from a needle exchange scheme being used as weapons by saying that potentially needles for use as weapons are available in prisons anyway.

A principal officer from the local prison said,

"They've got them now [weapons]. They won't introduce them because they're here now. If they want a weapon as a needle, they're here."

(PO66)

When prompted to consider the way a needle exchange could be introduced into a prison all staff could only envisage a system managed by health care staff.

A senior officer from the young offender institute described his belief,

"I think the only way they could resolve this problem if they wanted, if they were seriously considering accepting inmates who have got a drug problem, why don't they have a clinic in hospital where they can actually go in the hospital and take their intravenous drug in the hospital in front of an official and then retrieve, put the needle in, straight in to a sharp bin."

(SO41)

Some staff talked in terms of completely isolating wings where needle exchanges were being used by prisoners. An officer from the category C prison said,

"A specified secure wing. There's certain prisons which could easily achieve this their very geography, would allow them to isolate a wing, it must be isolated from the rest of the prison population. Yeah, so I mean the answer was yes, you know, there is room for needle exchanges but with such limitations."

(S9)

Another officer from the category C prison said,

"If we have an inmate who suffers umm, who needed a kidney operation or something we'd just send them out to an outside hospital and do it, now if we've got an inmate that needs detoxification there's an argument that says well why don't we send him to an outside detox unit, you know but then the other argument would say well he's serving a prison sentence, you can't send him you know until he's finished his sentence, what happens to the time he's doing his sentence, It's certainly a debatable point."

(S9)

A principal officer from the young offender institute said,

"I don't know of any prison that's allowed needles to be used; the only way that's possible is if the umm, inmate is on like a methadone treatment or something like this where they actually go to the hospital to be injected and then go away again but there would be no instance where umm needles would be actually issued to inmates in any prison they wouldn't happen, can't happen."

(PO31)

A principal officer from the local prison said,

"It would work and I know a lot of the inmates would prefer it, but whether we can administer it I don't know, I don't know how the staff would feel about it for a start. Whether you could do it under the hospital guise of a bit of privacy for the inmates, I don't know. It would have to be thrashed out."

(PO66)

There were a couple of participants that thought a needle exchange could be managed from the wing. An officer from the category C prison pointed out that a health care centre is not always accessible,

"There is actually a yellow cardboard box in each wing office for, like, razors and I mean, there's no reason why a, a needle box couldn't be put in there and issue out from the wings. You know save the medical centre doing it all the time. We know it's there so, I mean, come the evenings when the door is locked at nine o'clock if a guy wants to fix up and he's only got an old needle or something, there's no way he can get to the hospital wing then, when he might be in such a state the he's going to need a shot so, I think that ought to be looked at anyway."

(S3)

4.3.3.3 Bleach provision for decontamination of injecting equipment

Some responses were in favour of bleach provision; however, most responses centred on the conflict of providing bleach for prisoners to clean needles and syringes, when the drug strategy clearly focused on reducing the amount of illicit drug use in prison.

A non-discipline member of staff from the category C prison described the conflict,

"One of the major difficulties with it [bleach distribution] is I perceive that there's a conflict between the drug strategy which is directed towards getting inmates abstinent from drugs and the HIV policy which is actually covered by another committee which is going down the harm minimisation road and I don't think anybody's ever really sat down and had a good look at the fact the two policies are somewhat in conflict."

He went on to describe his own feelings of concern about a decontamination policy when the efficacy in terms of destroying the hepatitis virus was still not known,

"I would be very concerned if there was such a policy that it was done in such a way as to enable inmates to carry on using drugs in the prison and it would also concern me because inmates who were still using drugs in that way would then be under a false misapprehension that they were safe, possibly share spoons and other injecting equipment, umm, reduce the risk of catching HIV almost certainly and almost certainly it'll end up with hepatitis C or B as a consequence. The other thing is I mean nobody in prison is actually going to stand there for five minutes with a syringe full of bleach."

(DC17)

An officer from the category C prison described his belief that all the effort should be focused on stopping drug taking rather than minimising the risk of transmission of infection,

"I think if you stop them injecting heroin then you also stop the risk of transmitting diseases. I don't think the avenue of allowing them okay well if they do inject heroin then let's do it correctly, then let's do it, I think that's where again we have to differentiate between this and the public. The public are free, now they might be breaking the law by injecting heroin but they're free people, these people are actually serving a sentence and they are the prison department's responsibility for that period of time. No, I don't think you could go down that avenue.

(S9)

An officer from the young offender institute described his beliefs about distribution of bleach,

"I would have to disagree with it because any form of allowing prisoners to carry on what they see is their normal life which could be totally different to the way I see normal life or you see it, umm, we shouldn't be seen to be condoning that, again, it's illegal, drug taking in this country is illegal if we in prisons start saying to them well you can take a few drugs providing you keep clean needles, we're totally going against the prison policies."

(YO36)

An officer from the young offender institute compared the impact of distributing bleach without explicitly saying that the bleach is for decontamination of injecting equipment, against the impact of introducing needle exchange schemes,

"I can't really condone the issue of needles but I suppose I can't really see the problem of issuing some sort of cleaning equipment which could be used for many purposes."

(TU33)

Other participants accepted the harm minimisation principles of distributing bleach for decontamination of intravenous drug equipment. A principal officer from the young offender institute said,

"I think that if they have got themselves into a position to use it and they have got hold of the stuff, they should use it in as safe a manner as they can."

(PO34)

Some participants also recognised the benefits there may be to staff as this extract from an officer from the category C prison shows,

"If they were to be issuing something along the lines of bleach I personally would have no objection there, umm, hopefully you'd be reducing the risk, not only to other inmates but to staff as well in the long run, so from that point of view I'd have no real objection, I'm sure it's already being used from what's already available so again I can't see personally any objection to it."

(S7)

One of the officers described giving out bleach to prisoners despite the current policy and without explicitly acknowledging what the bleach would be used for,

"I mean if anyone comes down, our cleaners [prisoners] come down and we give bleach and detergent, I mean if the lads come down and want a bit of bleach, quite honestly I'll give them some bleach, I'd far rather them use bleach, dilute it and you know use."

(S8)

An officer from the category C prison explained that often bleach was accessible anyway,

"We are then seen to condone the use of hard drugs, taking hard drugs, there are particularly in this environment we are in here which is a very open environment, there are already these things available to these people, there is bleach available via the cleaners cause it's inmates who do the cleaning to clean works, there have been for example finds of syringes within hot water boilers for cleaning purposes and okay this is in a very open establishment but even in a closed establishment where there are the means for something like this to happen the inmates will find their ways, it's a fact of prison life."

(S6)

Some participants believed that the policy should be managed and introduced from the health care centre. The following extract from an officer from the young offender institute shows this view,

"I think if they need to do that it should be done maybe in the health care centre where it can be monitored."

(YO35)

Bleach tablets for cleaning purposes had previously been issued in prisons as part of the HIV strategy; however, they were distributed to all prisoners and it had not been explicitly stated that it could be used for intravenous drug equipment. A leaflet was available to describe effective cleaning of injecting equipment. The bleach tablets were quickly withdrawn because there was some concern that the bleach tablets were combustible. Some participants were concerned about a method of introducing decontamination agents without fully explaining how to use them.

A senior officer from the young offenders institute explained,

"We have a general leaflet in actual fact, umm, cause I can remember reading it, umm, if you put things in especially with, if you're talking about [this prison] then we're talking about young impressionable lads, because a lot of them although maybe aged

eighteen they have a mental attitude of about fourteen, umm suggestions puts ideas into their heads as well, if you leave something unsaid then quite often it doesn't happen."

(SO34)

A member of the health care team from the young offenders institute said,

"Oh I think there has to be a demonstration as well because if you say now have you understood and people are going to be nodding like that and umm, that's perhaps out of politeness or embarrassment because they haven't quite picked something up, the other point to remember of course is that some people can't read instructions because they've got dyslexia or just umm, poor educational attainment."

(MO37)

A member of the health care team from the local prison said that the emphasis should be placed on education and telling people not to share injecting equipment because of the risk of hepatitis,

"When people come in [into the local prison] when we health screen we advise them not to share needles or works or anything like that because there is hepatitis around and it is hepatitis C and so on, and we advise them not to, you know if they do, do anything, you know, they use their own works not to share because, so we, across the board all the [members of the health care team] advise them on reception."

(HCM61)

There were a number of people who saw the need for some sort of policy but saw a piecemeal introduction of a bleach policy on its own as problematic.

A member of the health care team from the category C prison said,

"I think there's a place, well I mean my actual feeling is there's a place for comprehensive strategy and I think it's not a question of do we or do we not have sterilising tablets, the question is do we have a policy which is going to say we're going to use a particular way of reducing the use of needles."

(MO18)

There was concern that prisoners may use bleach tablets inappropriately, that they may be used as a weapon. A number knew that bleach tablets had been introduced and almost immediately withdrawn on health and safety grounds but few could remember the exact details of what the health and safety issue was.

A member of the health care team from the local prison said,

"I think if you took them or swallowed them they were sort of internally corrosive so, from a health and safety point of view they're not really a good way of managing things in an institution."

(MO64)

An officer from the young offender institute said,

"Well I think, I mean some would drink it wouldn't they. Cause obviously it could be chucked in somebody's eyes or whatever they want to do with these things."

(TU33)

An officer from the category C prison said,

"Well you know there's lots of problems with anything like that in here. It's not used for that [needle decontamination], it's chucked over people."

(S4)

A member of the health care team from the category C prison said,

"Personally I don't actually think it will work. Bleach is, again that's something that can be abused. It is a potential weapon. They can just mix it with various substances and create all sorts of nasty things."

(FN11)

Other participants disagreed that they would be misused. For example, the health care manager from the local prison said,

"Well I know what they said was, they're combustible, you know, and that's why they withdrew them. I can't see that they would be abused other than if somebody felt like

overdosing or something and got hold of the bleach and swallowed them, that might be a problem. And the fact they look like tablets could be a problem but other than that I don't see why they shouldn't introduce them, except that it's not 100% safe anyway is it [referring to virucidal action of bleach for hepatitis]."

(HCM61)

A senior discipline officer from the local prison described the prison policy before the bleach tablets were withdrawn,

"We actually had it here already and we did not issue it here. We actually took the decision which went against the national directive which was to give this bleach for sterilisation purposes, and we didn't issue it here and then it very quickly got withdrawn anyway because of the dangers and it still hasn't been resolved."

(GO65)

The following extract, from a participant from a category C prison, illustrates the conflict that many staff expressed when asked if provision of bleach or other chemical disinfection agents for cleaning injecting equipment would be a good policy,

"No, because the system is totally against drug use in the prisons anyway and I don't think the Home Office or the powers that be would allow it. They said they did start this thing [introduction of bleach tablets] I don't really know why it got stopped."

(S1)

Another participant from a category C prison explained the conflict staff would feel,

"You're going to end up with a situation where, yes you're frowning on the use of drugs but you're prepared to encourage the cleaning of illicit articles umm which does seem a little hypocritical".

(S2)

A principal officer from the local prison said,

"It presents a security problem yeah, because bleach is caustic. We don't have it about the place. There would be a conflict yeah, a conflict of interest between security and clean needles."

The participant went on to describe his feelings about having a policy that distributes bleach without acknowledgement that the primary aim to enable cleaning of intravenous drug equipment,

"It sort of builds a dishonesty into it doesn't it because at the moment Mandatory Drug Testing is used as a deterrent but also as an encouragement to people to give up, you know umm, of course this would identify people there's targeted tests isn't there, you know there's reasonable suspicion and it's good suspicion if he comes and draws his bleach every week. There's definitely a conflict there isn't there."

(PO32)

A senior discipline officer from the local prison described how other policy would have to alter in order to accommodate HIV and hepatitis prevention policy,

"Something has to change dramatically for this to happen because the ownership of the needle with the inmate is illegal, so we're talking about the legality of something and knowing that he has something which is illegal and then giving him something to clean that and sterilise it, you've got to get rid of, move somewhere along the line, the legality of it all and we haven't done that, so therefore before ever one could even consider such a revolutionary thing, and I feel it's revolutionary, cause it sort of stuns me a little bit, here I am saying to the inmate, no you can wash your needle out, you make sure it's nice and clean before you inject and yet firstly he's not supposed to have it, he's not supposed to have heroin, he's not supposed to have a needle, there's a big change somewhere had got to take place and I don't know how that would happen, I don't honestly."

When he was asked if he believed that bleach or other decontaminate could be distributed by the health care staff he said,

"No, I think it's a non-starter. I cannot see any way that could be issued safely and in a controlled manner."

(GO65)

There were a number of participants who believed that if a needle exchange scheme was operational then there would be no need to distribute bleach. An officer from the category C prison described his viewpoint,

"If they've got a needle exchange then they shouldn't need the bleach really but you're always going to get these guys that, you know, still don't want you to know they're exchanging needles so er."

(S3)

Another participant when asked about a policy to decontaminate intravenous drug equipment said,

"I don't believe in drugs anyway but I think if you can't stop it, it's possibly better if you did a needle exchange at least you know that there's not going to be dangerous needles in the wings."

(S1)

4.3.3.4 Opiate detoxification

Most staff viewed a detoxification policy as congruent with the drug strategy and their role of preventing illicit drug use in prisons. The majority viewed methadone detoxification as being a beneficial policy if it enabled people to wean off drugs without methadone getting into the prison system and subsequently being misused.

An extract from a principal officer from the young offender institute illustrates this view,

"If it's used as a controlled method of helping people get off drugs, and it's done under conditions where they don't take it away and somebody else can get hold of it."

(PO40)

The local prison was the only prison to have a methadone detoxification policy. The policy encompassed more than prescribing methadone as there was a very active programme of counselling and complimentary therapies to give prisoners more support through their withdrawal programme.

The programme is viewed positively by all the staff at the local prison. A senior discipline officer from the local prison described the programme,

"I suppose the most positive thing we do here is our detoxification. And I think if a prisoner or not necessarily a prisoner, an inmate here at [local prison] wishes to avail

himself of the detoxification programme, then that, by replacing his craving for heroin, and offering him a substitute, a heroin substitute, that isn't injected, in fact it's taken orally, I think that's probably one of the most positive things I've seen, Followed up of course by the counselling and the whole ethos of the drug free wing. I think it's a very positive thing."

The participant went on describe other beneficial effects of the methadone programme,

"One of the things I've noticed here, is that since we've gone on to the methadone and the drug detoxification, the incidents on the wings have lessened, there is less what I call warfare, for want of a better word, there's less groups fighting for control of drugs that are going around, and there's a lot less behavioural problems for the inmates we've got. The gradual weaning off of the drugs, that's stopped the pressure for them, the demand on the wings and therefore it's took out a lot of the threat and everything else that was going on."

(GO65)

Very few participants spoke of negative experiences of the detoxification programme but there were one or two that felt it caused some problems. A principal officer from the local prison described one particular problem with having a detoxification programme,

"I'm not against them having it [methadone detoxification programme]. But I think it puts our prison in a terrible situation because very, very few other prisons are doing methadone treatment, so we may have somebody here that we can move on because he's sentenced, he may have been a security problem or whatever we need to move him on, because he's on methadone we can't do it, right. So that causes a problem, and I think we've had a bigger problem with drugs and disruption to the routine through this methadone treatment."

(PO66)

A member of the health care team from the local prison also described this problem,



"Some prisons don't, there's very few that do actually [offer detoxification programmes]. So sometimes they have to have finished their methadone programme before they go to another prison."

(N60)

A member of the health care team from the local prison described the difficulties of measuring the success of the detoxification programme,

"It depends what people feel is success, I can't answer that because we work within different parameters, I mean it is successful on the grounds that I think it reduces harm here and I believe it reduces the amount and frequency of illegal drug use in the prisons but, whether that has an outcome or whether that has any bearing on long term use or reuse, I don't think we know, I don't think anybody knows."

(MO64)

A senior officer from the local prison said about measuring success,

"I think it's working for some, umm, I think if it's a methadone reduction programme that's actually getting people off then albeit the fact that even outside they only like a 20% success rate, umm, if it gets, it gets one percent off it then okay it's certainly worth it for the individual that does get off."

(SO69)

A member of the health care team from the category C prison described the detoxification programme at that particular prison,

"We use benzodiazepines, Librium. Umm, I mean I don't have a policy of stating what the drug is that we're going to use but we certainly let, I mean the rumour has got round that we don't use opiates and I'm quite happy for them to have that rumour spread around. Certainly I would be reluctant to use opiates, not just methadone but actually any opiates, but in fact it may be that we would use opiate detoxification in certain circumstances if it was clinically necessary."

(MO18)

An officer from the young offender institute described detoxification at his establishment,

"They don't get anything here at all. The doctor's policy here is that the sooner they come down off the drug the better, he'd rather they do cold turkey and come down that way and I must admit, I believe in what he does wholeheartedly, I think it's a superb way to do it, umm, I mean we've, I can't, we've had the occasional lad that sort of wobbled and gone off the rails a little but most of them, I mean within a couple of weeks you see a total change in them."

(YO35)

A senior officer from the young offender institute described helping prisoners with drug problems as a responsibility of the Prison Service,

"That is one of the things I do actually agree with is methadone in weaning them off their drugs. Because I think it's part of our responsibility and I can't have the moral of saying people shouldn't take drugs if I'm not willing to do something to try and help them to get off."

(SO41)

Another senior officer described methadone detoxification from the perspective of the young offender institute,

"Yeah it should be used. Umm, anybody that's using drugs has got a real problem when they come into prison because officially they're not available, umm, anybody that's well and truly into it I mean needs to come off it some way or another, we as far as I know here don't use methadone to any degree, umm but then again I say that I mean although we get lads come in who's been using just about everything they can get their hands on, umm, we tend to make them go, I mean the only thing we give them is sleeping drafts usually umm, to try and get them through the night but they do it almost what we call 'cold turkey' which isn't cold turkey as far as you know, when their dependence isn't that high, so we can get them off it usually without methadone, but umm, in your adult nicks again, yeah, you've got another problem and anything that keeps them stable I suppose and brings them down off it you need to use it."

(SO34)

An officer from the category C prison said,

"We all know there is a drugs problem, there's no denying it umm, and the department know the drug problem is there and again would not deny it and anything seen to be trying to deal with the problem and actually taking positive action to reduce the number of people abusing drugs, or abusing themselves with drugs maybe a better way of putting it, umm, would be a good thing."

(S7)

Some participants talked about the cost of providing a comprehensive programme as being a problem.

A principal officer from the category C prison described the cost implications,

"Anything that is going to detoxify somebody needs to be encouraged. But what you'll find is that we can't afford it. So therefore um instead of going in for it wholeheartedly and trying to really get to grips with it then there is frustration because people send us inmates who are on the detox without us having the facilities to, to um really cope with that. So if we're going to do it, coupled with, coupled with the old HIV and AIDS bit um there needs to be belt and braces really. So it really needs to be tackled."

(S2)

A drugs counsellor at the category C prison described how he thought detoxification programmes might be provided,

"In an ideal situation I don't think all services can be provided in all establishments, if an inmate is identified as being an IV [intravenous] drug user, I mean my first thing I'd be wanting to look at would be detoxification, and there are facilities for that. However, to just detoxify someone, and most of the people we see by the way are polydrug users, it's not just a simple matter, they're likely possibly to have been using opiates, benzodiazapines, cocaine as well, the mixture is endless but I mean they're not simple detox problems, umm, and it's not just as you know glib as simple as saying oh well you use methadone as a detox and whatever, It has to be in-house, certainly in an establishment like [own prison] to run a detox regime with inmates

housed on normal location will be a complete nonsense, umm, I personally believe it needs to be monitored."

Later on in the interview he went on to say,

"You actually need to create services to meet needs and each establishment has different needs just by virtue of the regime and the kind of inmates they get in that particular establishment, the two go hand in hand, I wouldn't like to give the idea that I automatically want to link all these things up, yes there has to be the possibility of doing that but if an inmate wants to go through detox and not move onto treatment I would say fine, give him the opportunity to do that, He may actually need to go through the learning experience of falling flat on his face a few times and that might actually be what it takes to motivate him to move on."

(DC17)

A few of the participants were not in favour of an opiate detoxification programme.

An officer from the category C prison described his feelings,

"My view is that a methadone programme is inconsistent with the attitude of the prison in terms of addressing the drugs strategy umm, because it seems to be giving conflicting messages.

(S20)

An officer from the category C prison expressed his belief about methadone detoxification in the following way,

"No, I don't agree with them, flatly, just disagree. If an inmate's been taking drugs for a period of time and he wants to come off, then he should come off, now he knows the pitfalls of being on drugs."

(S14)

Some staff from the young offender institute believed that a detoxification programme would be unnecessary in their establishment. A principal officer said,

"There's not a need for it we don't get hard drug users so there's not need for it. Umm, I think if there was a situation and we do get one occasionally, I think he would

be moved somewhere more appropriate than here. I don't think it would happen here."

(PO31)

A number of participants believed that the prisoners on a methadone programme should be separated from the rest of the prison so that their programme was not interfered with by temptation of drugs available around the prison.

A principal officer from the local prison described it in the following way,

"If we are gonna do it [detoxification programmes], I think we should have it segregated somewhere. But physically we can't do that. We should have them away. They go on that programme, they don't have contact with other inmates because as soon as they have contact, it's a temptation isn't it. If they are not receiving what they need, it's a temptation to get it from somewhere else, so that should be taken away."

(PO66)

A member of the health care team from the local prison explained why it is necessary to have a more comprehensive system of tackling drug problems, not only within prison but also to establish proper throughcare back into the community,

"I think everybody should be tackling drug use problems and at least offering something. What we offer here, I mean it may sound very good and it sounds like it's quite in depth, but what we're really achieving is to start some kind of ball rolling, some motivation, some kind of little spark, just to make them think about their drug use. Where one, maybe in a thousand, will stop using that we've seen, but that's luck more than judgement, because we're a local, they are in and out quite quickly, therefore, we just have to start the ball rolling. They should be picked up by services on the out or when they start using straight away as soon as they get out of the gate, they can think about some of the things that we said about relapse prevention. What can I use, who can I contact, how can I get supported through this and stuff like this, just to start the ball rolling, but I think really that 100%, everybody should be interested in doing something about it."

(N60)

4.3.3.5 Barriers to policy development

One perception, voiced by many of the discipline staff, was that the prisoners would see some of the prevention policies, such as needle exchange, as a trap because of the policy emphasis on the current drug strategy; this has been discussed previously. However, it is an issue that would require considerable attention before any policy was developed. As an officer from the category C prison explained the basic conflict,

"If they're using needles, a needle means they must be using drugs and I mean in theory you're then going to nominate them for special attention for security as it were cause I mean obviously they are using drugs."

(S13)

In addition to the conflict between policies there was also a perception of conflict of the role of the officers and the role of wider society. A senior officer from the young offender institute explained,

"I think it's a conflict with my role and it's a conflict of the role that society must play towards offenders."

(SO41)

A barrier that was referred to a number of times was that of security because security in a prison setting is the overriding priority and health care measures have to be placed and managed within that framework. This view is explained by an officer from the young offender institute,

"I mean the security, that's what they're in here for they're in here to be held in custody you know and we have to do that, I mean as far as I'm concerned everything else you know, security overrides everything, security is the main thing."

(YO35)

Another factor that would affect policy development is the prominence of a particular issue. A number of staff voiced the concern that they felt that HIV and hepatitis prevention was not currently perceived to be a priority by prison service management.

An officer from the young offender institute described it as follows,

"I think it's sort of been put on the back burner, it's not a relevant issue at the moment or it's not an important issue which is okay for the management cause they're not on the ground floor working with these people on a daily basis so they're not actually in contact with these people do see what I mean, you know they're not on the shop floor, they're not going to get involved in scuffles with the inmates and things like this, so it's a typical thing of why should we worry about it, it doesn't concern us."

(YO35)

Some staff said it was the way the issues were tackled in a prison that prevented comprehensive policy development. A principal officer from the category C prison explained,

"If you are really trying to tackle a problem, what could be done is if you took, instead of a drug-free wing, a drug wing full of inmates that know they've got a problem and are trying to come off and trying to do something about it. Then you would, in that environment, open up these things or you know, to stay clean, to try and detox and all the rest of it er but that's, that's pie in the sky at the moment with you know, our finances."

(S2)

Another comment that draws attention to apparent gaps in provision is from a member of the health care team from the category C prison,

"Now we can say, right you must be drug free and then we will support you, rehabilitate you, on an abstinence model but to say we will, I mean the present policy in this prison, certainly the drug counsellor's views are that he's offering a service to people who want it, for those who cannot make the commitment he's offering nothing and doesn't feel he should and that's a common feeling amongst drug workers who run an abstinence model, but to say the only people with drug problems are people who are saying yes I've got a drug problem I now want to come off, isn't true and at the moment they are getting nothing and they would so much better if we maintained them and then offered needles and offered sterilisation, etc, etc, and in that sense it would probably be more sensible to say we would offer the abstinence model plus we in the health care centre will actually allow you to inject in the health care centre, and then the question of cleaning needles or other needles doesn't apply. You're then left

only with the people who are not prepared to even admit that they are using drugs, but to a certain extent I don't think that's too much of a problem cause with the MDT they're bound to test positive anyway within six months. So that group presumably is going to be a very small one."

(MD18)

4.3.3.6 Prison drug strategy

The Prison Service has developed a number of policies as part of the strategy to reduce the supply and use of drugs in prisons. The policies developed from the drug strategy that were available in the prisons where interviews took place were; (a) substance-free areas and an abstinence programme in the category C prison, (b) a therapeutic community in the young offender institute and (c) a methadone detoxification policy in the local prison. The staff regarded all of these policies very highly because they felt they were more compatible with their security role. Methadone detoxification has been discussed separately (see section 4.3.3.4), therefore, comments about therapeutic community and substance free areas will be outlined below. Mandatory drug testing will be covered in more depth because it prompted more controversial comment from the staff.

The *therapeutic community* in the young offender institute is a comprehensive abstinence based programme providing a counselling and support programme based in an area separate from the rest of the prison. An officer working on the therapeutic community defined it as,

"A model designed behind people who have a damaged lifestyle from drugs, crime and addiction, so it's somebody who has developed an addiction, I don't care if it's cars."

(TC38)

A drug counsellor was just establishing a *substance free* wing in the category C prison, he described it as,

"It's an abstinence based programme. I envisage a 13 week programme, umm, although there are counselling organisations and drug agencies outside who work on a harm minimisation approach, umm, how can you do that in a prison where the

expectation is that people are abstinent. We'll never have a drug free or a substance free wing, but we can have substance free inmates, that's the purpose of it, but I mean we are not so unrealistic as to believe that we will ever achieve a totally substance free wing. Something else that happens is there is actually a tendency for dealers to hide out on the wing because they can go outside [the wing] and do their dealing, come back in here and because non wing residents can't get onto the wing, umm, it's a good place to come so that they don't get hassle."

(DC17)

At the time of interviewing the substance free programme in the category C prison had not been operational for very long. An officer from the category C prison described it in the following way,

"Some say it is working well and some are saying it isn't, we hear all stories about it because you listen to the staff and you listen to the inmates and you get inmates that want to go in there because they know that if they get tested they don't lose their remission if they're found to be using but then again the counselling is there I think if they want it. You've got those that don't want to use drugs and thought they'd get into the wing and it would be drug free and they're finding that there's people in there openly using because they know they can't lose any remission for the first two or three times they get caught so they've asked to come out and, I think at the moment it's still going through it's settling down stage."

(S15)

The overwhelming response to *mandatory drug testing* (MDT) was that the policy fully accords with the role of prisons and prison staff. Although some staff were concerned about a potential shift in drug use from 'soft' to 'hard' drugs, this did not detract from the general positive feeling about MDT.

An officer from the category C prison described the initial reaction of staff to MDT,

"Well our initial reaction was when this came, when MDT was going to be introduced, it was they published a table saying that cannabis would be in the system for three weeks umm, but heroin would be out of the system within so many hours, our initial reaction was oh Christ it's going to push a lot of umm if you like soft drug users over to hard drugs. Soft drugs to me is cannabis, hard drugs being heroin, you know the

class A drugs. We thought that would be the case but we don't seem to have seen that, we know there's heroin in here, but I think the heroin users will be heroin users, cannabis smokers will be cannabis smokers and we haven't seen much of a change over."

(S8)

A principal officer from the local prison said,

"I've actually pointed out to the governors here that the you know the cannabis level has dropped and the opiates have gone up because it doesn't stay in the body so long."

(PO67)

A senior officer from the local prison described the impact of MDT as cosmetic,

"I doubt it would have that much of an impact now if you took it away umm, in so much as we don't catch many people with heroin we know there's an awful lot of it in the gaol but we don't catch anything like as many as we do with cannabis, umm, though having said that it's you know it's a good policy, in a sense I think it's more cosmetic, I doubt that it's stopped anybody using drugs umm, it may possibly have made them transfer to others umm, but the simple fact that we're still catching people if that's the right word, we're still identifying people that use a range of drugs. MDT having been in place for I don't know how many years now, probably about three years, it's not a deterrent, therefore, just so I mean is it really doing anything other than giving us perhaps a more accurate figures of the size of the problem. I think it's been valuable in that sense."

He went on to say,

"It's difficult to actually say if MDT has caused it, but there's certainly been a rapid growth in the use of heroin, here and in other establishments and prisoners themselves will tell you you're forcing me to use heroin, this has been said to me so many times, you know, because I can't have cannabis cause it's in me system for 30 days."

(SO69)

Another principal officer from the young offender institute describing an alteration in drug use said,

"I think it's certainly altered umm, a lot of drug users from cannabis, the problem with cannabis smoking is the smoke, you can smell it, others know you're doing it, it can indicate you to a test so to avoid that very thing what they will do they will have their visitors to bring up some pills, not cannabis as usual so yes, it's moved the emphasis away from cannabis although it's a general drug of use, When we first started doing MDT we had nothing but cannabis positives now we're getting all sorts of different drugs popping up on the results."

(PO31)

An officer described the change in drug taking behaviour in terms of his everyday observations,

"If you go back two years I could walk round, I could go to any wing in the prison, dormitories or house blocks and within half an hour probably have a collection of ten or fifteen bongs or pipes [to smoke cannabis], now in the same amount of time I go over the wings and I'd find one or two bongs, probably no pipes, and more than likely ten, twelve, maybe fifteen foils used for snorting, that they lay the heroin on and what have you for snorting. It's pushed the problem to a drug that stays in the system considerably less time."

(S7)

The reason that it was so difficult to identify who was smoking cannabis prior to MDT was explained by an officer at the category C prison,

"Mandatory drug testing is a very useful tool, I work in dormitory situations and the way that the rules are enforced, unless you actually find somebody using the drug, with it in his hand or his mouth, if it's six people sitting round a table with the drugs on the table, you couldn't actually put anybody on report cause they'd all say somebody else is using it or it wasn't mine and I was just sat there but now, of course, with the drug testing, you can have all those people tested and if they're positive, they're in trouble, but umm, it's a very useful tool and I'm very glad it's in."

(S10)

A member of the health care team from the local prison said that the detoxification programme had influenced the meaning of the MDT results,

"Well MDT really in the experience of this prison is only as it's laid out purely a testing phenomenon, there is no drift from cannabis use to opiate use in this prison and the statistics quite clearly show that in actual fact, the opiate use in this prison has dropped 20 odd percent in a year, but that is because we run a detoxification system so you can't put any sort of umm, correlation between people using these drugs and MDT. MDT is purely a testing phenomenon here, now in other prisons MDT may have different effects."

(MO64)

A principal officer from the young offender institute highlighted a particular problem in that once identified by MDT prisoners should be able to gain access to treatment programmes,

"MDT, well I'm one of the samplers, well I say sampler, one of the urine takers basically umm, I think I've been doing it for a couple of years now, I think it's very good, however, it's all very well placing these inmates on report for positive tests but then again if nothing's being done to address the actual drug behaviour. I know, I appreciate we've got more than other prisons, the therapeutic community, but then we've got juveniles here which are too young to go down there, so although I think MDT is good, it's very well thought out, it's a good tool for us against these lads, I still don't think there's enough being done to address these lads drug behaviour."

(PO39)

A principal officer from the category C prison highlighted a positive outcome for the prisoners who did not use drugs,

"The only person it will help is the person who doesn't take drugs and the person who is badgered on the landing to take drugs because there is a lot of peer pressure. The greatest pressure that we've got in here is peer pressure. And if you've got four or five inmates trying to persuade you to take a bit of blow [cannabis] or a little bit of smack [heroin], er for the sake of a phonecard then it can be quite wearing."

(S2)

In terms of a drug change in response to MDT a psychologist from the category C prison said,

"What I'm getting from inmates is yes it is, where there were little pockets of crack users and heroin users around, now it's much more widespread. People are turning more to opiate based drugs, you know pain killers and stuff like that than cannabis because they know it's out of their system a lot quicker. What seems, from what I was picking up staff will not acknowledge this, particularly the drug testing and stuff will not acknowledge it, but the proportion seems to be steadyish maybe slightly increasing towards opiate finds, I think opiate finds in terms of searching has started to go up slightly, umm and they're not making the connection. I mean if you're getting a higher proportion of opiate positives tests to me it stand to reason it be a vast amount more being used because it's out of their system so quickly whereas cannabis is not really changing very much, maybe going down slightly."

(P21)

This perceived shift in drug use because of MDT was described by a drug counsellor as misplaced,

"When an inmate comes up to me and says something along the lines of, you're making me use opiates because the cannabis can be detected for up to 28 days and opiates can only be detected for three days, this is symptomatic of addiction. Only somebody who can't conceive of actually facing life without some sort of mood altering chemical in their system would actually come up with a statement like that. If they were a social drug user, who just occasionally used cannabis they'd go, sod it, they'd be annoyed and they'd knock it on the head, or they would make an informed decision as to whether they wanted to risk the consequences."

(DC17)

4.4 SUMMARY OF ANALYSIS

The results of the interviews with staff show that HIV and hepatitis B and C prevention is a complex issue in a prison environment. The policies explored are the harm reduction measures provided in other non-hospital community settings. The introduction of these policies in prisons would establish a principle of equivalence of health care. However, the staff had deep misgivings about needle exchanges and

bleach provision for cleaning intravenous drug equipment. The concerns centred on the conflicts staff described with their legal and security role and the conflict with the drug strategy aimed at stopping illicit drug use in prisons. The community harm reduction measures also have the long-term goal of stopping illicit drug use; however, these strategies also accept that a reliance on interventions encouraging abstinence from drug use is impractical and therefore in recognition of the compelling public health demands of preventing HIV and hepatitis B and C these policies have become accepted as standard health care practice (Rhodes 1994a).

Condom provision in prison was less controversial in terms of the current policy, which provides condoms on prescription from the health care centre. However, there seemed to be little take up of condoms by prisoners and there was little recognition of the need for strengthening this policy because prisoner same sex relationships were not apparent and not considered to be commonplace.

4.4.1 THE PREDOMINANT CONCERN

The predominant concern of the participants, particularly the discipline staff, is that the prevention policies discussed in the interviews are to do with sex and drug misuse; activities considered criminal within the prison environment. The behaviours and associated behaviours are generally met with disciplinary measures and not health measures. The drug strategy has wide endorsement from the participants although as stated by MacDonald (1997) the focus of the policy is on testing and restricting supply and there is less effort directed towards treatment. Some participants in this study echoed this view. There were descriptions of impressive staff initiatives, particularly the opiate detoxification programme in the local prison, the therapeutic community in the young offender institute and the substance-free unit in the category C prison; however, these initiatives depended on individual staff and governors to take them forward and are not part of a comprehensive policy framework.

Staff were supportive of Mandatory Drug Testing, even with its apparent unintended policy consequences, because it is valued for its immediate objective of 'stamping out drug use'. However, the long-term aim of many of the harm reduction strategies also has the same objective of reducing and stopping illicit drug use. Community drug policy also encompasses the public health short-term aim of preventing the

transmission of blood-borne virus infection. Therefore, broadening the focus of the approach to the prison drug strategy to recognise the importance and place of the associated public health issues may be helpful. Based on the evidence from this study there would have to be a recognition that a shift in attitude would take a great deal of preparatory work in terms of education and training which would ideally be achieved in conjunction with the community drug agencies and sexual health advisors.

Preventive health behaviour change in individuals or organisations can take many years; this change has been described by Sexton (1997) who outlined the process of prevention, and has also been described in models such as the Transtheoretical Model of Change. Change of this magnitude would require strategic direction and commitment, particularly in terms of finance for development, education and maintenance of policies. Currently the responsibility for health care lies with the governors and therefore prevention, which has long term outcomes, may suffer when competing against other more immediate service issues.

If a prisoner has an addiction, which in some way may relate to his or her criminal behaviour but is unable to access equivalent addiction services, then rehabilitation is harder to achieve. As some staff indicated, prison can be viewed as an opportunity to help with addiction alongside developing other life skills such as literacy and anger management.

4.4.2 KNOWLEDGE AND TRAINING

Most participants expressed concern about the lack of updated and ongoing training. In addition, concern was expressed by many at the lack of hepatitis training generally and specifically hepatitis C training.

The participants reported high levels of drug taking in prisons; therefore, it would seem prudent to suggest that trained addiction staff and sexual health advisors be employed to work in prisons and also to take on some responsibility for staff training and raising levels of awareness about the principles of the addiction policies. Health care staff in post seemed to have little input into training and support in these areas.

4.4.3 PREVENTION OF SEXUAL TRANSMISSION

Most participants were happy to continue to have condoms supplied on prescription through the health care centre. However, the staff at the young offender institute were generally very concerned about the legal age of consent and therefore a policy had not been discussed and developed. In the category C prison condom uptake by prisoners was limited to one or two people and condoms had not been issued at all in the local prison and the young offender institute.

Some prison officers talked about the moral aspects of same sex sexual activity; however, most reported concerns with legal and security issues which they talked of in terms of being problematic for their discipline and security role. Staff generally seemed unaware of the 'Dear Doctor' letter in terms of it clarifying the legal position. The staff felt much more comfortable with the health care staff issuing condoms than them being freely available in the wings. This may be a result of the confusion about the legal position or it may be attributable to the perceived threat to security. However, illicit drugs are currently concealed and smuggled effectively without condoms therefore, better provision of condoms would possibly have very little impact on this situation.

4.4.4 PREVENTION OF PERCUTANEOUS TRANSMISSION

Opiate detoxification was generally well accepted because of its congruence with the current drug strategy approach to drug misuse in prisons.

The majority of discipline and health care staff described difficulties with a needle exchange scheme. However, the concerns expressed by staff were remarkably similar to the concerns expressed by staff at Hindlebank Prison before the needle exchange scheme was introduced; a difficulty principally with the apparent incompatibility of this preventive health measure with the illegal status of drugs. In the evaluation of the Hindlebank pilot the fears expressed with regard to increased consumption of drugs and the use of syringes for weapons were not confirmed (Nelles & Furhrer 1995). However, the strength of feeling of staff and the current political climate should not be ignored and decisions about a needle exchange in prison may have to wait until there is a change in attitudes that incorporates a greater emphasis on treatment of drug misuse, equivalent to that available in the community, where there is an acceptance and understanding of the public health role.

Most participants also had similar conflicts about the acceptance of drug misuse in prisons when bleach distribution was discussed. Some mentioned the uncertain effectiveness of bleach. In other community settings the advice with regard to bleach is that its effectiveness should not be relied on and it should only be used as a last resort. Therefore, it becomes ethically difficult to advocate bleach in a prison setting without having a more comprehensive prevention programme incorporating a needle exchange. It is possible that prevention policy could be approached in piecemeal way, which would be one way of moving policy forward; each policy paving the way for the next. However, given the limitations of bleach, a policy incorporating bleach should only be implemented as part of a more comprehensive policy structure, even if implementation of the whole policy is planned over a period of time.

There is clearly a need for careful consideration of the balance between security and public health in a prison environment; however, as previously stated, the AIDS Advisory Committee (1995) recommends a more enlightened use of discipline in this area of policy so that treatment becomes the preferred response rather than a disciplinary response. A shift in the way these prevention issues are perceived will then pave the way to working through some of the complexities that may then lead to the adoption of the principle of equivalence of preventive health care.

4.4.5 EVALUATION OF INTERVIEWS

The interviews went well and participants were generally eager to discuss HIV and hepatitis B and C prevention in prisons. The exploration of the prevention issues across different categories of prison highlighted some important differences that may influence the acceptance and development of policy.

4.4.2 PROBLEMS ENCOUNTERED

There was one difficulty encountered in study one; in the prison where the research was not introduced to staff at a staff meeting there was less understanding about how the research would be conducted. This led to initial problems with the length of time allocated by the prison for staff interviews and the numbers of staff available for interview when the researcher visited the prison. The difficulty was quickly resolved when the researcher discussed the research with the security officer.

4.5 CONCLUSION

It will be valuable to further explore some of the apparent differences between the prisons found in study one; such as, the difficulties with the legal age of consent in the young offender institute and the differences described in drug taking in the three prisons. In addition, it would be valuable to explore in a more systematic way the perceived influence of staff and public attitudes on the development of policy and the willingness of staff to implement any of the policies discussed.

These issues were therefore incorporated in the questionnaire study in the second phase of the research.

CHAPTER 5

Study Two: Staff Questionnaire

This chapter outlines the design, sampling procedure, analysis and results of the staff questionnaire. The main findings arising from the analyses are highlighted for inclusion in the main discussion in Chapter Seven.

5.1 DESIGN OF STAFF QUESTIONNAIRE

The design of the questionnaire was guided by two considerations; firstly, and foremost, the aim of the questionnaire was to explore on a larger sample of prison staff the key themes that emerged from the qualitative staff interviews. The second influence on the design was the theoretical model, the Theory of Planned Behaviour. This model was selected retrospectively to the qualitative analysis because of its fit with the themes that emerged from the interviews; the model was not used in a formal sense, but the dimensions were useful in selecting items to include on the questionnaire. The themes that arose from the qualitative analysis have implications for education, training and shaping policy development. Therefore, the following research questions were developed:

- What are the training needs of staff and are there particular training issues?
- How do the staff perceive the prevalence of infection of HIV and hepatitis B and C and what is the perception about the level of risk behaviour?
- What are the staff attitudes towards preventive policy issues relating to condoms, bleach, needle exchange, detoxification, drug-free areas and mandatory drug testing?
- How do the staff believe policy development in this area could and should proceed?

These research questions influenced by the design perspectives are the basis of the questionnaire outlined in appendix 2.

5.2 THE QUESTIONNAIRE

The questionnaire comprised two distinct sections; the first comprised biographical details, a section to identify some knowledge issues specifically applying to a prison situation, and a section designed to highlight identified training needs. The second section of the questionnaire comprised statements derived from the data from the staff qualitative interviews; these were developed into a study instrument that included Likert-scaled statements. The Likert-scales addressed the most common themes arising from the staff interviews; occupational risk, condom access, needle exchange, bleach provision for cleaning intravenous drug equipment, opiate detoxification, Mandatory Drug testing and beliefs about how policy development on these issues could proceed in prisons. Within each of these thematic scales the components of the Theory of Planned Behaviour helped organise and construct the scale; thus sub-scales exploring the following constructs were developed:

- attitudes towards the policy measures identified
- the subjective norm, which is how the participant perceives specific significant others' preferences about the policies termed normative beliefs
- behavioural intention towards policy measures explored
- perceptions of control over policy development (Conner & Sparks 1996).

Three additional emergent themes were explored in the Likert-scale. The first to discover whether the respondent believed that there was indeed risk behaviour to warrant the particular prevention measure. The second to explore respondent beliefs about the impact of the policies in terms of reducing the transmission of HIV, hepatitis B and hepatitis C and the third was concerned with views about who should manage prevention policies in prison.

5.2.1 PILOT TESTING THE QUESTIONNAIRE

The questionnaire was pilot tested on four staff in two prisons, they were asked to assess the questionnaire for the following:

- how long it took to complete the questionnaire
- if the language was simple and understandable

- if there were any ambiguous statements
- face validity; if on the face of it the questionnaire was framing appropriate and relevant statements
- content validity; if in their judgement the questionnaire covered all the relevant issues about HIV and hepatitis prevention in prisons.

Following the pilot phase, a revision of the questionnaire was made to cover the issues raised. A statement was added to cover health care staff and discipline staff jointly managing prevention policy. Some minor alterations were made to the layout and wording to improve the layout and clarity of the questionnaire. The timing for completing the questionnaire was judged to be approximately 20 minutes.

5.3 PARTICIPANTS

A random stratified sample of prison staff were selected from seven prisons. Two prisons each were randomly selected from a list of category C prisons, a list of category B local prisons and a list of young offender institutes in England and Wales. An additional category B local prison was selected because the Governor from one of the prisons selected from this category said that only 18 questionnaires could be distributed. The staff were selected to give a representation of the main categories of discipline and health care staff within the individual prisons.

The characteristics of the study population in terms of job description are shown in Table 5.1.

Table 5.1 Job title of participants

JOB TITLE	FREQUENCY	PERCENT OF SAMPLE
Governor	5	2.7
Principal officer	11	6.0
Senior officer	31	17.0
Basic grade officer	90	49.5
Officer support grade	13	7.1
Doctor	2	1.1
Nurse	6	3.3
Health care officer	5	2.7
Health care manager	1	0.5
Administration staff	5	2.7
Educational staff	8	4.4
Probation staff	3	1.6
Psychologist	1	0.5
Drug worker	1	0.5
Total	182	100

Table 5.1 displays the job title of the respondents, about half of the sample were basic grade officers, which would appear appropriate, because basic grade prison officers are the largest part of the workforce.

The gender, years of prison work experience and age range of the study population are shown in Table 5.2.

Table 5.2 Description of sample; gender, job experience and age range

SAMPLE CHARACTERISTIC	DESCRIPTION	NUMBER	TOTAL
Respondents' Gender	Males	147	182
	Female	35	
Years of prison experience	Up to 5 years	58	182
	6 - 10 years	62	
	11+ years	62	
Age Range	20-30 years	26	182
	31-40 years	64	
	41-50 years	57	
	51-65 years	34	

Table 5.2 shows the distribution of males to females and the age range of the sample. There are many more male respondents than female respondents however, there are very many more male officers than female. The prison employment experience of respondents is relatively evenly distributed. 66% of the sample were aged between 31 and 50 years old.

5.4 PROCEDURE

Table 5.3 Distribution method for questionnaire

PRISON	CATEGORY	NUMBER Q'S	DISTRIBUTION
A	YOI	207	Addressed-all staff
B	YOI	150	Addressed-random selection
C	C	120	Via Liaison
D	C	120	Via Liaison- unnamed
E	B Local	130	Via Liaison- unnamed
F	B Local	18	Via Liaison - unnamed
G	B Local	150	Addressed - random selection

Different distribution approaches were used for the questionnaires because the prisons responded in different ways to the researcher's request for questionnaire distribution. The first point of contact in each randomly selected prison was the Governor. Each Governor was asked to identify a contact person in the prison who would be responsible for liaison with the researcher to identify a stratified sample of the staff and to enable the distribution of the questionnaire. The identified liaison person in each prison was contacted by telephone and in some instances agreed for the questionnaire to be distributed in individually addressed envelopes. However, in other prisons the identified liaison person was unable to facilitate this method of distribution saying it was administratively difficult and therefore suggested ways that would be acceptable within their own prison's operational policies. In one prison a greater number of questionnaires was distributed because the only staff list that could be provided did not identify the different jobs and disciplines of the staff. In other

prisons the liaison member of staff said that distribution would be achieved by putting an unmarked letter into each staff pigeonhole; sometimes only an estimate of the number of staff could be given. Therefore, the response rate is an approximation because the true rate of distribution is unknown.

A covering letter explaining the study and a freepost return envelope was included in the questionnaire package. A guarantee of confidentiality and anonymity was given. The letter stated the study was funded by a Department of Health studentship and not funded or managed by the Prison Service. Respondents were informed in the letter that completion of the questionnaire was mainly in tick box format and that it would take approximately 20 minutes.

Table 5.4 shows the response rate for each security category of prison involved in the study.

Table 5.4 Response rate by categories of prison

PRISON	TYPE	Q'S	RESPONSE
A and B	YOI	357	18% n= 67
C and D	C	240	19% n=46
E, F and G	B Local	298	23% n=69

The overall response rate for the questionnaire was 20%, n = 182.

5.5 RESPONSE RATE

895 questionnaires were distributed and 182 questionnaires were returned giving an overall response rate of 20%. A covering letter was sent with the questionnaire explaining the importance of the study and stating that the respondent's individual

response was important to be able to help influence and develop important preventive policy. Assurances of confidentiality and anonymity were given. Two reminder letters were sent in an attempt to maximise the response rate. Additionally, a prize draw with six voucher prizes was offered as an incentive to participate in the study, a £25 voucher as first prize and five £5 vouchers. It was clearly stated in the covering letter that the aim of the prize draw was a token to acknowledge the person's time and effort for completing the questionnaire.

The apparent poor response rate may demonstrate a respondent bias (Sackett 1979). Several reasons could be surmised for this kind of bias operating; firstly, it may have been that those staff who are interested in policy issues in general responded, or, secondly, it may have been those staff who are interested in issues concerning HIV and hepatitis issues may have responded. It is difficult to identify if and why a bias of this nature could have been operating because the guarantee of anonymity prevented comparison of responders with non-responders. However, it must be acknowledged that it may also reflect the difficulties within this study of ensuring effective distribution. On contacting the liaison contact after distribution, one person said that distribution was difficult because some staff were on long-term sick leave and some staff had left. One liaison officer had left the prison so there were no feedback comments from that particular prison, one liaison officer stated that he had distributed three other questionnaires at around about the same time and therefore as far as he could recall the questionnaires had gone out without problem, but the distribution of three questionnaires within a relatively short period of time may have affected the response rate.

5.6 ANALYSIS OF THE QUESTIONNAIRE

Data from 182 questionnaires were entered for analysis. The questionnaire was analysed using the Statistical Package for the Social Sciences (SPSS).

Descriptive statistics were used to describe the population, frequencies of agree, disagree and undecided and the responses to statements related to risk.

Likert-scaled responses were analysed for group means and standard deviations to display the trend of response for the total sample. The seven positions on the Likert scale were scored 1-7 (very strongly agree (1), to very strongly disagree (7)).

Chi-square tests (χ^2) was performed on Likert-scaled data to compare the responses for the predictor variables. The predictor variables of type of prison, job discipline and age ranges were postulated to affect the responses about policy statements. In order to apply the χ^2 test for the predictor variables the Likert responses (1= very strongly agree, 2 = strongly agree, 3 = agree, 4 = undecided, 5 = disagree, 6 = strongly disagree, 7 = very strongly disagree) were collapsed into three categories of agree (1-3), undecided (4) and disagree (5-7), for analysis. Where the expected values in any table fell below 5 it was reported in the results, however if more than one-fifth of the cells had an expected value below 5 apparent significant results were not reported (Swinscow 1986).

The job title of respondents were aggregated into three categories for analysis; prison discipline staff (1), health care staff (2), and other staff (3). It should be noted that these categories of staff are not equally distributed, there were 150 prison discipline staff, 14 health care staff and 18 other staff.

The reliability of the attitude scales and the normative belief scales were measured for internal consistency of items using Cronbach's alpha. All of the attitude and normative belief scales had acceptable alpha scores, a score should be above 0.70 but probably no higher than 0.90 (Streiner & Norman 1995). The scores will be reported in the thesis corresponding to the appropriate scale. The alpha was also calculated when each statement on the scale was removed, however there was little change in the composite score, indicating that no items were redundant to the scales; therefore, only the composite score will be reported in the thesis.

5.7 RESULTS

5.7.1 PREVENTION SERVICES CURRENTLY IDENTIFIED

Table 5.5 presents the respondents' views of the HIV and hepatitis prevention services currently available at their own prison. The Table presents in descending order the yes responses to the statement; "Does your prison offer the following services for Prisoners".

Figure 5.5 Number responding positively to the question, "Does your prison offer the following services for Prisoners?"

TYPE OF SERVICE	CAT B	CAT C	YOI	TOTAL
Education and information about HIV	57	43	57	157 (86.7%)
Leaflets and posters about HIV	60	42	52	154 (85.1%)
Education and information about hepatitis	46	37	51	134 (74%)
Leaflets and posters about hepatitis	46	34	40	120 (66.3%)
Drug-free areas	15	44	37	96 (53%)
Drug-free therapeutic community	5	33	25	63 (43.8%)
Detoxification on entry with other <u>prescribed drugs</u>	35	4	20	59 (32.4%)
Confidential access to condoms <u>managed by health care staff</u>	15	16	19	50 (27.6%)
Maintenance therapy with other <u>prescribed drugs</u>	27	4	15	46 (25.6%)
Detoxification on entry to prison with <u>prescribed Methadone</u>	32	2	11	45 (24.9%)
Maintenance therapy with prescribed <u>Methadone</u>	18	4	8	30 (16.5%)
Confidential access to condoms <u>managed by discipline staff</u>	3	9	5	17 (9.4%)
Confidential access to condoms <u>managed by health care and discipline</u>	3	8	4	15 (8.4%)
Bleach provision for cleaning needles <u>managed by health care staff</u>	2	1	1	4 (2.2%)
Needle exchange scheme	1	0	0	1 (0.6%)
Bleach provision for cleaning needles <u>managed by discipline staff</u>	1	0	0	1 (0.6%)
Bleach provision for cleaning needles <u>managed by health care and discipline</u>	0	1	0	1 (0.6%)

These views may not reflect the actual provision; services available may be higher or lower than those reported. However, the perceived level of bleach, needle exchange, condoms and Methadone provision fall below 25%, whereas, educational materials and drug-free areas are at the top of the table with reported provision above 50%. Drug-free therapeutic communities are a more specialist provision; however, 43.8% stated that they had a therapeutic community in their prison.

5.7.2 CLEANING INTRAVENOUS DRUG EQUIPMENT

Table 5.6 Response to statements: "Intravenous drug users can protect themselves from HIV by washing out shared 'works' with water before using them" and to the same statements used to ascertain the response to washing with water for protection against hepatitis B and hepatitis C and, in addition, to the same statements relating to the protective effects of bleach against HIV, hepatitis B and hepatitis C viruses

AGENT USED FOR CLEANING IDU	TYPE OF VIRUS	% AGREE	% UNDECIDED	% DISAGREE
Water	HIV (n=179)	12.3%	11.2%	76.5%
	Hepatitis B (n=179)	6.7%	13.4%	79.9%
	Hepatitis C (n=178)	6.2%	16.9%	77%
Bleach	HIV (n=180)	44.4%	27.7%	27.8%
	Hepatitis B (n=181)	42.5%	29.8%	27.6%
	Hepatitis C (n=180)	40%	31.1%	28.9%

The data in Table 5.6 relate to the benefit of using particular agents to clean shared intravenous injecting equipment. Water has no virucidal properties and therefore should not be considered as a safe practice. Bleach has virucidal properties and has been considered as the disinfectant of choice for HIV decontamination of injecting equipment, but its virucidal action against hepatitis B and C is uncertain. Research demonstrates that bleach cannot be relied upon as a complete and safe virucidal for

syringe decontamination (see literature review heading 2.6 'Chemical disinfection for injecting equipment'). However, cleaning syringes does have a recognised place in harm minimisation providing it is viewed as part of a larger prevention programme and its uncertain effectiveness is made explicit to the intravenous drug user.

Responses to the statement clearly indicated that staff felt more indecision about the protective effects of bleach.

The mean response (1 = very strongly agree, 7 = very strongly disagree) for the whole sample for each of these statements is as follows:

- Intravenous drug users can protect themselves from HIV by washing out shared 'works' with water before using them - mean 5.33 (SD 1.63).
- Intravenous drug users can protect themselves from hepatitis B by washing out shared 'works' with water before using them - mean 5.45 (SD 1.48).
- Intravenous drug users can protect themselves from hepatitis C by washing out shared 'works' with water before using them - mean 5.43 (SD 1.46).
- Intravenous drug users can protect themselves from HIV by washing out shared 'works' with bleach before using them - mean 3.82 (SD 1.74).
- Intravenous drug users can protect themselves from hepatitis B by washing out shared 'works' with bleach before using them - mean 3.85 (SD 1.69).
- Intravenous drug users can protect themselves from hepatitis C by washing out shared 'works' with bleach before using them - mean 3.91 (SD 1.65).

The responses to the statement for different disciplines were aggregated into three categories and the results are outlined in Table 5.7.

Table 5.7 Response to the statements: "Intravenous drug users can protect themselves from HIV by washing out shared 'works' with water before using them" and to the same statements used to ascertain the response to washing with water for protection against hepatitis B and hepatitis C and, in addition, to the same statements relating to the protective effects of bleach against HIV, hepatitis B and hepatitis C viruses - statements analysed by job discipline

BELIEFS ABOUT CLEANING 'WORKS'	DISCIPLINE STAFF % RESPONSE			HEALTH CARE STAFF % RESPONSE			OTHER STAFF % RESPONSE	
		Water	Bleach		Water	Bleach		Water
Very strongly agree, strongly agree, agree	HIV	14.2	43.2	HIV	0	71.4	HIV	5.6
	Hep B	7.4	40.9	Hep B	0	71.4	Hep B	5.6
	Hep C	7.5	39.9	Hep C	0	57.1	Hep C	0
								27.8
Undecided		Water	Bleach		Water	Bleach		Water
	HIV	9.5	26.4	HIV	23.1	14.3	HIV	16.7
	Hep B	12.8	28.9	Hep B	15.4	14.3	Hep B	16.7
	Hep C	16.3	30.4	Hep C	15.4	14.3	Hep C	22.2
Very strongly disagree, strongly disagree, disagree	HIV	76.4	30.4	HIV	76.9	14.3	HIV	77.8
	Hep B	79.7	30.2	Hep B	84.6	14.3	Hep B	77.8
	Hep C	76.2	29.7	Hep C	84.6	28.6	Hep C	77.8
								22.2

The χ^2 test did not reveal statistically significant differences between the groups for job discipline. Health care staff correctly identified that water was not an effective decontamination agent for intravenous injecting equipment. However, a high number of health care staff agreed, strongly agreed or agreed with the statement regarding

the effectiveness of bleach as a decontamination agent for HIV and hepatitis B and to a lesser extent, but still eliciting the majority response for hepatitis C.

5.7.3 STAFF VIEW OF OCCUPATIONAL RISK

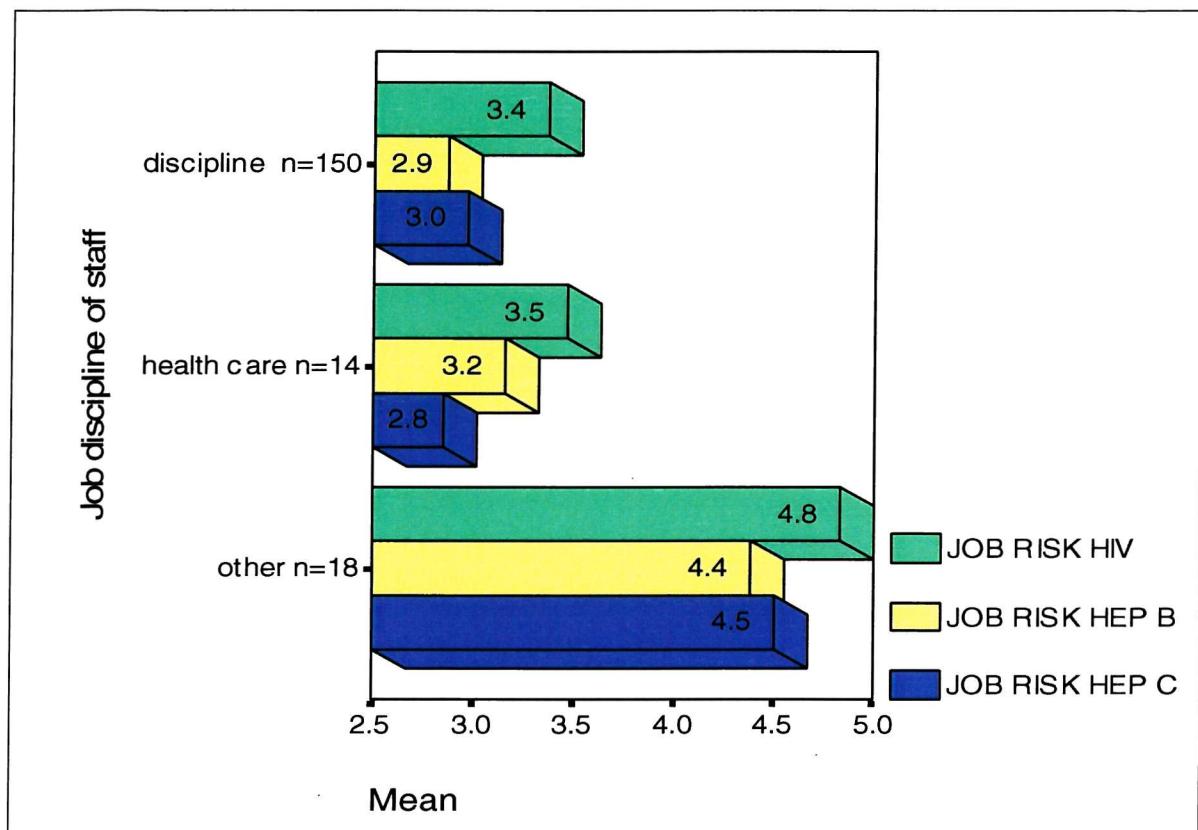
The whole sample mean response to the statements regarding the occupational risk of virus transmission is outlined below, (1 equates to very strongly agree and 7 relates to very strongly disagree):

- I feel that my job puts me at high risk of contracting HIV compared to other non-medical jobs - mean 3.53 (SD 1.63).
- I feel my job puts me at high risk of contracting hepatitis B compared to other non-medical jobs - mean 3.04 (SD 1.52).
- I feel my job puts me at a high risk of contracting hepatitis C compared to other non-medical jobs - mean 3.09 (SD 1.40).

56.6% of staff, mean 3.53 (SD 1.63), very strongly agreed, strongly agreed or agreed that their job put them at high risk of HIV. 72.5%, mean 3.04 (SD 1.52), very strongly agreed, strongly agreed or agreed that they felt that their job put them at high risk of hepatitis B and 68.9%, mean 3.09 (SD 1.40), of staff very strongly agreed, strongly agreed or agreed that their job put them at very high risk of hepatitis C.

χ^2 test was applied to the predictor variables of age range and type of prison and did not reveal statistically significant results. The variable job discipline was aggregated into three categories of health care staff, discipline staff and other staff to enable analysis. However, differences in group size for the number of responses for job discipline, resulted in more than one-fifth of cells falling below the expected count of five therefore the χ^2 test result will not be reported statistically.

Figure 5.1 Response to the statements: "I feel my job puts me at high risk of contracting HIV compared to other non-medical jobs" and "I feel my job puts me at high risk of contracting hepatitis B compared to other non-medical jobs" and "I feel my job puts me at high risk of contracting hepatitis C compared to other non-medical jobs" - statements analysed by job discipline



However, figure 5.1 demonstrates that there was relatively little difference in the means between health care staff and discipline staff. 'Other' staff showed a higher disagreement with the statements but this was probably because they were less in direct daily contact with prisoners.

5.7.4 COMPULSORY TESTING OF PRISONERS

The response to the statement, 'Compulsory testing of prisoners for HIV and hepatitis on reception would not be helpful', elicited a tendency to disagree with the statement, mean 4.31 (SD 1.81) where 1 is equal to very strongly agree and 7 is equal to very strongly disagree. There are strong human rights and public health arguments against this viewpoint that are discussed in the literature review.

5.7.5 CONDOMS

This section will outline the questionnaire analysis concerning condom policy related beliefs in the following areas:

- 5.7.5.1 attitudes to condoms
- 5.7.5.2 risk behaviour related to condoms
- 5.7.5.3 beliefs about preventive benefits of a condom policy
- 5.7.5.4 normative beliefs regarding condom policy
- 5.7.5.5 management of condom policy
- 5.7.5.6 intention to be involved in condom policy

5.7.5.1 Attitudes to condoms

Figure 5.2 Questionnaire response to statement: "It is a good policy to allow prisoners to have confidential access to condoms"

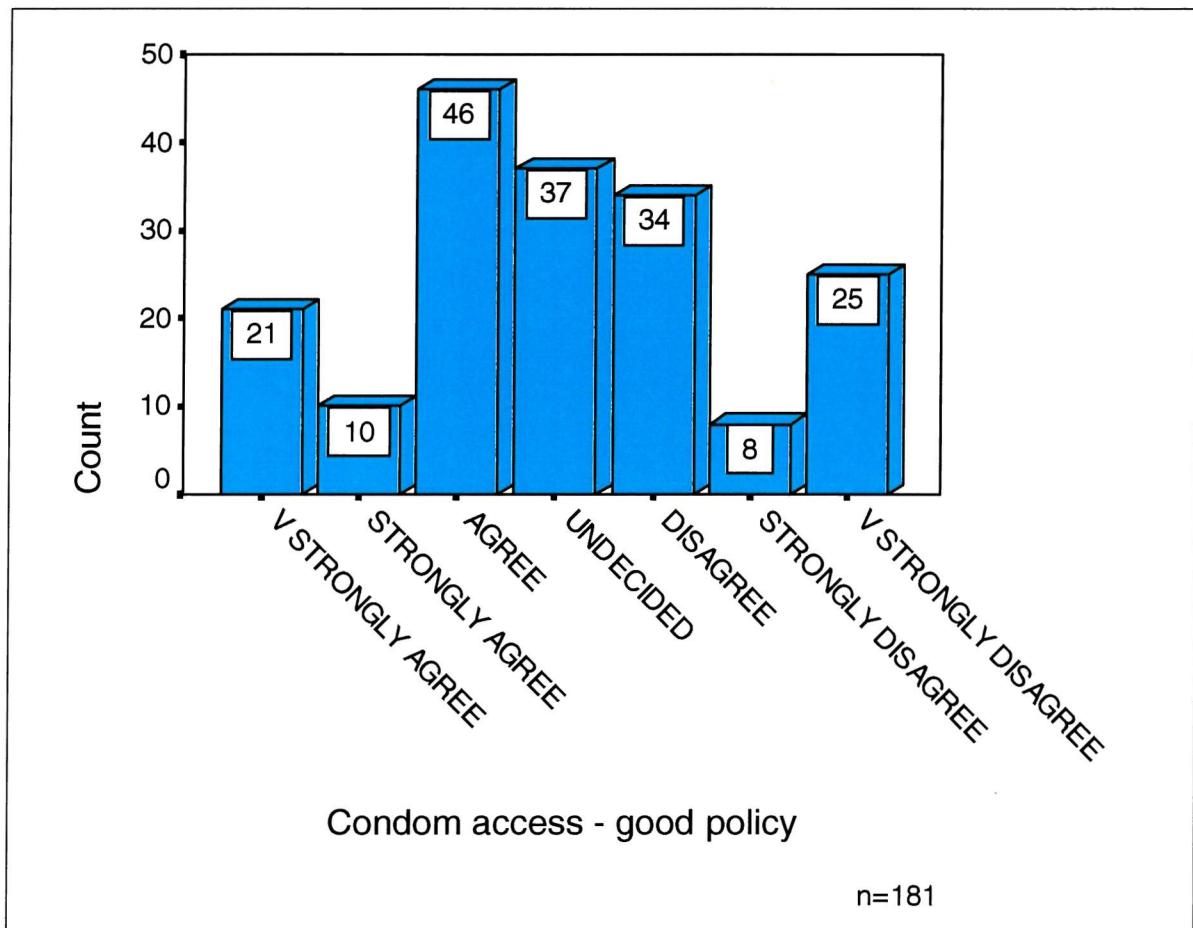


Figure 5.2 shows the response to the statement, "It is a good policy to allow prisoners to have confidential access to condoms for use in prisons", demonstrates a tendency towards clustering around midpoint of the scale, mean 3.98 (SD 1.77), 1 equates to very strongly agree and 7 relates to very strongly disagree. When categories of response were aggregated χ^2 test of association for security category of prison and job discipline a significant association for job discipline and type of prison was shown.

Table 5.8 Response to statement "It is a good policy to allow prisoners confidential access to condoms for use in prison" analysed by types of prison

Response	CAT B LOCAL	CAT C PRISON	YOI	OVERALL %
VSA,SA,A	37.7%	62.2%	34.3%	42.5%
Undecided	18.8%	15.6%	25.4%	20.4%
VSD,SD,D	43.5%	22.2%	40.3%	37.0%
Mean response	4.19 (SD 1.75)	3.24 (SD 1.64)	4.25 (SD 1.77)	3.98 (SD 1.77)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

The response from category C prisons demonstrates a greater acceptance than the response from the shorter stay category B local prisons and the young offender institutes, ($\chi^2 = 10.586$, $df = 4$, $p=0.032$).

Table 5.9 Response to statement: "It is a good policy to allow prisoners confidential access to condoms for use in prison" analysed by job discipline

Response	Discipline staff	Health care	Other	Overall %
VSA,SA,A	36.9%	78.6%	42.5%	42.5%
Undecided	20.8%	14.3%	22.2%	20.4%
VSD,SD,D	42.3%	7.1%	16.7%	37.0%
Mean response	4.23 (SD 1.76)	2.43 (SD 1.34)	3.11 (SD 1.32)	3.98 (SD 1.77)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

There is an association between health care staff and giving a positive response to the policy ($\chi^2 = 13.643$, $df = 4$, $p=0.009$), however, it should be noted that 2 cells have an expected count less than 5. Also that the categories of staff were not equally distributed.

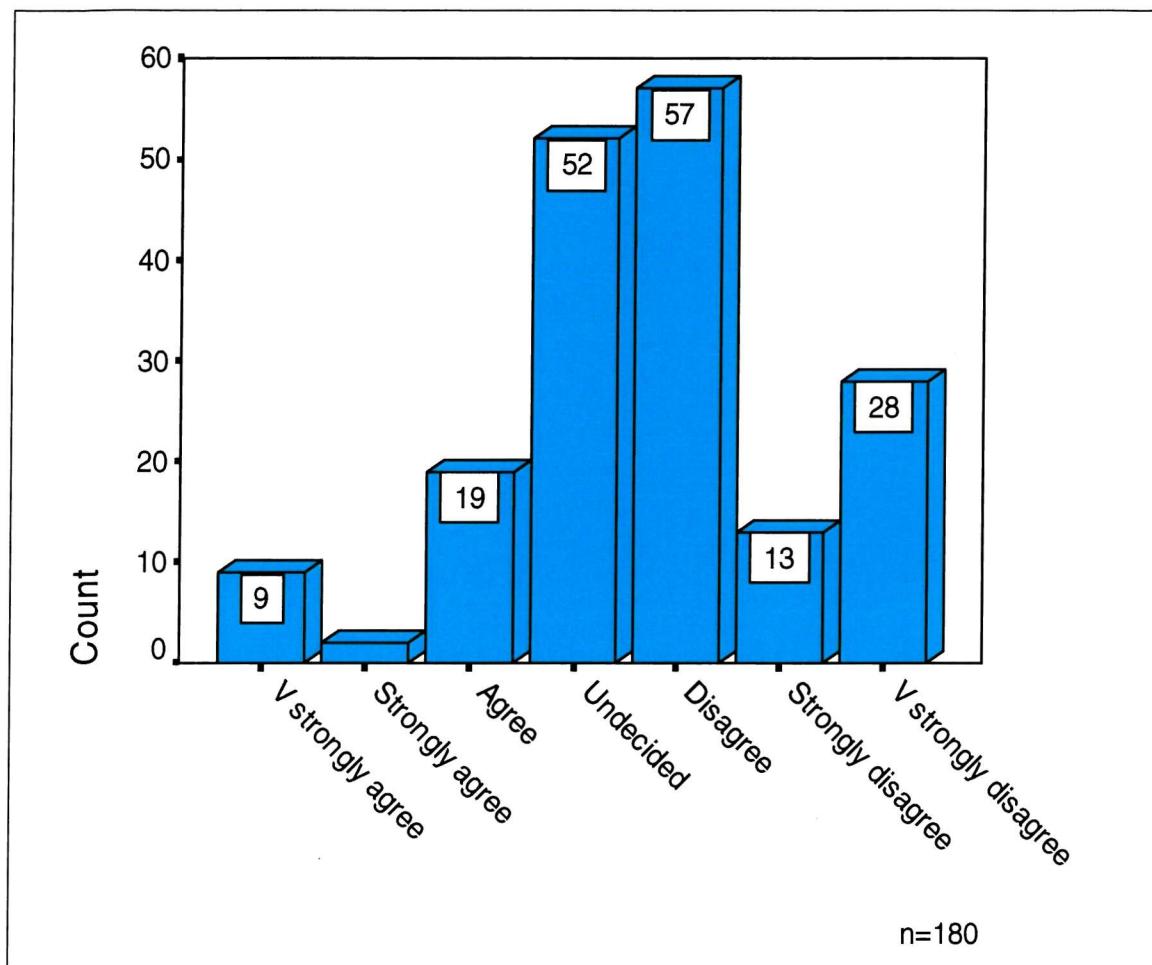
No statistical association was found for age range.

Overall means of other items relating to beliefs about condoms were; condoms compromise security (mean 3.82 SD 1.63), condoms present a conflict for law and order role of prisons (mean 3.66 SD 1.58), condoms cause conflict for discipline and security role of prison officers (mean 3.39 SD 1.58), condoms condone homosexuality (mean 3.59 SD1.73).

Cronbach's alpha for the 5 item scale concerning beliefs about condoms is: $\alpha = .8472$

5.7.5.2 Risk behaviour related to condoms

Figure 5.3 Questionnaire response to "A condom policy is not necessary because same sex sexual activity is not a problem in this prison"



The overall mean response to the statement "A condom policy is not necessary because same sex sexual activity is not a problem in this prison" was 4.65 (SD1.48) where a value of 1 equates to 'very strongly agree' and a value of 7 relates to 'Very strongly disagree'. When the categories were collapsed 16.7% of respondents' very strongly agreed, strongly agreed or agreed with this statement, 28.9% were undecided and 54.4% disagreed with the statement, demonstrating that more staff felt that a policy was necessary because of risk behaviour (see figure 5.3).

Table 5.10 Response to statement "A condom policy is not necessary because same sex sexual activity is not a problem in this prison" analysed by type of prison

Response	Category B local	Category C	YOI	Overall %
VSA,SA,A	7.2%	20.5%	23.9%	16.7%
Undecided	36.2%	27.3%	22.4%	28.9%
VSD,SD,D	56.5%	52.3%	53.7%	54.4%
Mean response	4.97 (SD 1.41)	4.61 (SD 1.24)	4.34 (SD 1.64)	4.65 (SD 1.48)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

A chi-square statistic did not show a significant association by type of prison.

Table 5.11 Response to statement "A condom policy is not necessary because same sex sexual activity is not a problem in this prison" analysed by job discipline

Response	Discipline staff	Health care	Other	Overall %
VSA,SA,A	18.2%	14.3%	23.9%	16.7%
Undecided	30.4%	0%	38.9%	28.9%
VSD,SD,D	51.4%	85.7%	55.6%	54.4%
Mean response	4.54 (SD 1.48)	5.64 (SD 1.45)	4.78 (SD 1.44)	4.65 (SD 1.48)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

No statistical association was identified for job discipline; however, it is interesting to note that although health care staff had a higher rejection of the policy statement (where 1 relates to very strongly agree and 7 equates to very strongly disagree) there was still 14.3% that generally agreed with the statement.

No significant association was found for age range.

5.7.5.3 Beliefs about prevention of virus transmission related to condoms in prison

Table 5.12 Response to the statements; "The provision of condoms in prison would reduce transmission of HIV" and "The provision of condoms in prison would reduce the transmission of hepatitis B" and "The provision of condoms in prison would reduce the transmission of hepatitis C"

Response	HIV (n=181)	Hep B (181)	Hep C (180)
VSA,SA,A	70.7%	64.1%	59.4%
Undecided	19.3%	23.8%	25.0%
VSD,SD,D	9.9%	12.2%	15.6%
Mean response	2.93 (SD 1.33)	3.12 (SD 1.32)	3.24 (SD 1.35)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

The mean response to the statements concerning the provision of condoms reducing the transmission of HIV and hepatitis B and C shows a tendency to agree with the statement; HIV mean 2.93 (SD 1.33), hepatitis B mean 3.12 (SD 1.32), hepatitis C mean 3.24 (SD 1.35), where 1 equates to very strongly agree and 7 relates to very strongly disagree. χ^2 = not significant for type of prison, job discipline and age range.

It should be noted that there is a proportion of respondents who generally disagreed with the statements - 9.9% for HIV transmission, 12.2% for hepatitis B transmission and 15.6% for hepatitis C transmission. A number of reasons could be hypothesised for the disagreement with the policy reducing transmission;

- the sexual rate of transmission of hepatitis C is lower than for HIV and hepatitis B and HIV and any debate about infectivity may have caused confusion, although the percentage agreeing with the statement was lower than for HIV or hepatitis B
- staff may believe that having condoms may not necessarily reduce risk behaviour
- it may be that some staff felt the statement presented a conflict of attitude for them as they may have fundamentally believed that condoms should not be provided in prisons.

Further exploration of this result would be required to understand fully the underlying beliefs.

Figure 5.4 Mean response to statements: "The provision of condoms in prison would reduce transmission of HIV" and "The provision of condoms in prison would reduce the transmission of hepatitis B" and "The provision of condoms in prison would reduce the transmission of hepatitis C" - analysed by type of prison

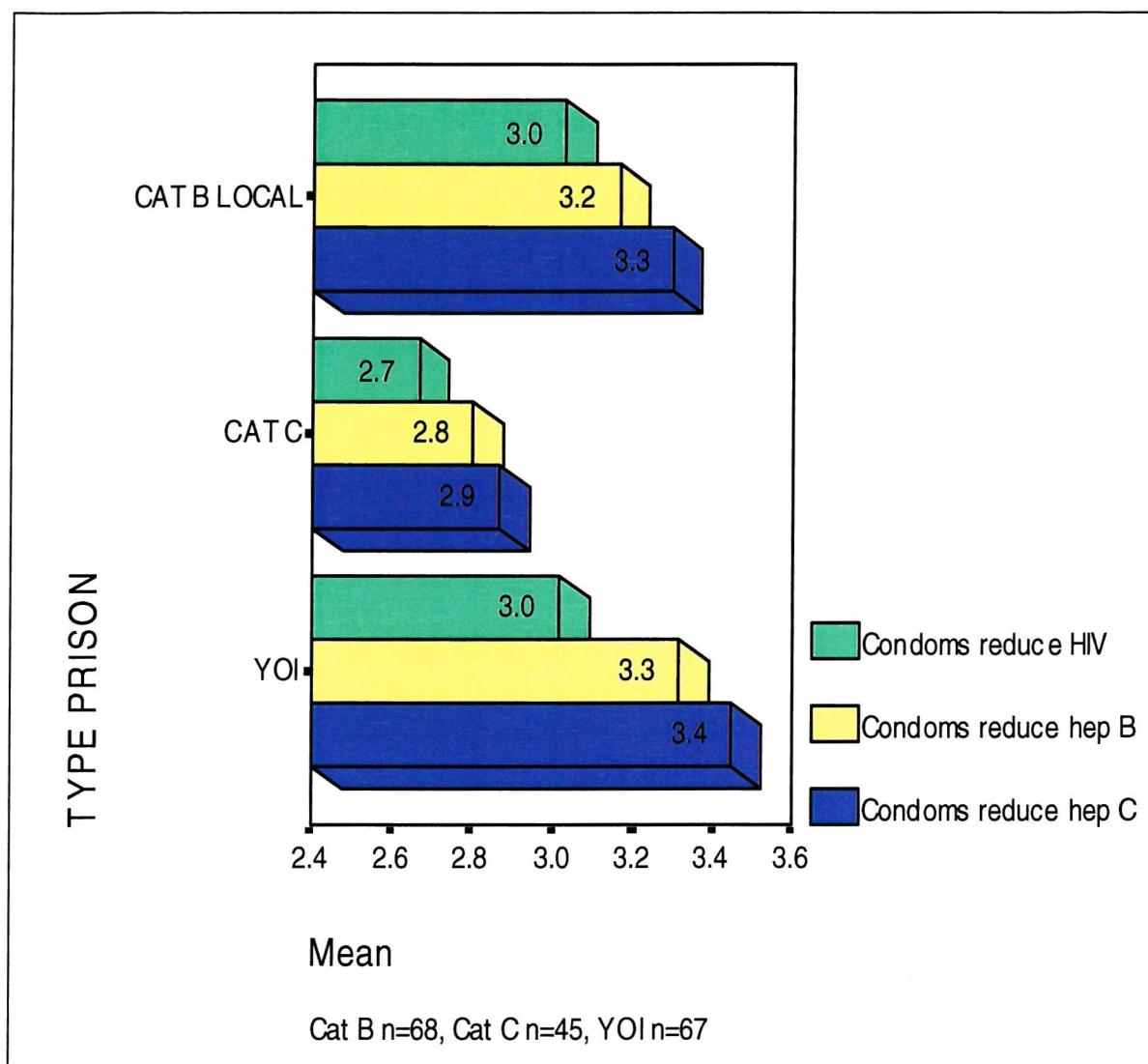


Figure 5.4 demonstrates a positive mean tendency from all prisons to the statements concerning condoms reducing the transmission of the viruses HIV, hepatitis B and hepatitis C although the difference in proportions between the prisons was not statistically significant at the 5 per cent level.

5.7.5.4 Normative beliefs related to condoms

The following section will describe how the respondents perceive the likelihood that certain salient referents view confidential access to condoms for prisoners. The referents were the most commonly identified groups mentioned in the interviews with prison staff; namely, prison officers, prison health care staff, the public and prisoners. The respondent's own view of how favourable the policy is also displayed.

Table 5.13 Response to statements: "The majority of prison officers are in favour of a policy to allow prisoners confidential access to condoms in prison" and "In general prison health care staff are in favour of a policy to allow prisoners confidential access to condoms in prison" and "The general public would be in favour of a policy of confidential access to condoms in prison" and "The majority of prisoners would be in favour of a policy to allow prisoners confidential access to condoms in prison" and finally, "I am in favour of a policy that makes condoms available to prisoners for use within prisons"

Response	PO favour condom policy	HCS favour condom policy	Public favours condom policy	Prisoners favour condom policy	I favour condom policy
VSA,SA,A	13.3%	32.0%	7.8%	33.9%	37.0%
Undecided	32.0%	50.8%	32.8%	33.9%	16.0%
VSD,SD,D	54.7%	17.1%	59.4%	32.2%	47.0%
Mean response	4.73 (SD 1.35)	3.84 (SD 1.02)	5.01 (SD 1.27)	4.05 (SD 1.34)	4.33 (SD 1.72)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree, PO = prison officers, HCS = health care staff

In response to statements about the beliefs of other salient groups to favouring condoms in prisons for prisoners, respondents displayed the greatest level of disagreement with the statement for the general public, the beliefs about prison officers were less rejecting than the general public but nevertheless a rejecting response. Beliefs about health care staff demonstrated a mean slightly more accepting of the statement. The respondents viewed prisoners as having a more neutral response although still displaying the second highest percentage agreement with the statement. The respondents personal response to condoms being available

in prisons for prisoners was overall a rejecting response; however, this was not as rejecting as the beliefs about the general public and prison officers.

Figure 5.5 Response to statements: "The majority of prison officers are in favour of a policy to allow prisoners confidential access to condoms in prison" and "In general prison health care staff are in favour of a policy to prisoners confidential access to condoms in prison" and "The general public would be in favour of a policy of confidential access to condoms in prison" and "The majority of prisoners would be in favour of a policy to allow prisoners confidential access to condoms in prison" and finally, "I am in favour of a policy that makes condoms available to prisoners for use within prisons" - analysed by type of prison

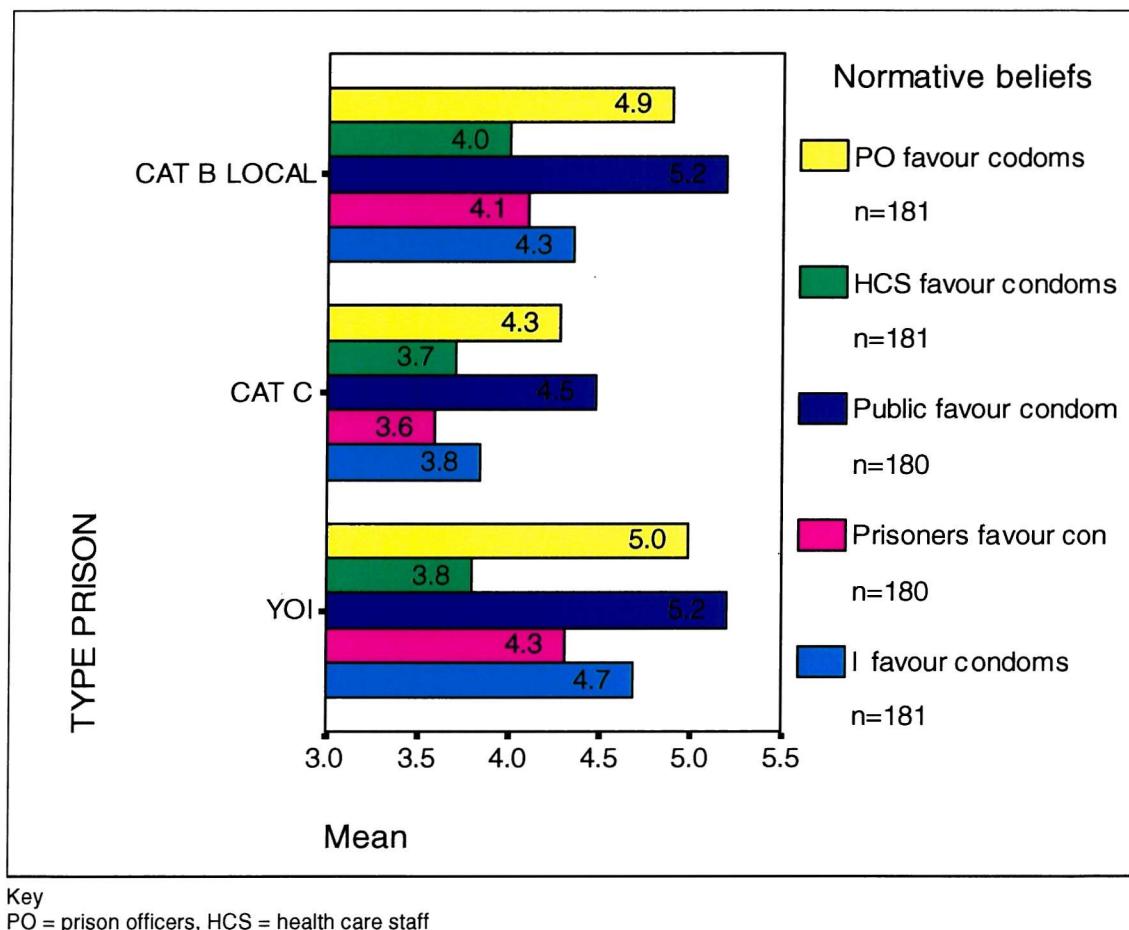
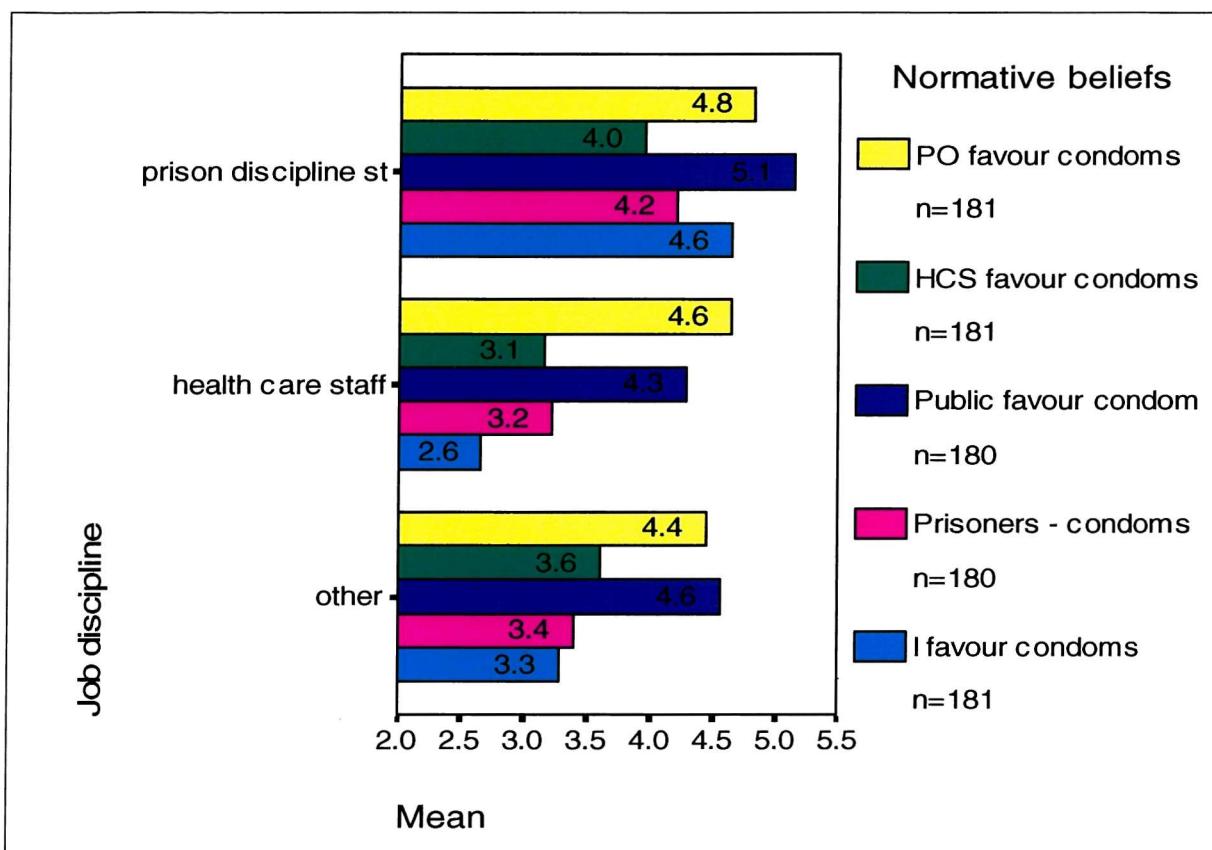


Figure 5.5 displays the mean response by type of prison for all the referents identified. It shows that health care staff are viewed as having a more accepting approach to the statement than the general public who were perceived to have the least accepting response to the statement.

Figure 5.6 Response to statements: "The majority of prison officers are in favour of a policy to allow prisoners confidential access to condoms in prison" and "In general prison health care staff are in favour of a policy to prisoners confidential access to condoms in prison" and "The general public would be in favour of a policy of confidential access to condoms in prison" and "The majority of prisoners would be in favour of a policy to allow prisoners confidential access to condoms in prison" and finally, "I am in favour of a policy that makes condoms available to prisoners for use within prisons" - analysed by job discipline



When the statements were analysed with χ^2 for job discipline (Figure 5.6) it is seen that health care staff viewed themselves to be accepting of the statement: "I am in favour of a policy that makes condoms available to prisoners for use within the prison", mean 2.6. Prison discipline staff saw themselves as least accepting of this statement, mean 4.6. One expresses a very strongly agree and 7 exhibits a very strongly disagree response.

When the statement is analysed with χ^2 for the predictor variables of age range, type of prison and job discipline the following significant results were shown:

Table 5.14 Table showing statistically significant results of the predictor variables towards the normative belief statements: "The majority of prison officers are in favour of a policy to allow prisoners confidential access to condoms in prison" and "In general prison health care staff are in favour of a policy to prisoners confidential access to condoms in prison" and "The general public would be in favour of a policy of confidential access to condoms in prison" and "The majority of prisoners would be in favour of a policy to allow prisoners confidential access to condoms in prison" and finally, "I am in favour of a policy that makes condoms available to prisoners for use within prisons"- χ^2 test

STATEMENT	PREDICTOR VARIABLE	SIGNIFICANT RESULT
Prison officers favour condoms in prison	Type of prison	Category C - $\chi^2 = 11.410$, df 4, p=.022
Health care staff favour condoms in prison	Job discipline	Health care staff - $\chi^2 = 20.820$, df 4, p=.000
General public favour condoms in prison	Type of prison	Category C - $\chi^2 = 11.598$, df 4, p=.021
Prisoners favour condoms in prison	Type of prison	Category C - $\chi^2 = 10.031$, df 4, p=.04

Table 5.14 shows the significant results when the χ^2 test was applied to the predictor variables.

No association with the any of the statements was demonstrated for the predictor variable age range.

To the statement "The majority of prison officers are in favour of a policy to allow prisoners confidential access to condoms in prison" a statistically significant association was demonstrated for category C staff where a greater percentage of that staff group (24.4%) were found to very strongly agree, strongly agree or agree with the statement, compared to 13% of category B staff and 6% of YOI staff $\chi^2 = 11.410$, df 4, p=.022. However, the category C staff group also demonstrated that 37.8% were undecided about the statement and 37.8% generally disagreed with the statement.

The response to the statement, "In general health care staff are in favour of a policy to allow prisoners confidential access to condoms in prison" demonstrated a statistically significant result for health care staff being more likely to very strongly agree, strongly agree or agree with the statement (78.6%) than prison discipline staff (28.2%) or other staff (27.8%) χ^2 20.820, df 4, p=.000.

There was a statistically significant difference in the response for the type of prison to the statement, "The general public would be in favour of a policy of confidential access to condoms for prisoners within a prison". The category C prison responses demonstrated a lower percentage of disagreement to the statement at 40%, whereas the category B response was 63.8% and the YOI response was 68.2% for disagreement. It should be noted however, that one cell had an expected count less than the value of five, (χ^2 =11.598, df 4, p= .021).

In response to the statement, "The majority of prisoners would be in favour of a policy to allow prisoners confidential access to condoms in prison", type of prison demonstrated a statistically significant result. Category C prison responses were more likely to favour this response, 50% agreeing compared with 33.3% of the category B staff and 23.9% of the YOI staff (χ^2 =10.03, df 4, p=. 04).

No significant differences in responses for the predictor variables of type of prison, age range and job discipline were found for the statement " I am in favour of a policy that makes condoms available to prisoners for use within prisons".

The Cronbach's alpha score for the 5 statements in the normative belief scale is: $\alpha = .7873$

5.7.5.5 Management of condom policy

Table 5.15 Response to statements: "If a condom policy were operational inside a prison it should be managed by the prison health care staff"; "If a condom policy were operational within a prison it should be managed by discipline staff; "If a condom policy were operational within a prison it should be managed jointly by discipline and health care staff" and "If a condom policy were operational inside a prison it should be managed by outside agencies"

Response	Health Care	Discipline staff	Health + Discipline	O/S agencies
VSA,SA,A	71.3%	12.8%	29.1%	6.1%
Undecided	14.9%	28.5%	29.6%	17.8%
VSD,SD,D	13.8%	58.7%	41.3%	76.1%
Mean response	3.12 (SD 1.32)	4.69 (SD 1.33)	4.17 (SD 1.41)	5.34 (SD 1.30)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree, O/S = outside agencies

Table 5.15 outlines the frequency of responses to the statements concerning who should manage condom policies in prisons. The mean response clearly favours health care staff managing the condom policy (mean 3.12, SD 1.32, where 1 responds to very strongly agree and 7 to very strongly disagree). The least favourable choice for management of a condom policy is outside agencies (mean 5.34, SD 1.30). There was also a strong rejection of the statement, "If a condom policy were operational inside a prison it should be managed by discipline staff" (mean 4.69, SD 1.33). Joint management of a condom policy by health care and discipline staff was more favourable than discipline staff on their own but still came out with more rejecting responses than accepting of the statement (mean 4.17, SD 1.41).

Figure 5.7 Means responses from statements: "If a condom policy were operational inside a prison it should be managed by the prison health care staff"; "If a condom were operational within a prison it should be managed by discipline staff"; "If a condom policy were operational within a prison it should be managed jointly by discipline and health care staff" and "If a condom policy were operational inside a prison it should be managed by outside agencies"

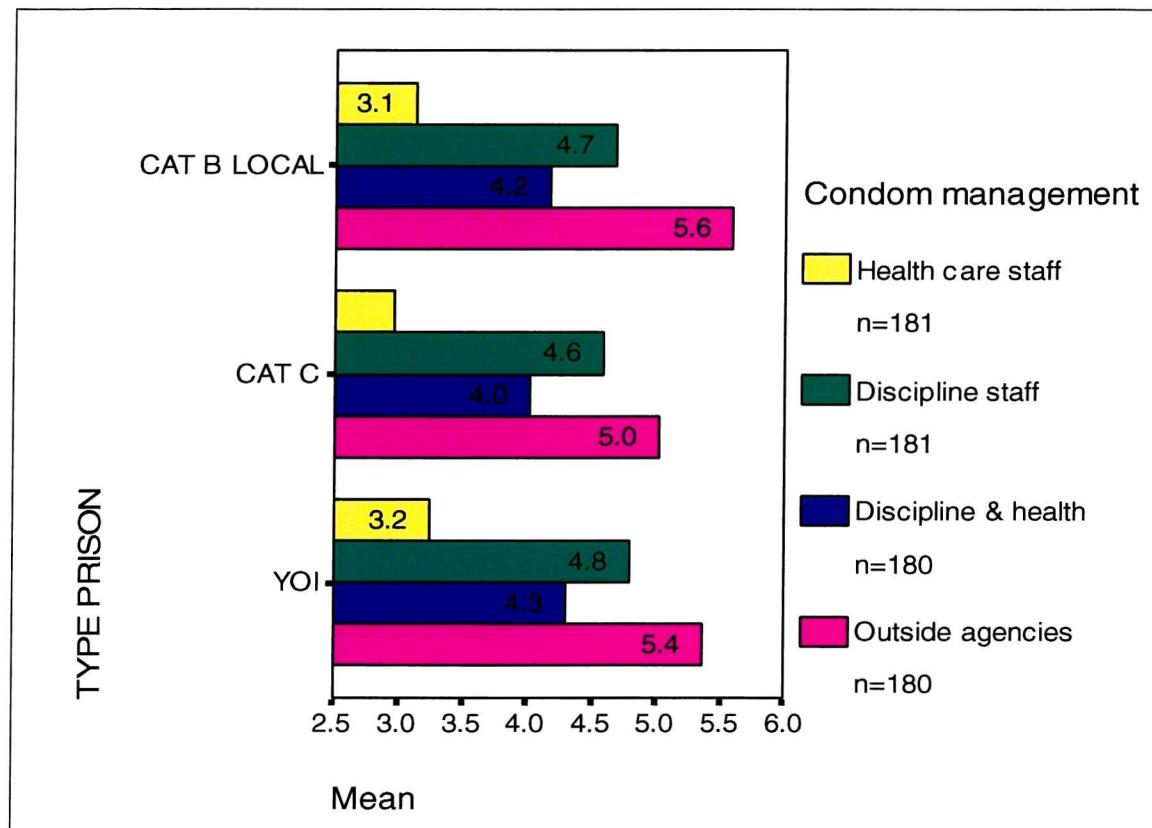


Figure 5.7 displays the mean results by type of prison for the statements regarding who should manage condom policy in prisons. Again, this confirms the picture that health care staff are perceived as the most appropriate group to manage a condom policy with outside agencies perceived as the least appropriate group.

χ^2 test for the predictor variables of age range, job discipline and type of prison yielded no significant differences in responses between groups.

5.7.5.6 Intentions towards condom policy

Figure 5.8 Response to the statement, "If a condom policy were in place I would fully implement the policy"

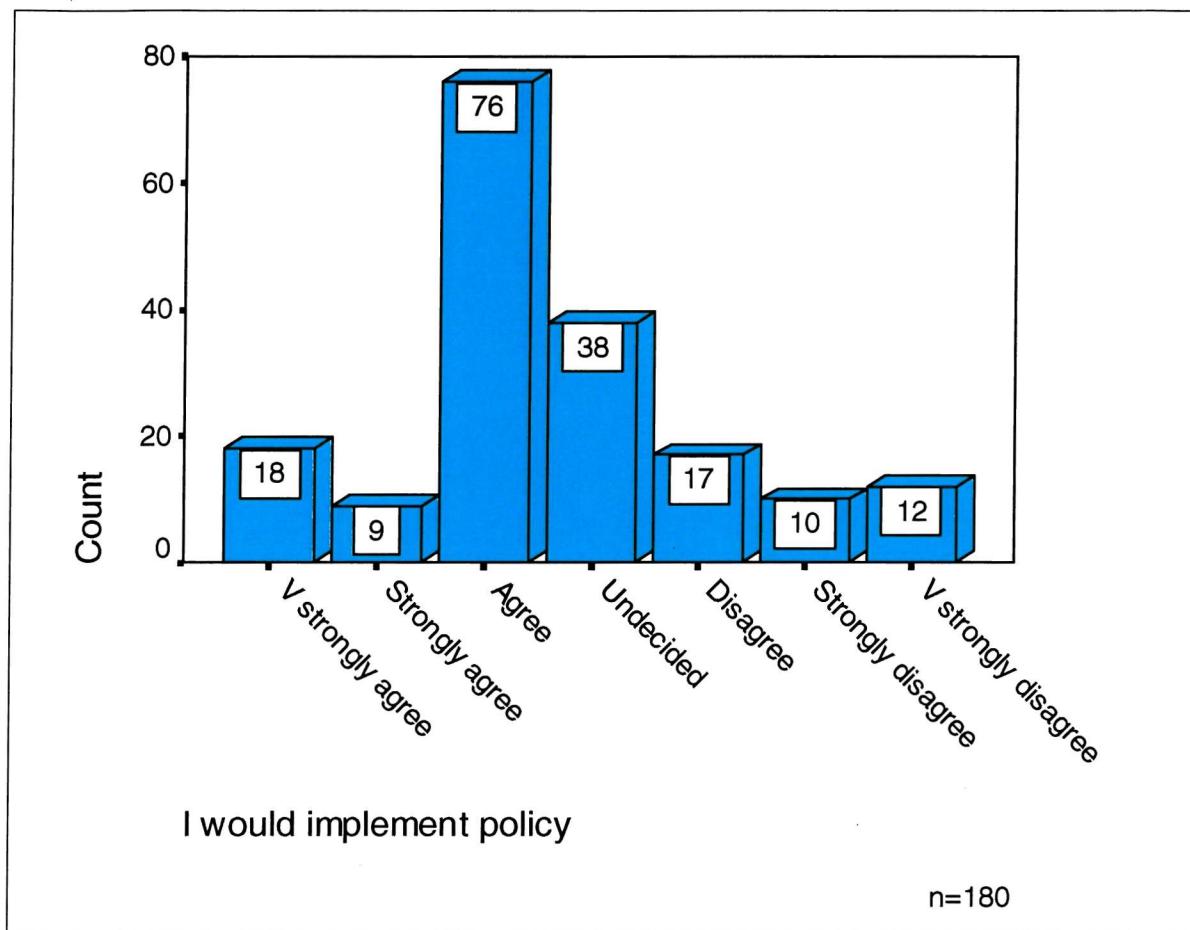
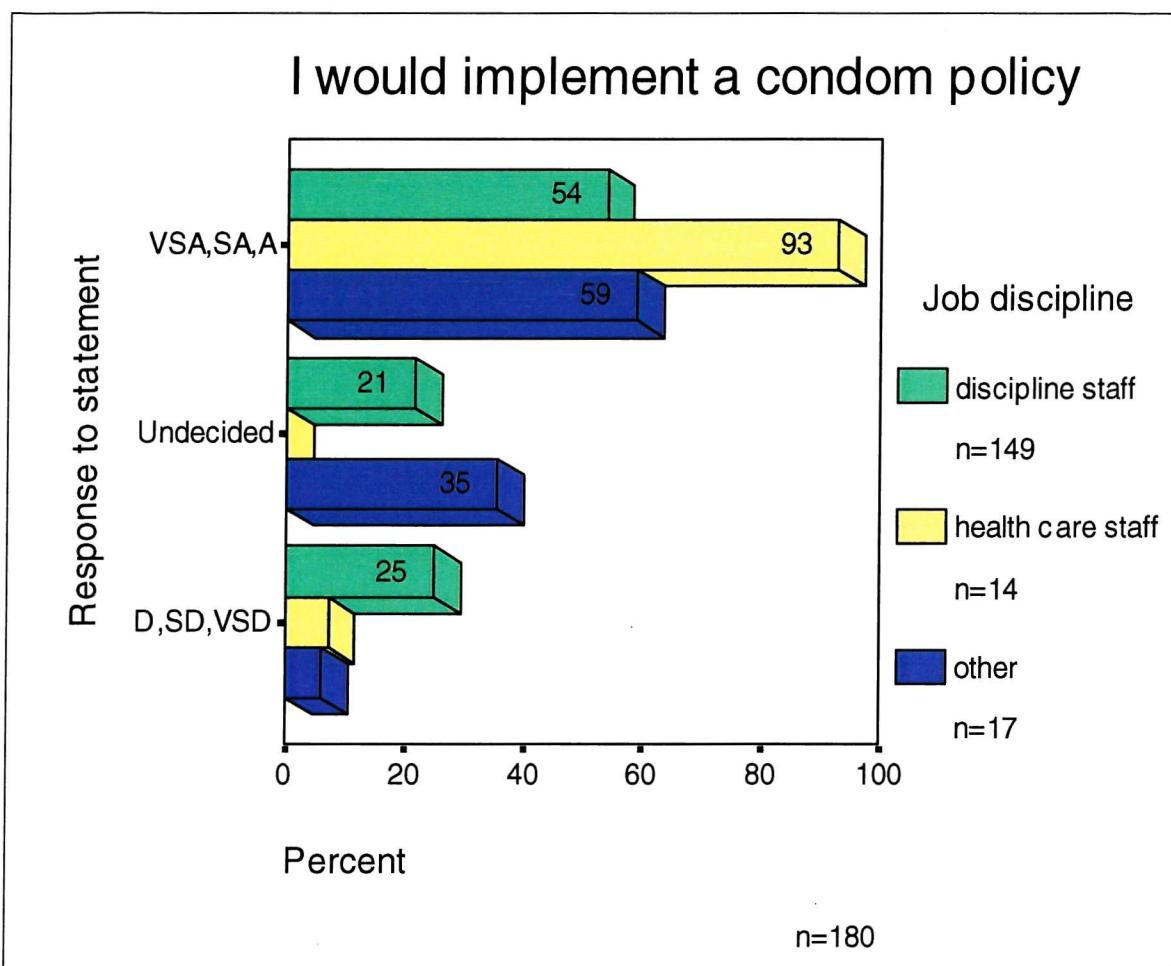


Figure 5.8 shows that 103 respondents agreed that they would fully implement a condom policy. Mean 3.58 (SD 1.51).

χ^2 test for the predictor variables of age range and type of prison demonstrated no significant differences in responses between groups.

The contingency table for the predictor variable job discipline displayed four cells that fell below the expected level of five therefore the χ^2 test result is not reported. However, job discipline did show some supportive results. These are described in figure 5.9.

Figure 5.9 Response by job discipline to the statement, "If a condom policy were in place I would fully implement the policy"



Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Figure 5.9 shows that the majority of staff would implement a condom policy, however of the discipline staff there was still 21% undecided and 25% who generally disagreed with the statement.

5.7.6 NEEDLE EXCHANGE

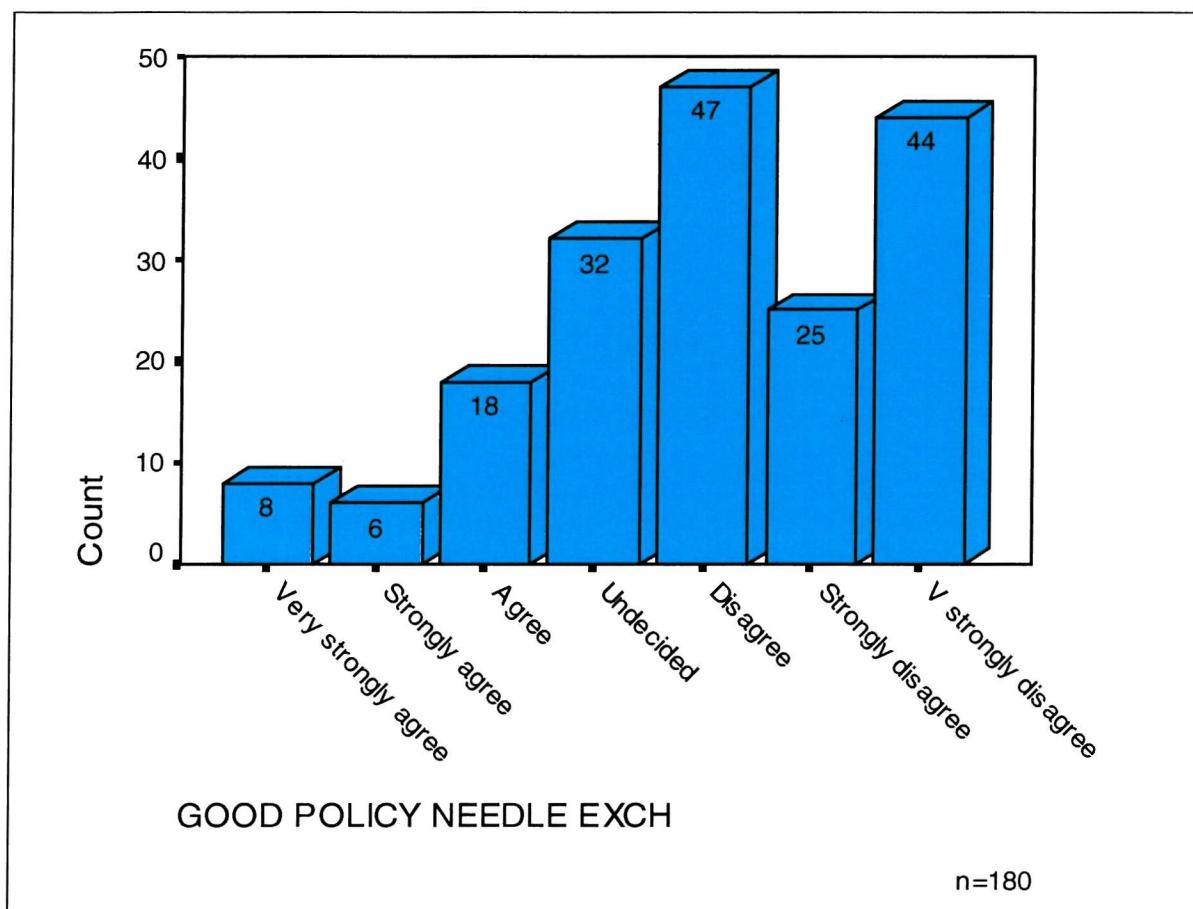
This section will present the results concerning needle exchange related beliefs in the following domains:

- 5.7.6.1 attitudes towards a needle exchange scheme in a prison setting
- 5.7.6.2 risk behaviour related to a needle exchange in a prison setting

- 5.7.6.3 beliefs related to the prevention benefits from a needle exchange scheme in a prison
- 5.7.6.4 normative beliefs related to needle exchange schemes
- 5.7.6.5 management of needle exchange schemes
- 5.7.6.6 stated intention to be involved in a needle exchange programme.

5.7.6.1 Attitudes towards needle exchange:

Figure 5.10 Response to the statement, "It would be a good policy to allow needle exchange schemes in prisons"



The mean response to the statement, "It would be a good policy to allow needle exchange schemes in prison" is 4.97 (SD1.65) where 1 relates to very strongly agree and 7 equates to very strongly disagree. This shows that there was a greater tendency for staff to disagree with the statement; overall 17.8% of staff agreed with the statement, whereas 64.4% of staff disagreed.

The predictor variables of age range and type of prison did not show a significant difference in the responses from the groups. Job discipline demonstrated an interesting trend; however, the χ^2 test can not be reported as over a fifth of cells fall below the expected count of five. However, the percentages and means are outlined below:

Table 5.16 The response to the statement, " It would be a good policy to allow needle exchange schemes in prison" outlined by job discipline

Response	Discipline staff	Health care	Other	Overall %
VSA,SA,A	14.1%	46.2%	27.8%	17.8%
Undecided	14.8%	23.1%	38.9%	17.8%
VSD,SD,D	71.1%	30.8%	33.3%	64.4%
Mean response	5.19 (SD 1.62)	3.69 (SD 1.60)	4.11 (SD 1.28)	4.97 (SD 1.65)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.16 shows that discipline staff was more likely to disagree with the statement (mean 5.9) whereas health care staff were more likely to agree with the statement (mean 3.69).

Other attitude statements concerning needle exchange in prisons are presented in table 5.17.

Table 5.17 Analysis of attitude statements: "Needle exchange schemes for use inside prison compromises security"; "A needle exchange in prison would cause a conflict for the law and order role of prisons"; "A needle exchange in prison would cause a conflict for the discipline and security role of prison officers"; "Needles from a needle exchange in a prison could be used as weapons"; "A needle exchange in a prison would be like condoning drug use" and "A needle exchange scheme would increase intravenous drug use in prisons"

ATTITUDE STATEMENT - NEEDLE EXCHANGE	N	MEAN	STD. DEVIATION	VSA, SA, A %	UNDECIDED %	D,SD,VSD %
Needle exchange compromises security	179	2.69	1.48	75.4	12.3	12.3
Needle exchange conflict for the law and order role of prisons	180	2.61	1.52	75	15.6	9.4
Needle exchange conflict for discipline and security role of prison officers	180	2.45	1.44	80	11.7	8.3
Needles from a needle exchange could be used as weapons	180	2.16	1.31	90.6	4.4	5.0
Needle exchange would be like condoning drug use	180	2.53	1.59	78.9	7.2	13.9
Needle exchange would increase IVDU in prisons	180	2.73	1.53	69.4	16.7	13.9

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.17 demonstrates that the majority of staff agreed with the statements outlined below arranged in sequence by strength of belief:

- Needles from a needle exchange in a prison could be used as weapons 90.6%
- A needle exchange in prison would cause a conflict for the discipline and security role of prison officers 80%

- A needle exchange in a prison would be like condoning drug use 78.9%
- Needle exchange schemes for use inside prisons compromises security 75.4%
- A needle exchange in prison would cause a conflict for the law and order role of prisons 75%
- A needle exchange scheme would increase intravenous drug use in prisons 69.4%

These beliefs indicate that the general attitudes of staff to introducing a needle exchange are negative.

The predictor variables of age range and type of prison elicited non-significant chi-square test results. The contingency tables for job discipline had more than one-fifth of the cells with an expected cell count below five therefore, statistical significance will not be reported. However, although generally health care staff showed a majority in agreement with the statements they were also more likely than discipline staff to disagree with the statement in four of the statements.

Table 5.18 The percentage response to the belief statements of health care staff: "A needle exchange in prison would cause a conflict for the discipline and security role of prison officers"; "A needle exchange in a prison would be like condoning drug use" "A needle exchange in prison would cause a conflict for the law and order role of prisons"; "Needle exchange schemes for use inside prison compromises security"
- the discipline staff response is outlined in brackets

Statement	AGREE %	U %	DISAGREE %
A needle exchange in prison would cause a conflict for the discipline and security role of prison officers	53.8 (85.9)	7.7 (8.7)	38.5 (5.4)
A needle exchange in a prison would be like condoning drug use	61.5 (82.6)	0 (5.4)	38.5 (12.1)
A needle exchange in prison would cause a conflict for the law and order role of prisons	53.8 (79.9)	7.7 (14.1)	38.5 (3.1)
Needle exchange schemes for use inside prisons compromises security	46.2 (83.1)	7.7 (8.1)	46.2 (8.8)

Table 5.18 shows that prison discipline staff (percentage of response shown in brackets) had a higher, although not statistically significant, percentage of their group agree with the statements than health care staff. Health care staff show an equal division in their response to the statement that needle exchange schemes for use inside prisons compromise security, 46.2% agreed and 46.2% disagreed. However, for the other statements over half the health care staff agree with the statements.

The Cronbach's alpha score for the 7 item attitude scale concerning beliefs about needle exchange is: $\alpha = .9145$.

5.7.6.2 Risk behaviour related to needle exchange

Figure 5.11 Response to the statement, "A needle exchange is not necessary because intravenous drug use is not a problem in this prison".

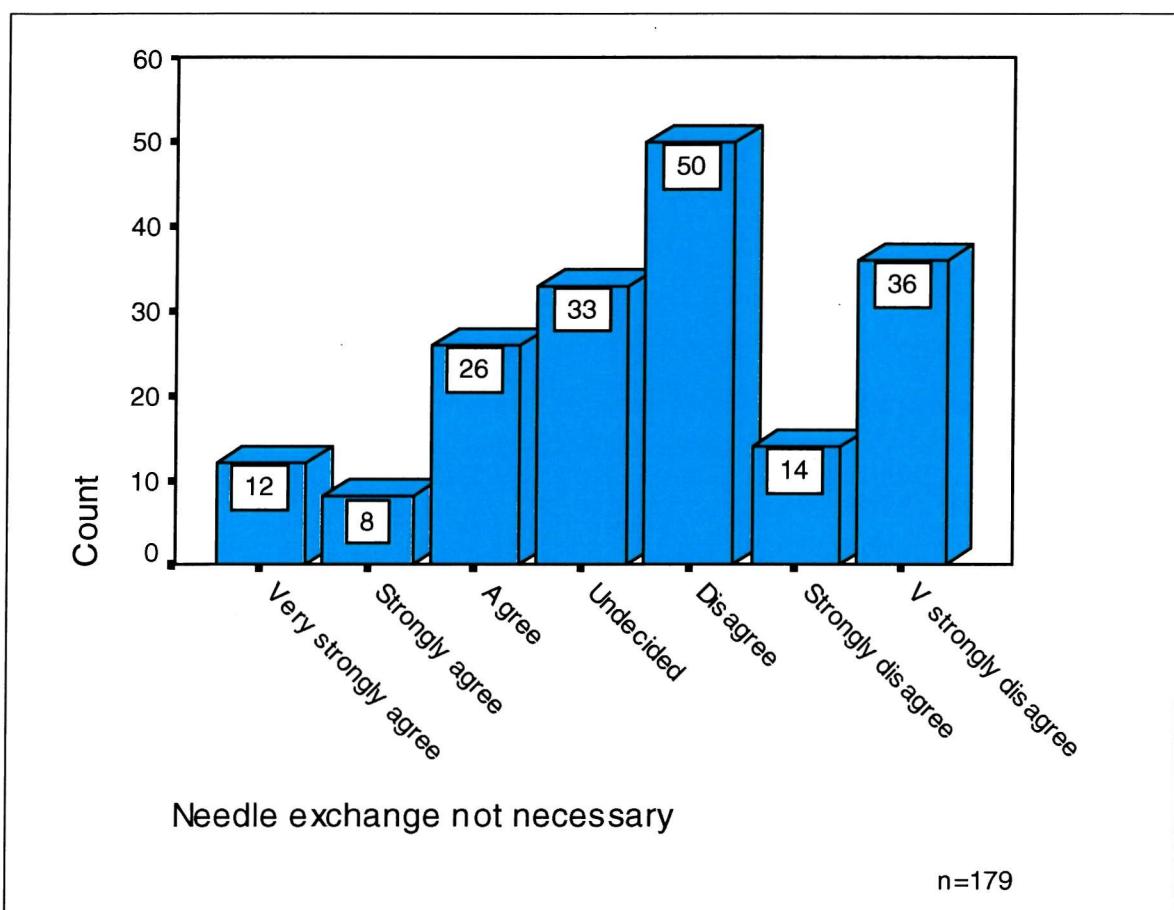


Figure 5.11 demonstrates a greater tendency to disagree with the statement that, "A needle exchange is not necessary because intravenous drug use is not a problem" mean 4.60 (SD 1.73) where 1 equals very strongly agree and 7 equals very strongly disagree. However, 25.7% very strongly agreed, strongly agreed or agreed with the statement. The predictor variables did not demonstrate a difference in group

response for age range or job discipline; however, χ^2 test revealed a statistically significant difference between the groups for the type of prison.

Table 5.19 Response to statement, "A needle exchange is not necessary because intravenous drug use is not a problem in this prison", outlined by type of prison

Response	Category B local	Category C	YOI	Overall %
VSA,SA,A	11.8%	28.9%	37.9%	25.7%
Undecided	23.5%	6.7%	21.2%	18.4%
VSD,SD,D	64.7%	64.4%	40.9%	55.9%
Mean response	5.03 (SD 1.57)	4.73 (SD 1.85)	4.08 (SD 1.68)	4.60 (SD 1.73)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.19 clearly demonstrates a difference between types of security category to the statement with the young offender institutions' responses showing less acceptance of the statement, mean 4.08. 37.9% very strongly agreed, strongly agreed or agreed with the statement and 40.9% strongly disagreed with the statement. $\chi^2 = 17.927$, df = 4, p = .001.

5.7.6.3 Beliefs about prevention related to needle exchange

Table 5.20 outlines the response to statements about needle exchange schemes in prisons reducing the transmission of HIV, hepatitis B and hepatitis C.

Table 5.20 Responses to belief statements: "The provision of a needle exchange in prison would reduce the transmission of HIV", "The provision of a needle exchange in prison would reduce the transmission of hepatitis B" and "The provision of a needle exchange in prison would reduce the transmission of hepatitis C"

STATEMENT	N	AGREE %	UNDECIDED %	DISAGREE %	MEAN
The provision of a needle exchange in prison would reduce the transmission of HIV	180	61.7 (n=111)	22.2 (n=40)	16.1 (n=29)	3.25 (SD 1.54)
The provision of a needle exchange in prison would reduce the transmission of hepatitis B	180	59.4 (n= 107)	25.6 (n=46)	15.0 (n=27)	3.26 (SD 1.53)
The provision of a needle exchange in prison would reduce the transmission of hepatitis C	179	58.1 (n=104)	26.3 (n=47)	15.6 (n=28)	3.28 (SD 1.55)

The χ^2 test was applied to all the statements for the strength of association with the predictor variables; age range, job discipline and type of prison. The result indicated no significant differences between the groups. The majority response was that introducing a needle exchange would lower the risk of transmission of these viruses. However, the number of respondents who were undecided or disagreed with the statements are noteworthy;

- 38.3% were undecided or disagreed that a needle exchange would reduce transmission of HIV
- 40.6% were undecided or disagreed that a needle exchange would reduce the transmission of hepatitis B
- 41.9% were undecided or disagreed that a needle exchange would reduce the transmission of hepatitis C.

Although the majority of the responses agreed with the statement, it could be hypothesised that the slight differences in the strength of response and the relatively large undecided/disagree responses may be attributable to one of the following factors:

- a lack of knowledge or feeling secure in their own knowledge levels about the transmission routes of the viruses

- the strength of response against the statement relating a needle exchange being a good policy in prison (see figure 5.9) may have influenced beliefs about the benefits of a needle exchange
- the staff may not have been convinced that prisoners would take up the policy and there is some evidence for this in the qualitative analysis.

5.7.6.4 Normative beliefs concerning needle exchange policy

Table 5.21 illustrates how the respondents perceive how certain salient referents would favour a needle exchange in a prison setting. The referent groups were those most commonly identified in the face to face interviews with prison staff.

Table 5.21 Respondents' perception of salient referent views: "The majority of prison officers are in favour of a policy to allow needle exchange in prison", "In general prison health care staff are in favour of a needle exchange in prison", "The general public would be in favour of a needle exchange within a prison", "The majority of prisoners would be in favour of a needle exchange within a prison" and "I am in favour of a needle exchange scheme within prison"

STATEMENT	N	AGREE %	UNDECIDED %	DISAGREE %	MEAN
The majority of prison officers are in favour of a policy to allow needle exchanges in prison	180	3.2 (n=7)	22.3 (n=42)	72.8 (n=131)	5.48 (SD 1.32)
In general health care staff are in favour of a needle exchange in prison	179	17.3 (n= 31)	49.2 (n=88)	33.5 (n=60)	4.44 (SD 1.31)
The general public would be in favour of a needle exchange policy in prison	180	3.3 (n=6)	25.6 (n=46)	71.1 (n=128)	5.43 (SD 1.36)
The majority of prisoners would be in favour of a needle exchange policy in prison	178	50 (n=89)	25.3 (n=45)	24.7 (n=44)	3.63 (SD 1.57)
I am in favour of a needle exchange policy in prisons	180	13.3 (n=24)	14.4 (n=26)	72.2 (n=130)	5.42 (SD 1.72)

The pattern of the strength of belief demonstrated in the mean value presents an interesting picture (where one is equal to very strongly agree and 7 relates to very

strongly disagree). It is generally believed that prison officers would least favour a needle exchange in prison out of the groups, followed closely by the general public and the self-evaluation of the how favourable the respondent finds a needle exchange policy. 49.2% of respondents were undecided how health care staff would evaluate a needle exchange in prison (mean 4.44). Fifty per cent of respondents agreed that prisoners would be in favour of a needle exchange in prison (mean 3.63).

The χ^2 test was applied to all the statements for the strength of association with the predictor variables; age range, job discipline and type of prison. The only significant result was for age range related to the statement regarding health care staff favouring a needle exchange. 38.5% of those in the 20 -30 year old range agreed with the statement, "In general prison health care staff are in favour of a needle exchange in prison", whereas the response was 17.5% in the 31 -40 age range, 15.8% in the 41 - 50 age range and 3.1% in the 51 -65 year old age range ($\chi^2 = 14.65$, df = 6, p =.028; 1 cell had an expected count less than 5). The number of respondents agreeing with this response decreases with age, however, the number of respondents in the undecided category increases with age; 42.3%, 44.4%, 50.9% and 62.5% in the four age groups respectively.

On statistical analysis, two issues were highlighted for job discipline in the health care staff group. χ^2 test results will not be reported because in both cases greater than one-fifth of cells had an expected count below five. The first issue identified was that a greater percentage of health care staff agreed with the statement, "In general prison health care staff are in favour of a needle exchange in prison"; 38% of health care staff compared to 14.9% of prison discipline staff, and 22.2% of other staff. The second issue highlighted was that 53.8% of health care staff agreed with the statement, " I am in favour of a needle exchange policy in prisons", compared to 9.4% of prison discipline staff and 16.7% of other staff.

The Cronbach's alpha scale score for 5 normative belief statements concerned with needle exchange is: $\alpha = .7584$.

5.7.6.5 Management of needle exchange

Staff generally felt fairly negatively about a needle exchange in prisons; however, it appears from responses to statements regarding management of a policy that health care staff managing the policy would be an acceptable way forward.

Figure 5.12 Mean response to statements; "If a needle exchange policy were operational inside a prison it should be managed by health care staff", "If a needle exchange were operational inside a prison it would be managed by discipline staff", "If a needle exchange were operational within a prison it should be managed jointly by health care and discipline staff" and "If a needle exchange were operational within a prison it should be managed by outside agencies"

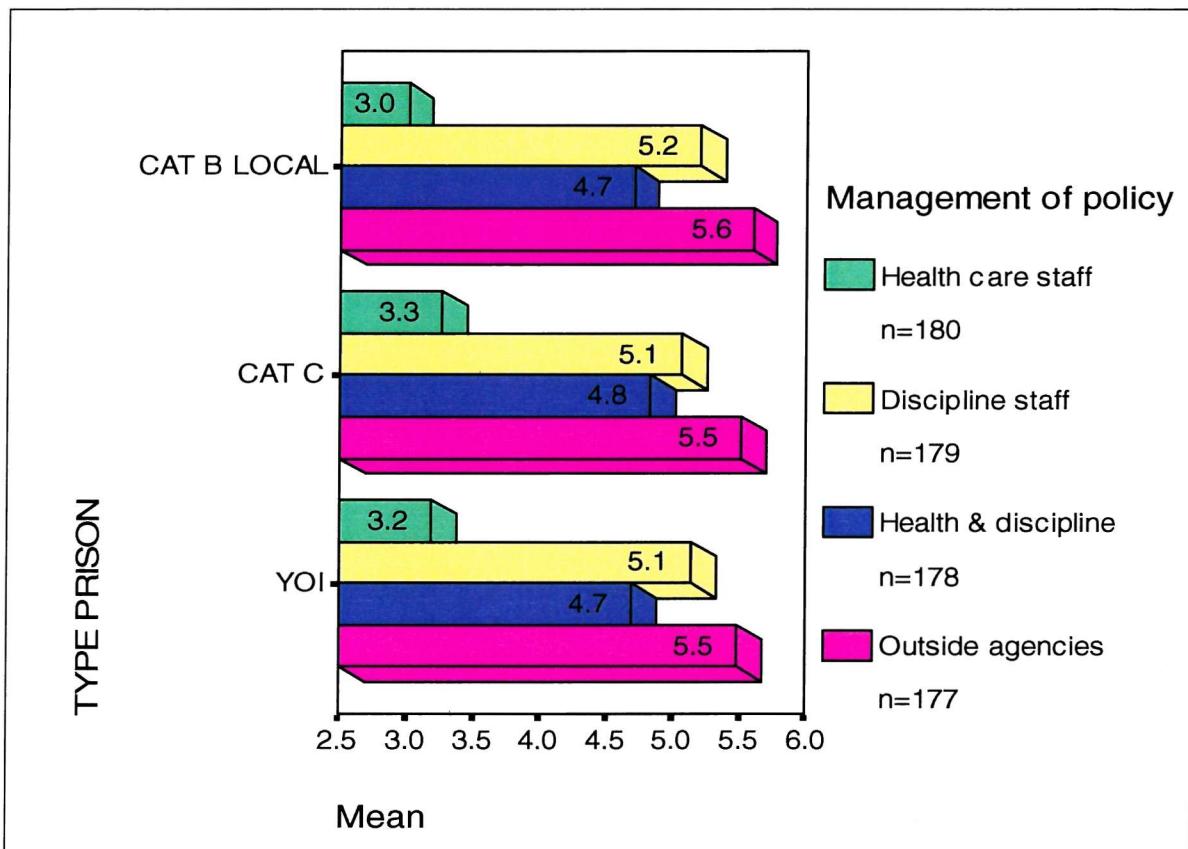


Figure 5.12 shows the mean response (where 1 equals very strongly agree and 7 relates to very strongly disagree) to potential management of a needle exchange policy described by security category of prison. The results clearly indicate a strong preference for health care staff alone, with the least preferred option being an outside agency.

Table 5.22 Management of needle exchange policy statements; "If a needle exchange policy were operational inside a prison it should be managed by health care staff", "If a needle exchange were operational inside a prison it would be managed by discipline staff", "If a needle exchange were operational within a prison it should be managed jointly by health care and discipline staff" and "If a needle exchange were operational within a prison it should be managed by outside agencies"

STATEMENT	N	AGREE %	UNDECIDED %	DISAGREE %	MEAN
If a needle exchange were operational inside a prison it should be managed by health care staff	180	71.4 (n=130)	12.6 (n=23)	15 (n=27)	3.14 (SD 1.57)
If a needle exchange were operational inside a prison it should be managed jointly by health care and discipline staff	178	20.8 (n=37)	19.1 (n=34)	60.1 (n=107)	4.70 (SD 1.59)
If a needle exchange were operational inside a prison it should be managed by discipline staff	179	10.6 (n=19)	17.9 (n=32)	71.5 (n=128)	5.11 (SD 1.43)
If a needle exchange were operational inside a prison it should be managed by outside agencies	177	5.6 (n=10)	15.8 (n=28)	78.5 (n=139)	5.53 (SD 1.37)

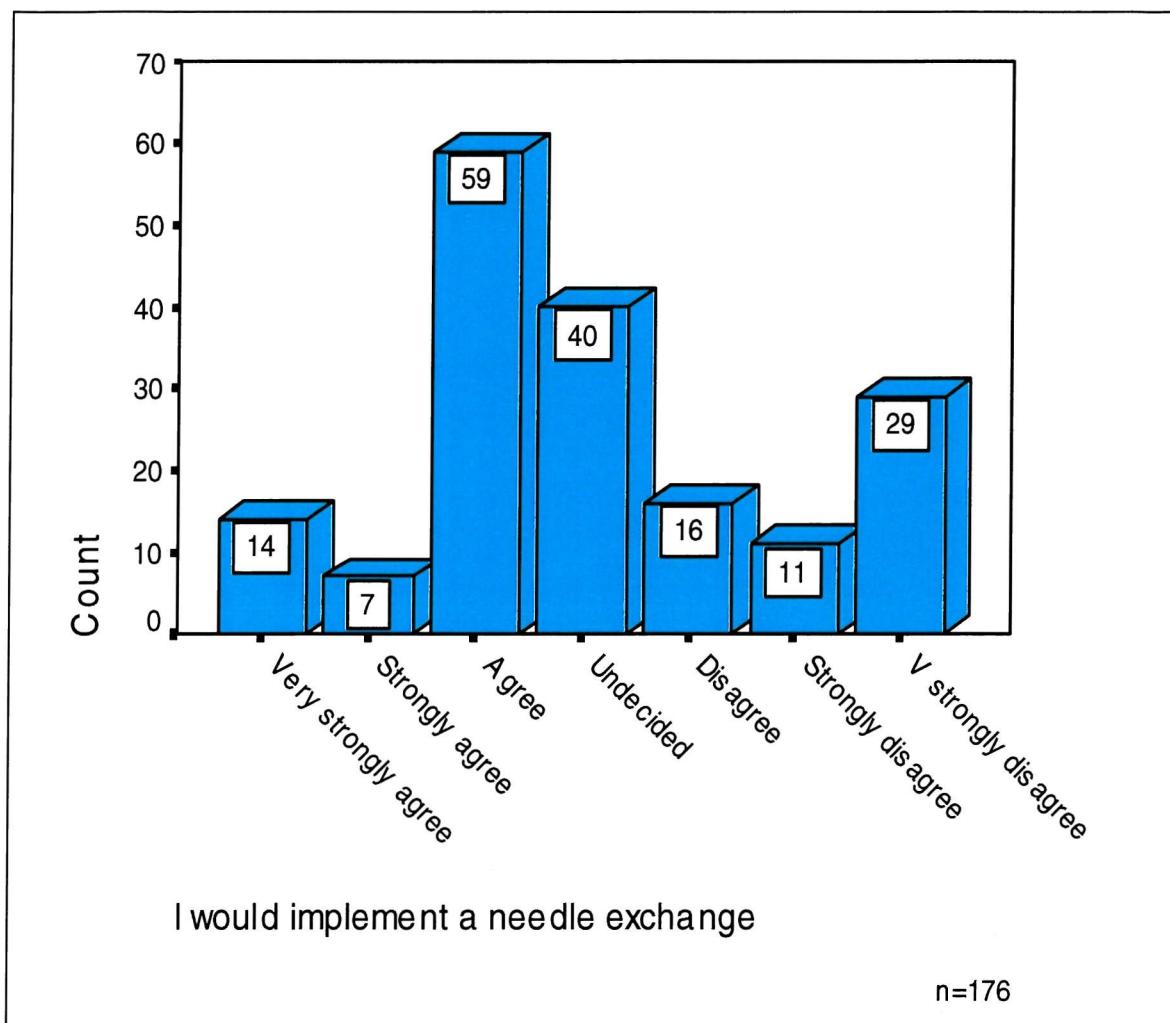
Table 5.22 demonstrates that 71.4% agreed that if a needle exchange policy was introduced it should be managed by health care staff; the acceptability of other staff groups managing the policy decreased markedly.

χ^2 test demonstrated no significant differences between groups in these responses for the predictor variables of age range, type of security category prison and job discipline.

5.7.6.6 Intention towards a needle exchange scheme

The response to the statement, 'If a needle exchange policy were in place I would fully implement the policy', is summarised in figure 5.13.

Figure 5.13 Response to the statement; "If a needle exchange policy were in place I would fully implement the policy"



The mean response to the statement concerning personal intention to implement a needle exchange policy is, mean 4.06 (SD 1.75) where 1 is equivalent to very strongly agree and 7 equals very strongly disagree. 45.5% agreed with the statement, 22.7% were undecided and 31.8% disagreed. Although there is a greater than expected number of respondents generally agreeing that they would implement the policy, there were a higher combined percentage, 54.5% of those who were undecided or generally disagreed.

χ^2 test demonstrated no significant differences between groups in these responses for the predictor variables of age range, type of security category prison and job discipline.

5.7.7 BLEACH

This section displays the analysis for bleach policy related beliefs in the following domains:

- 5.7.7.1 attitudes to bleach
- 5.7.7.2 risk behaviour related to bleach
- 5.7.7.3 beliefs about the preventive benefits of a bleach policy
- 5.7.7.4 normative beliefs regarding a bleach policy
- 5.7.7.5 management of a bleach policy
- 5.7.7.6 intentions to implement a bleach policy

5.7.7.1 Attitudes to bleach

The mean response to the statement, "It is a good policy to allow prisoners bleach for cleaning intravenous drug equipment in prison", is 4.94 (SD 1.64), where 1 relates to very strongly agree and 7 equals very strongly disagree. This demonstrates a greater tendency for staff to disagree with the statement; 19.6% of staff agree, whereas 62% of the staff disagreed.

Figure 5.14 Response to the statement, "It is a good policy to allow prisoners bleach for cleaning intravenous drug equipment"

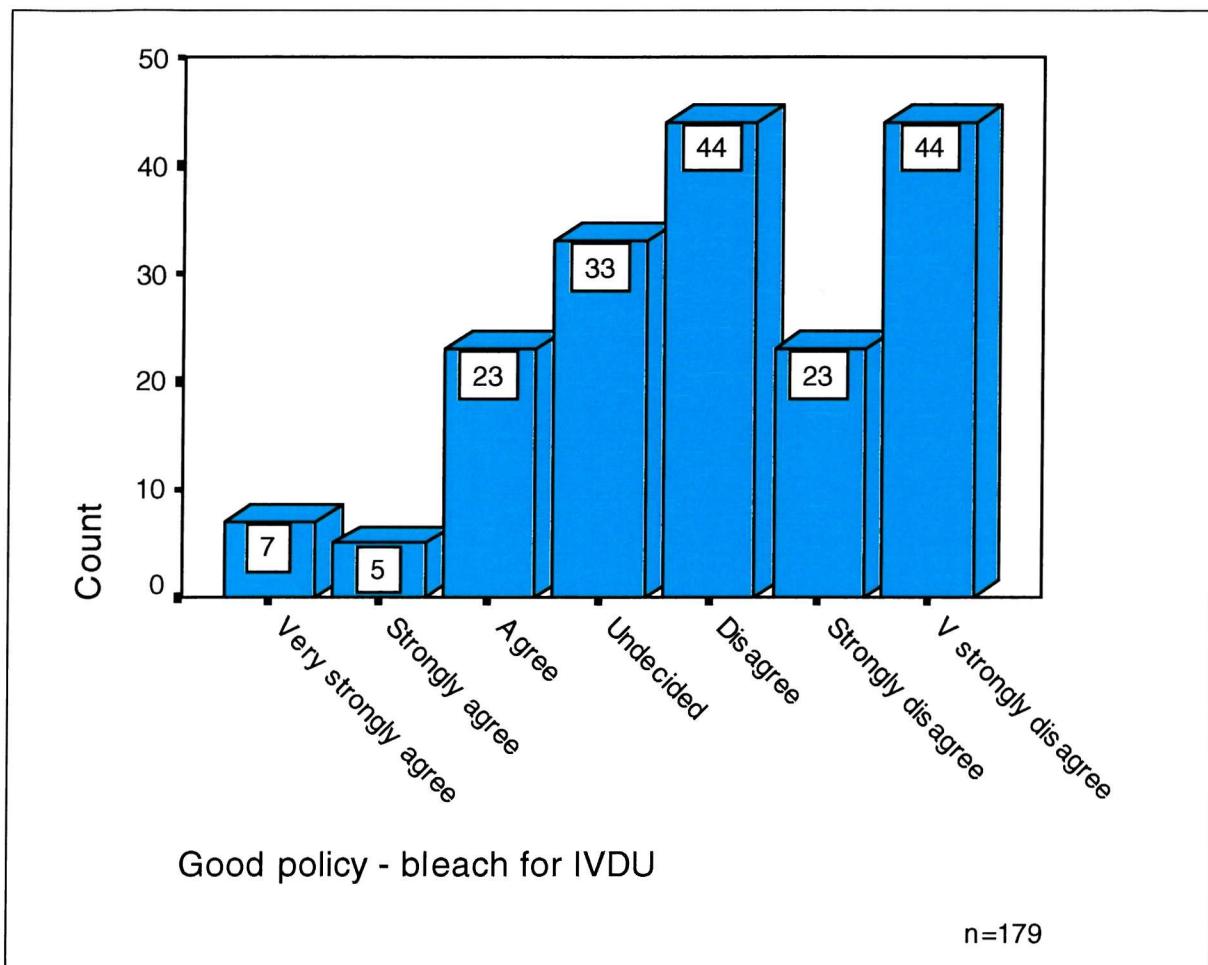


Figure 5.14 shows the results by number of respondents.

The predictor variable of age range and security type of prison showed no difference in response between the groups on χ^2 test. The χ^2 test for job discipline had four cells below the expected level of 5 therefore the results cannot be reported as statistically significant; however, as expected the majority of health care staff (69.2%) agreed with the statement whereas only 13.5% of prison discipline staff and 33.3% of other staff did so.

Other statements in the questionnaire relating to attitude to bleach provision are reported in table 5.23.

Table 5.23 Analysis of attitude statements; "Distributing bleach to prisoners for cleaning 'works' compromises security", "Providing bleach for cleaning 'works' in prison would cause a conflict for the law and order role of prisons", "Providing bleach for cleaning 'works' in prisons would cause a conflict for the discipline and security role of prison officers" and "Having bleach for cleaning 'works' available in a prison would be like condoning drug use"

ATTITUDE STATEMENT	N	MEAN	STD. DEVIATION	VSA,SA,A %	UNDECIDED	D,SD,VSD %
Bleach distribution for cleaning 'works' compromises security	180	3.14	1.49	63.3 (114)	17.8 (32)	18.9 (34)
Bleach for cleaning 'works' would cause a conflict for the law and order role of prisons	180	3.24	1.47	58.3 (105)	22.2 (40)	19.4 (35)
Bleach for cleaning 'works' would cause a conflict for the discipline and security role of prison officers	180	3.01	1.38	66.7 (120)	20.6 (37)	12.8 (23)
Having bleach for cleaning 'works' in prison would be like condoning drug use	179	3.21	1.49	59.2 (106)	21.2 (38)	19.6 (35)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.23 demonstrates that the majority of respondents believe that bleach for cleaning intravenous drug equipment compromises security, causes a conflict for the law and order role of prisons, causes a conflict for the discipline and security role of prison officers and condones the use of drugs in prisons.

The Cronbach's alpha for the 7 attitude statements concerned with bleach provision is: $\alpha = .8772$

5.7.7.2 Risk behaviour related to bleach provision

Figure 5.15 Responses to the statement, "A bleach policy is not necessary because intravenous drug use is not a problem in this prison"

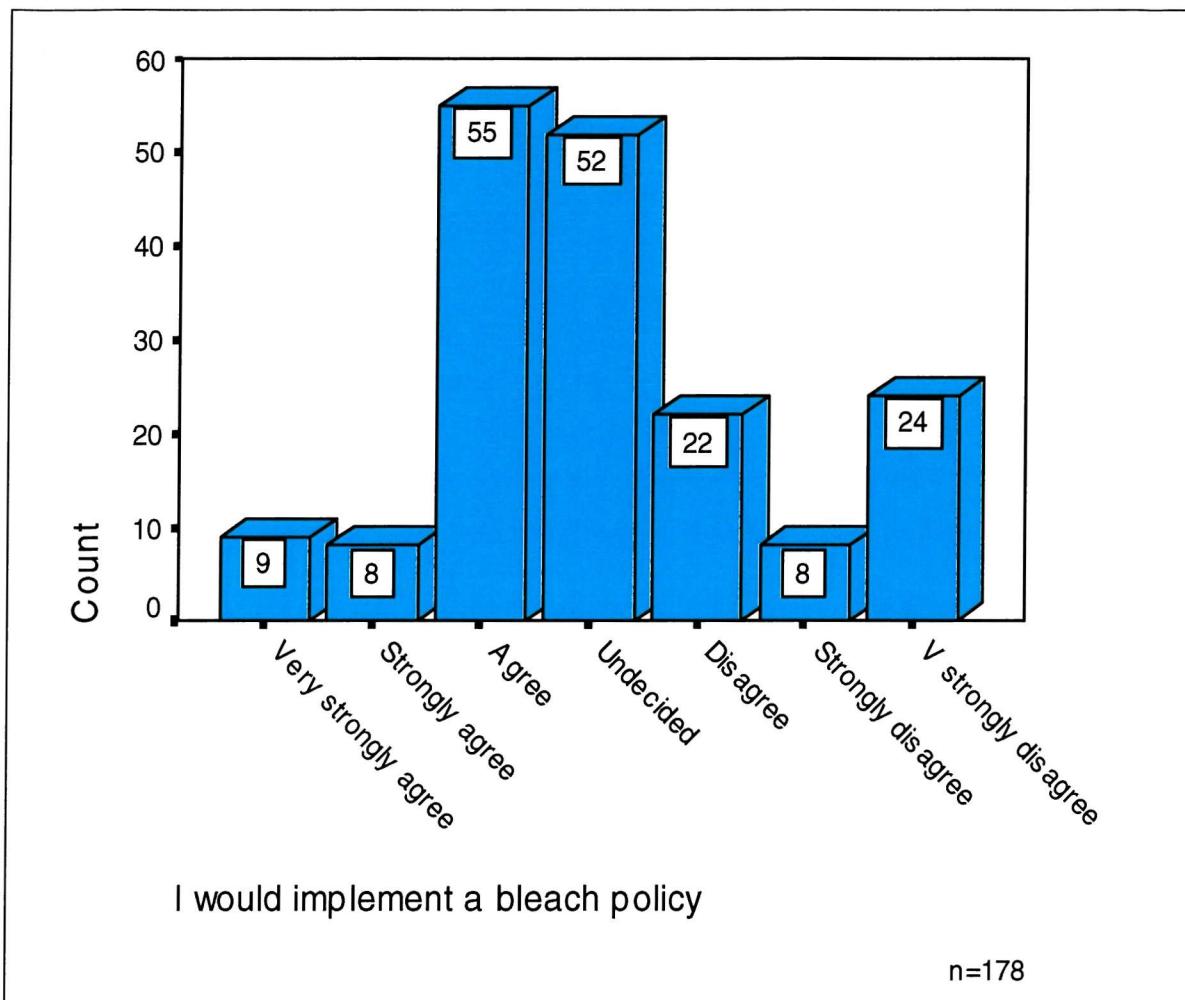


Figure 5.15 shows the response to the statement, "A bleach policy is not necessary because intravenous drug use is not a problem in this prison". The mean response to the statement is 4.47 (SD 1.63), where 1 on the scale relates to very strongly agree and 7 equals very strongly disagree. 23.5% agreed, 26.9% were undecided and 48.4% disagreed.

The predictor variables for age range and job discipline demonstrated no significant difference between groups on χ^2 test. The predictor variable type of security prison showed a higher percentage of undecided and a lower percentage response to disagree; Table 5.24 outlines the results.

Table 5.24 Response to the statement "A bleach policy is not necessary because intravenous drug use is not a problem in this prison", analysed by type of prison

Response	Category B local	Category C	YOI	Overall %
VSA,SA,A	16.2%	28.9%	27.3%	23.5%
Undecided	23.5%	20%	36.4%	27.4%
VSD,SD,D	60.3%	51.1%	36.4%	49.2%
Mean response	4.75 (SD 1.55)	4.44 (SD 1.98)	4.21 (SD 1.42)	4.47 (SD 1.63)

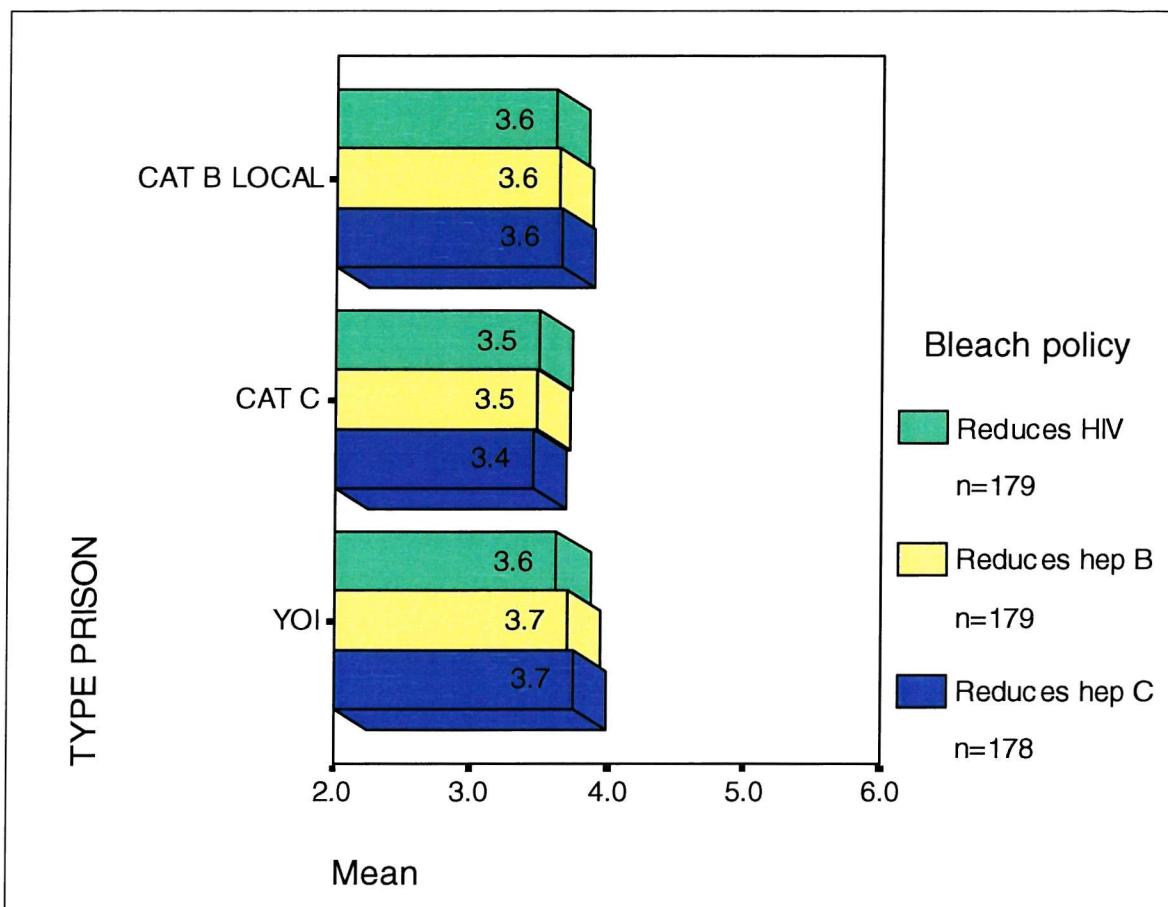
Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

$\chi^2 = 9.669$, df = 4, p = .046. The mean for the staff respondents from the young offender institutes was lower than the other groups at 4.21 (SD 1.42) displaying more uncertainty and less rejection of the statement than the other groups about the bleach policy not being necessary because drug use is not a problem in their prison.

5.7.7.3 Beliefs about the preventive benefits of bleach

Figure 5.16 Response to statements; "The provision of bleach in prison would reduce the transmission of HIV", "The provision of bleach in prison would reduce the transmission of hepatitis B" and "The provision of bleach in prison would reduce the transmission of hepatitis C"



1 refers to very strongly agree and 7 relates to very strongly disagree. Figure 5.16 shows that there was very little difference in the responses from the groups for the security types of prison in the study. The overall mean response to each of the statements is illustrated in table 5.25.

Table 5.25 Response to statements; "The provision of bleach in prison would reduce the transmission of HIV", "The provision of bleach in prison would reduce the transmission of hepatitis B" and "The provision of bleach in prison would reduce the transmission of hepatitis C"

STATEMENT	N	VSA, SA, A %	UNDECIDED	D,SD,VSD %	MEAN
The provision of bleach in prison would reduce the transmission of HIV	179	46.9 (n=84)	34.1 (n=61)	19 (n=34)	3.56 (SD 1.55)
The provision of bleach in prison would reduce the transmission of hepatitis B	179	45.8 (n=82)	34.6 (n=62)	19.6 (n=35)	3.60 (SD 1.53)
The provision of bleach in prison would reduce the transmission of hepatitis C	178	44.4 (n=79)	36 (n=64)	19.7 (n=35)	3.63 (SD 1.49)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

The responses to the statements show that almost half of all respondents believe that bleach would reduce the transmission rates of the viruses.

χ^2 test demonstrated no significant difference in responses from the groups for the predictor variables of age range, job discipline and type of prison.

5.7.7.4 Normative beliefs about a bleach policy

Table 5.26 will show how staff perceive other salient groups' views about a bleach policy.

Table 5.26 How staff perceive other salient groups' views about bleach for cleaning intravenous drug equipment

STATEMENT	N	AGREE %	UNDECIDED %	DISAGREE %	MEAN
The majority of prison officers are in favour of prisoner access to bleach for cleaning 'works'	179	2.2 (n=4)	30.7 (n=55)	67 (n=120)	5.24 (SD 1.22)
In general prison health care staff are in favour of a policy to allow prisoners access to bleach in prison for cleaning 'works'	179	15.1 (n=27)	52.5 (n=94)	32.4 (n=58)	4.42 (SD 1.24)
The general public would be in favour of making bleach available for prisoners to clean 'works'	179	4.5 (n=8)	31.3 (n=56)	64.2 (n=115)	5.16 (SD 1.25)
The majority of prisoners would be in favour of a policy to allow prisoners access to bleach for cleaning 'works'	178	45.5 (n=81)	32 (n=57)	22.5 (n=40)	3.75 (SD 1.43)
I am in favour of a policy that makes bleach for cleaning 'works' available to prisoners	179	15.6 (n=28)	21.2 (n=38)	63.1 (n=113)	5.03 (SD 1.57)

Table 5.26 illustrates a pattern of beliefs about how other groups view bleach for decontamination of intravenous drug equipment. The means for prison officers and general public show a majority disagreeing with the statements, with healthcare staff having a majority undecided responses. It was perceived by almost half the staff that prisoners would be in favour of making bleach available for use to clean drug injecting equipment.

χ^2 test highlighted no statistically significant differences between the groups for the predictor variables of age range and type of prison. Job discipline demonstrated differences but because of group sizes the test was not reliable; however, the results will be reported as a percentage difference.

- For the statement concerning health care staff favouring a bleach policy a greater number of health care staff generally agreed with the statement, 46.2% compared to 10.8% for discipline staff and 27.8% for other staff.

- For the statement concerning the public favouring a bleach policy 23.1% of health care staff generally agreed with the statement compared with 2% for prison discipline staff and 11.1% for other staff.
- For the statement concerning self endorsement of a bleach policy 61.5% of health care staff generally agreed with the statement compared with 10.1% of prison discipline staff and 27.8% of other staff.

Figure 5.17 presents a visual representation of the mean responses to the normative statements by type of prison.

Figure 5.17 Response to the statements; "The majority of prison officers are in favour of prisoner access to bleach for cleaning 'works'", "In general prison health care staff are in favour of a policy to allow prisoners access to bleach in prisons for cleaning 'works'", "The general public would be in favour of a policy of making bleach available for prisoners to clean 'works'", "The majority of prisoners would be in favour of a policy to allow prisoners access to bleach for cleaning 'works'" and "I am in favour of a policy that makes bleach for 'works' available to prisoners"

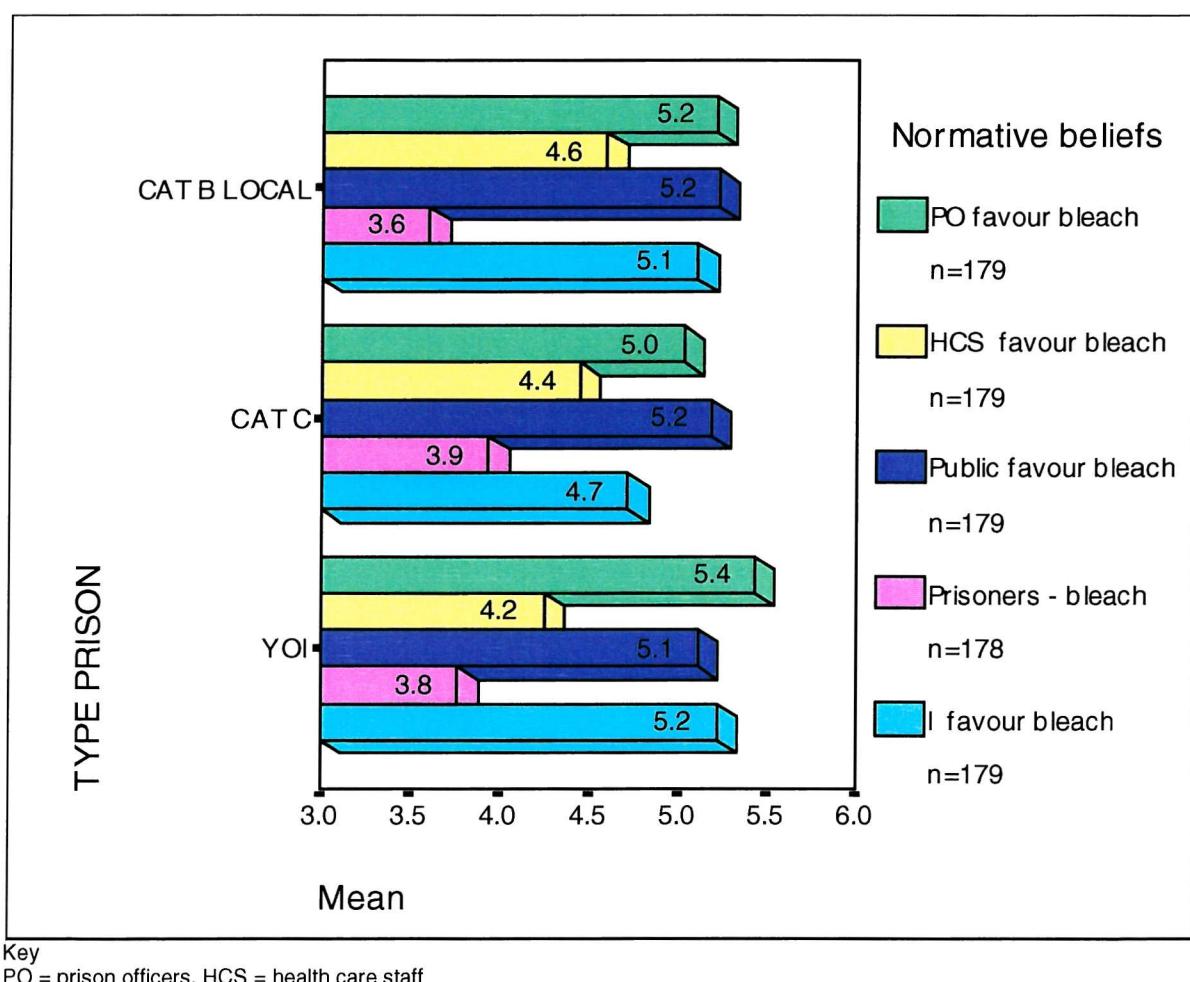


Figure 5.17 shows similar mean responses from the different types of prisons to the normative statements about bleach for cleaning intravenous drug equipment.

The Cronbachs' Alpha score for the 5 item scale concerning normative beliefs is: $\alpha = .7875$

5.7.7.5 Management of a bleach policy

Table 5.27 shows the response to the statements concerning who should manage a bleach policy in prisons.

Table 5.27 Response to statements concerning management of bleach policy

RESPONSE	HEALTH CARE	DISCIPLINE STAFF	HEALTH AND DISCIPLINE STAFF	OUTSIDE AGENCIES
VSA,SA,A	50.8% (n= 91)	22.3 (n=40)	24.6% (n=44)	5% (n=9)
Undecided	24.6% (n=44)	23.5% (n=42)	30.2% (n=54)	25.7% (n=46)
D,SD,VSD	24.6% (n=44)	54.2% (n=97)	45.3% (n=81)	69.3% (n=124)
Mean response	3.61 (SD 1.42)	4.65 (SD 1.47)	4.44 (SD 1.49)	5.36 (SD 1.36)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.27 clearly demonstrates that staff identifies more favourably health care staff to manage a bleach policy, with 50.8% in general agreement. The least favourably viewed to manage such a policy was outside agencies, 69.3% generally disagreed with the statement, followed by discipline staff on their own and then health care and discipline staff combined, for whom 45.3% generally disagreed.

χ^2 test demonstrated no significant difference in responses from the groups for the predictor variables of age range, job discipline and type of prison.

5.7.7.6 Intention to implement a bleach policy

Figure 5.18 Response to the statement, "If bleach were available for the purpose of cleaning 'works' I would fully implement the policy"

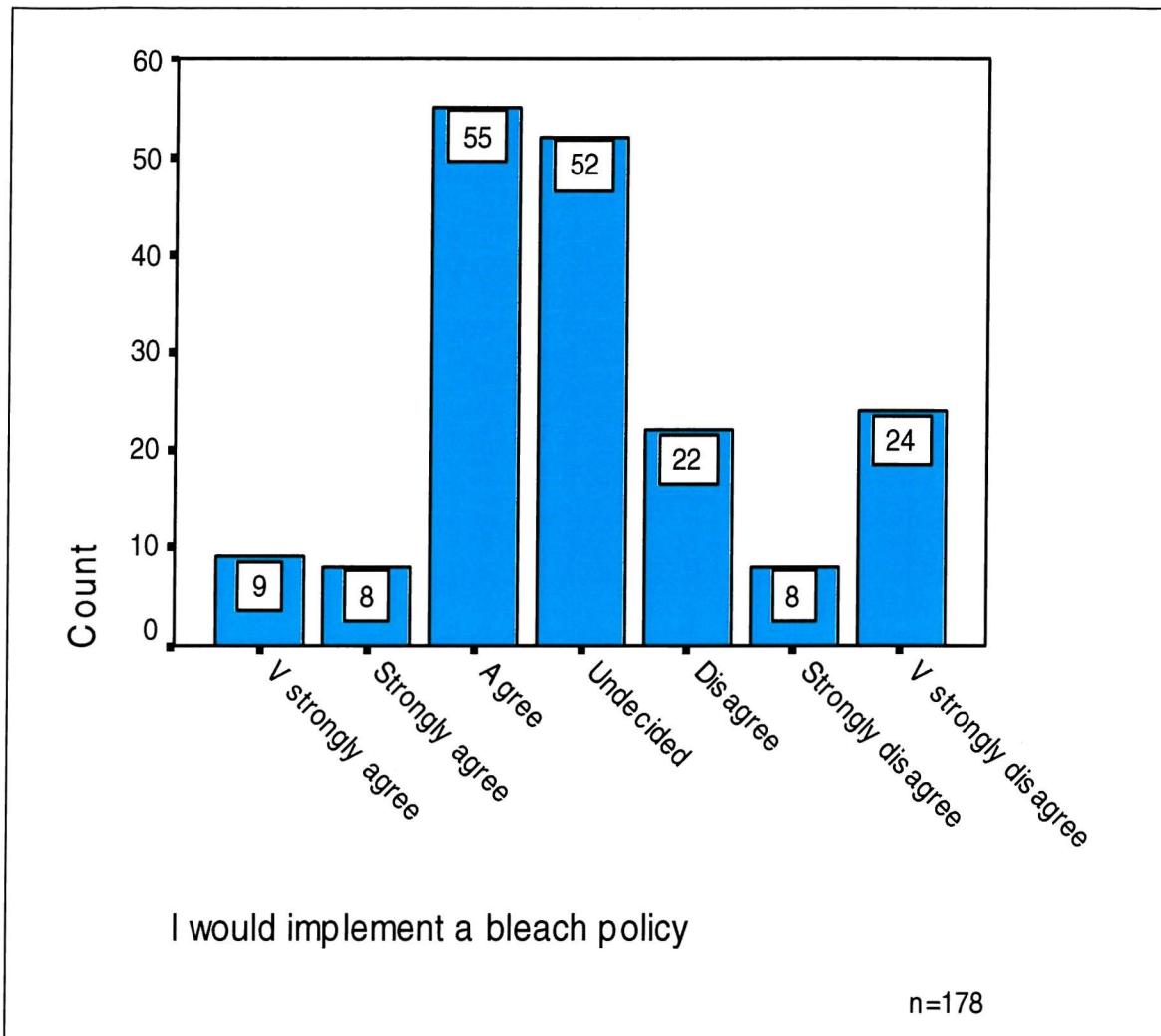


Figure 5.18 illustrates the number of responses to the statement, "If bleach were available for the purpose of cleaning 'works' I would fully implement the policy". The mean response to the statement is 4.07 (SD 1.57), where 1 is equivalent to very strongly agree and 7 equals very strongly disagree. 40.4% (n=72) of staff agreed with the statement, 29.2% (n=52) were undecided and 30.3% (n=54) disagreed.

χ^2 test revealed no differences in responses in the groups of the predictor variables of age range, type of prison and job discipline. The number of staff generally agreeing to this statement would not have been predicted because of the negative response to the statement about bleach being a 'good policy' (see figure 5.14).

5.7.8 OPIATE DETOXIFICATION

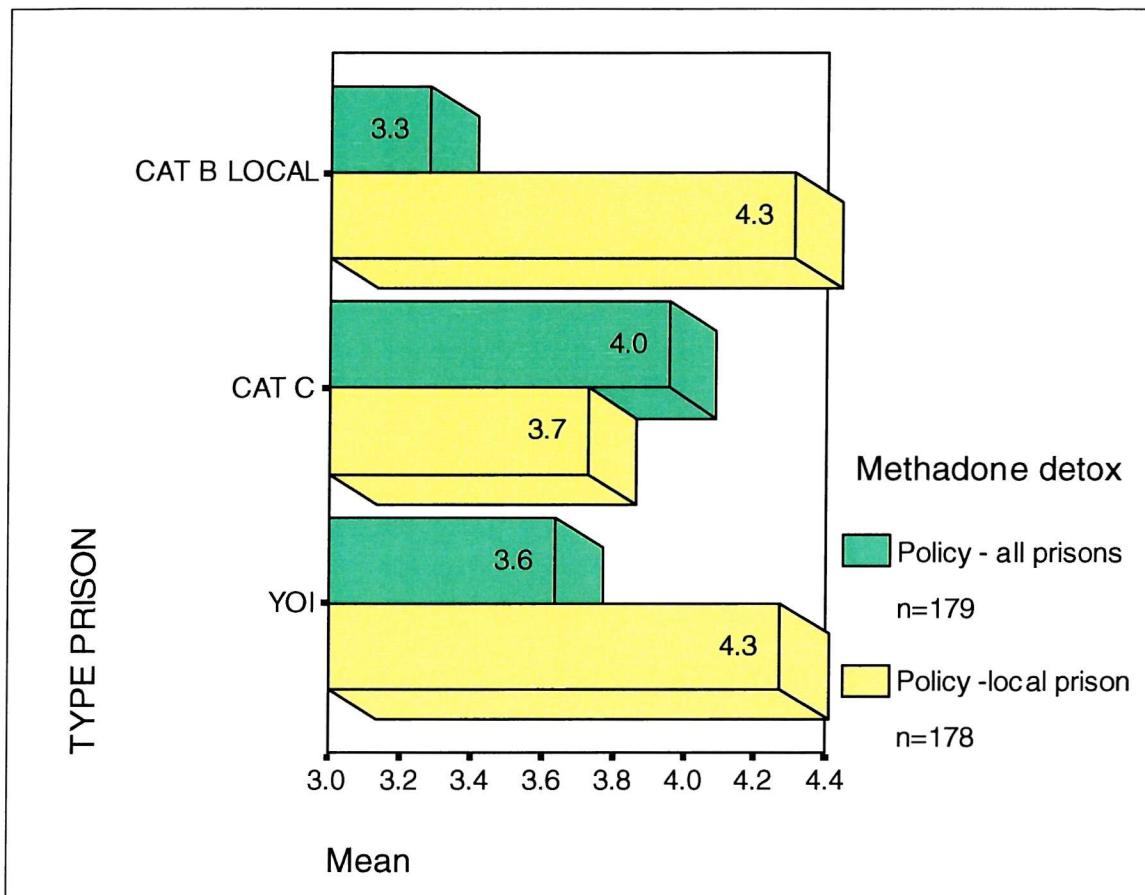
This section will describe the analysis of beliefs concerning methadone detoxification for opiate addiction in prisons categorised as follows:

- 5.7.8.1 attitudes towards methadone detoxification in prisons
- 5.7.8.2 risk behaviour related to methadone detoxification in a prison setting
- 5.7.8.3 the prevention benefits related to methadone detoxification
- 5.7.8.4 normative beliefs concerning methadone detoxification
- 5.7.8.5 management of methadone detoxification regimens in prison
- 5.7.8.6 stated intentions to implement methadone detoxification policy

5.7.8.1 Attitudes towards opiate detoxification in prisons

There are other substances that can be used for opiate detoxification but as methadone is the predominant substance in use (and additionally there are guidelines on its use from the prison Health Care Directorate) the questionnaire focused on Methadone as a regimen for detoxification. Policy developments in prisons in England and Wales recommend the availability of short-term methadone detoxification for opiate users on entry into prison (Rhodes 1994b). However, there appears to be patchy implementation of this policy recommendation (MacDonald 1999). Most methadone policy initiatives have been in Local Category B prisons. Therefore, in the statements concerning beliefs about methadone detoxification being a good policy a distinction was made between 'all' prisons and 'local' prisons.

Figure 5.19 Response to the statements: "It is a good policy to have methadone detoxification (withdrawal treatment) for prisoners in all prisons" and "It is a good policy to have methadone detoxification (withdrawal treatment) for prisoners in Local prisons"



The mean for the whole sample for the statement, "It is a good policy to have Methadone detoxification (withdrawal treatment) for prisoners in all prisons" is 3.58 (SD 1.73); the majority of respondents (57.5%) agreed with the statement.

The mean for the whole sample for the statement, "It is a good policy to only have Methadone detoxification for prisoners in local prisons", is mean 4.14 (SD1.57), 46.1% disagreed. Therefore, staff tended to be more rejecting of the view that such a procedure should only be operational in local category B prisons which, is current policy practice.

Statistically significant results of χ^2 test for predictor variable of age range, job discipline and type of prison are outlined in table 5.28.

Table 5.28 Statistically significant responses to the statements; It is a good policy to have methadone detoxification (withdrawal treatment) for prisoners in all prisoners" and "It is a good policy to only have methadone detoxification for prisoners in Local prisons"

STATEMENT	PREDICTOR VARIABLE	χ^2 TEST
It is a good policy to have methadone detoxification for prisoners in all prisons	Job discipline	χ^2 not reported over one-fifth of cells below expected 5
	Type of prison	$\chi^2 = 10.488$, df = 4, p=.033
It is a good policy to only have methadone detoxification for prisoners in local prisons	Type of prison	$\chi^2 = 12.683$, df = 4, p= .013

It can be inferred from Table 5.28 that staff from the category B local prisons and young offender institutes more positively responded to having a methadone policy in all prisons, whereas the responses from the category C prisons were more in favour of the policy in a local prison.

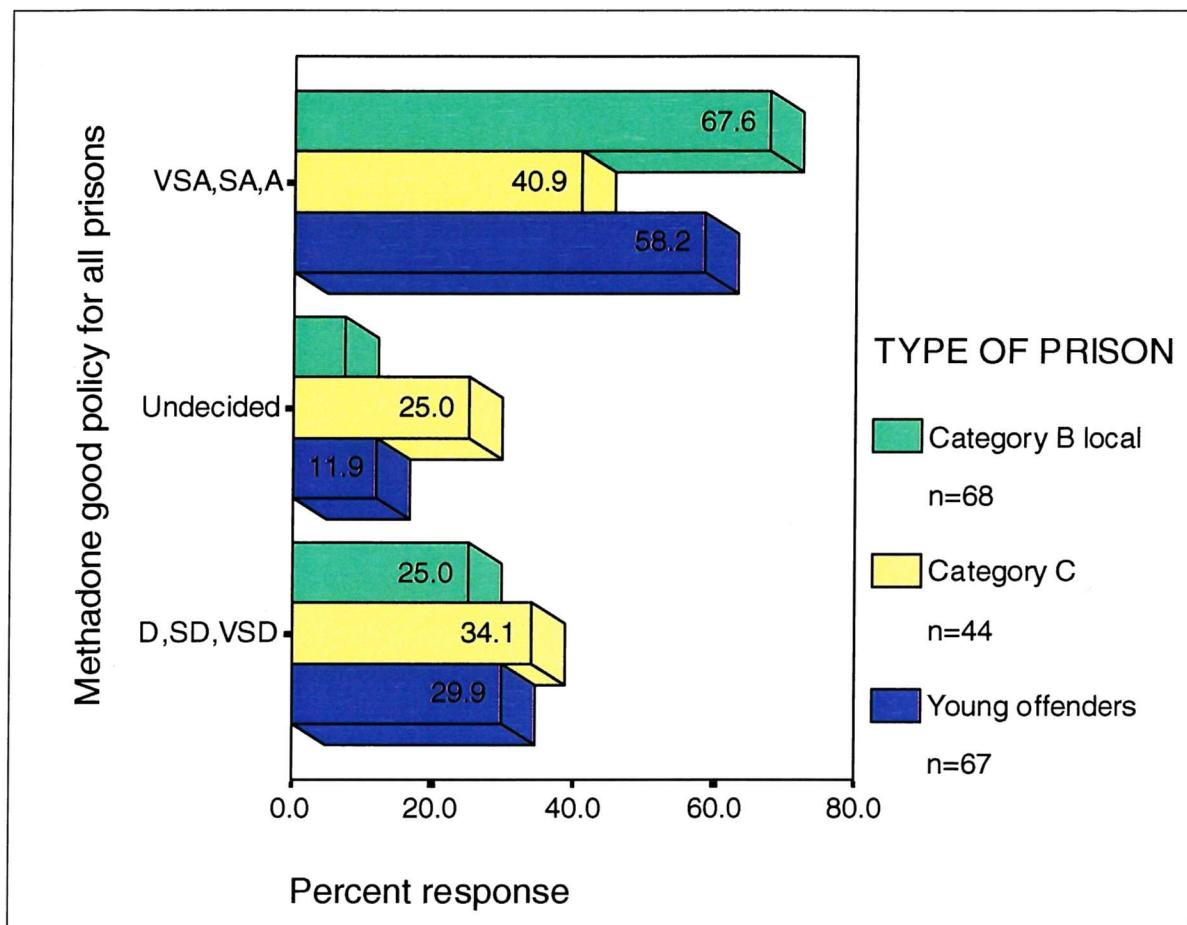
Statistical results are not reported for job discipline for the statement concerning Methadone detoxification in all prisons; however, it is noteworthy that health care staff had a higher disagreement with this statement than the other groups.

57.1% of health care staff disagreed with the statement, whereas only 29.3% of discipline staff and 5.6% of other staff did so. Health care staff also had a majority disagree response to methadone detoxification in local prisons. There could be a number of reasons for this response:

- health care staff could view other therapeutic methods of detoxification as more effective, for example, counselling and support approaches such as therapeutic communities
- health care staff could view other chemical methods of detoxification as more effective

- health care staff may not view prison as the appropriate place for withdrawal from opiates.

Figure 5.20 Response by type of prison to the statement: "It is a good policy to have methadone detoxification (withdrawal treatment) for prisoners in all prisons"

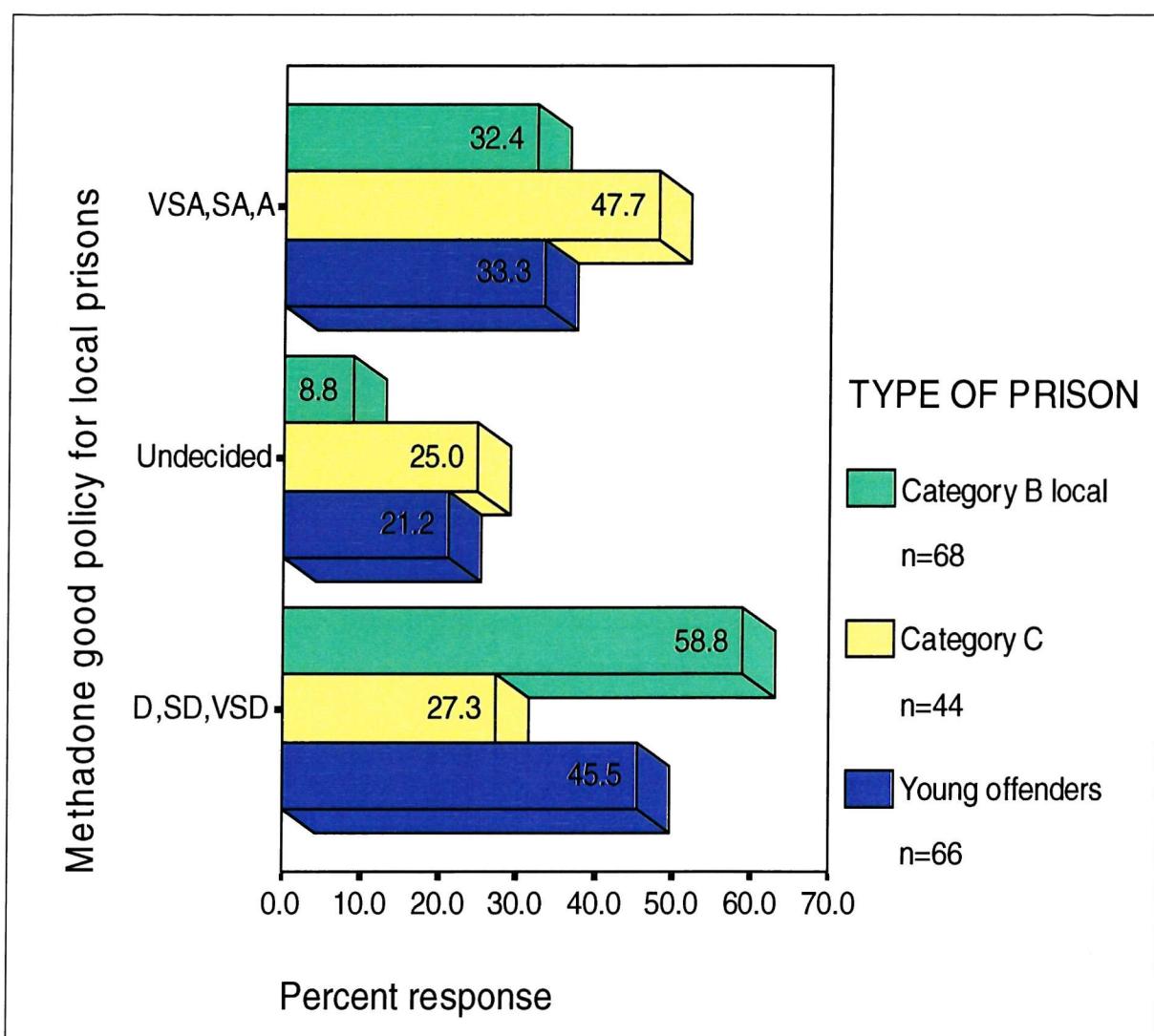


Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Figure 5.20 shows the statistically significant result for the statement concerning Methadone detoxification in 'all' prisons ($\chi^2 = 10.488$, df = 4, p=.033); category C prisons responded with a higher undecided and a greater level of disagreement. 25% of category C responses were undecided and 34.1% disagreed with the statement, although the majority response from this group was 40.9% who generally agreed with the statement. For comparison with the other groups, 25% of category B local and 29.9% of the young offender institute responses generally disagreed with the statement and 7.4% of the category B local responses and 11.9% of the young offender institute responses were undecided.

Figure 5.21 Response by type of prison to the statement: "It is a good policy to only have methadone detoxification for prisoners in local prisons"



Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Figure 5.21 shows the statistically significant result for the statement concerning methadone detoxification in 'local category B' prisons ($\chi^2 = 12.683$, df = 4, p= .013); the category C response to the statement demonstrates that 47.7% very strongly agreed, strongly agreed or agreed. This was the majority response for the group and higher than the other types of prison; category B local response was 32.4% were generally in agreement and the young offender institute response was 33.3% in general agreement. The category B responses showed a higher disagree response than the other types of prison; 58.8% for B category B local prison, 27.3% for the category C response and 45.5% for the young offender institute response.

The results could reflect that the higher number of category B local prison responses reporting methadone detoxification provision (see Table 5.5); it may reflect support for a general widening of provision to all prisons rather than just in local prisons.

The Cronbach's Alpha score for the 6 items concerning methadone detoxification is: $\alpha = .7855$.

5.7.8.2 Risk behaviour related to opiate detoxification in a prison setting

Figure 5.22 Response to the statement, "Methadone is not necessary because there is no hard drug use at the prison"

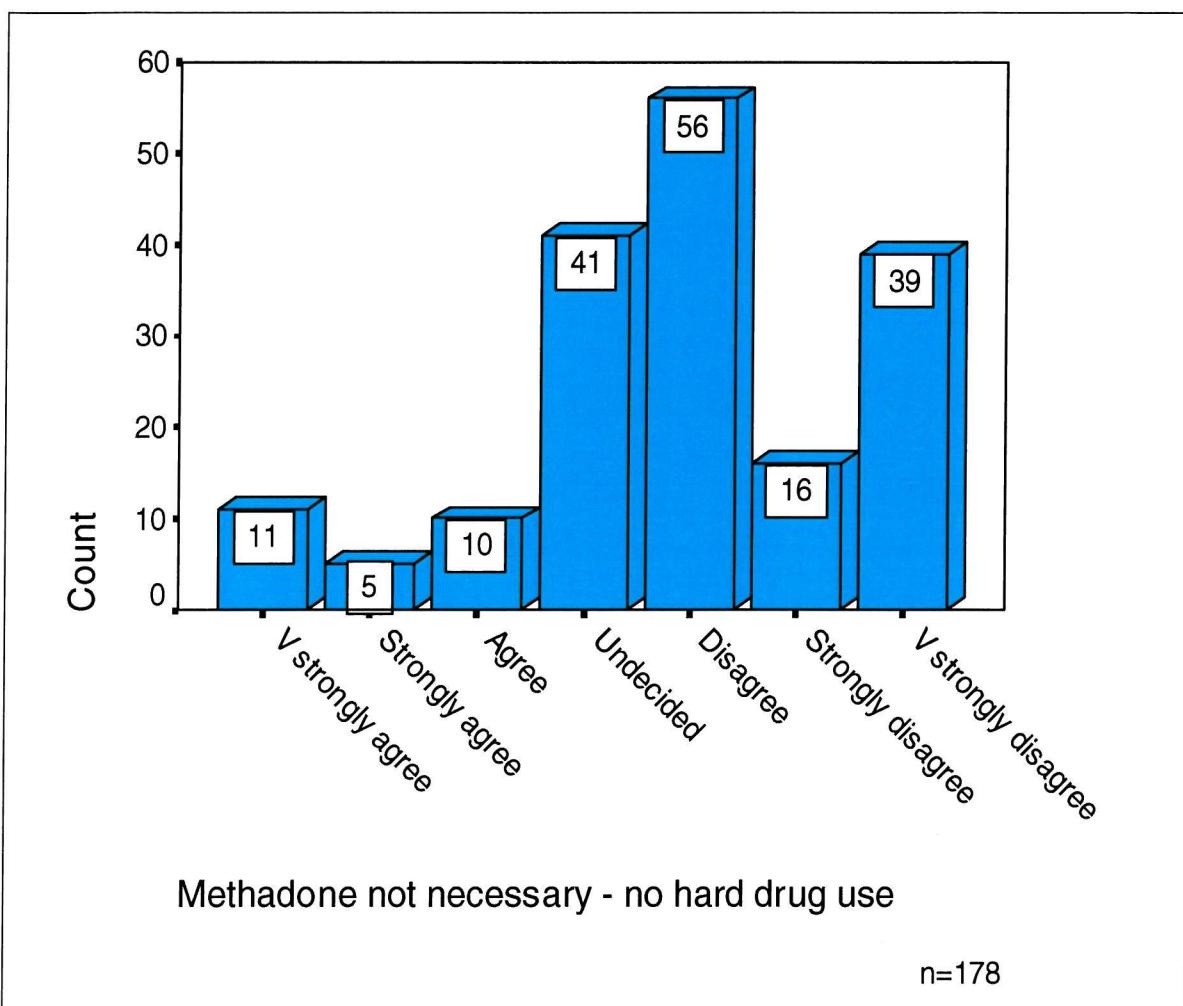


Figure 5.22 shows the distribution of response to the statement "A Methadone detoxification policy is not necessary because 'hard' drug use is not a problem in this prison" (mean 4.85, SD 1.63) which demonstrates a greater tendency to disagree with the statement. 14.6% agreed with the statement, 33.7% were undecided and 36.5% disagreed with the statement.

χ^2 test did not reveal statistically significant results for the predictor variables of age range and job discipline. However, for type of prison a statistically significant result was found; see Table 5.29 below.

Table 5.29 Response to the statement, "A methadone detoxification policy is not necessary because 'hard' drug use is not a problem in this prison"

TYPE OF PRISON	METHADONE DETOXIFICATION NOT NECESSARY		
	% VSA,SA,A	% UNDECIDED	% D,SD,VSD
Category B local	2.9 (n=2)	19.1 (n=13)	77.9 (n=53)
Category C	27.9 (12)	14 (n=6)	58.1 (n=25)
Young offenders	17.9 (n=12)	32.8 (n=22)	49.3 (n=33)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.29 shows that respondents in category C prisons and the YOI were more likely to agree than those in the category B local prison. Additionally, the young offender response shows a greater undecided response than the other two types of prison ($\chi^2 = 21.446$, df = 4, p =.000).

5.7.8.3 The prevention benefits related to methadone detoxification

Prescribing methadone as a substitute opiate drug is a well-recognised harm reduction strategy. This is essentially because oral methadone helps the drug user to avoid the harms associated with injecting (Rhodes 1994b). The responses to the statements concerned with the prevention of transmission of viruses are outlined in table 5.30.

Table 5.30 Responses to statements; "The provision of methadone detoxification in prison would reduce the transmission of HIV", "The provision of methadone detoxification in prison would reduce the treatment of hepatitis B" and "The provision of methadone detoxification in prison would reduce the transmission of hepatitis C"

STATEMENT	n	VSA,SA,A %	UNDECIDED %	D,SD,VSD %
The provision of methadone detoxification in prison would reduce the transmission of HIV	178	29.8 (n=53)	33.7 (n=60)	36.5 (n=65)
The provision of methadone in prison would reduce the transmission of hepatitis B	178	28.7 (n=51)	37.1 (n=66)	34.3 (n=61)
The provision of methadone in prison would reduce the transmission of hepatitis C	177	26.5 (n=47)	39 (n=69)	34.5 (n=61)
Mean		4.15 (SD 1.56)	4.12 (SD 1.54)	4.16 (SD 1.51)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

The mean results for the statements demonstrate that the responses to the statement are relatively similar across the responses. It is clear that a large number of staff were not convinced of the benefit of methadone prevention of HIV and hepatitis B and C.

There were no group differences in the responses from the predictor variables of age range, type of prison and job discipline.

5.7.8.4 Normative beliefs concerning methadone detoxification in prisons

Table 5.31 shows the respondents perception of how salient groups view methadone detoxification. Salient groups were identified from the in-depth interviews with prison staff.

Table 5.31 Response to statements; "The majority of prisoners would be in favour of a methadone detoxification policy", "I am in favour of a methadone detoxification policy for prisons", "In general prison health care staff are in favour of a methadone detoxification policy", "The general public would be in favour of a methadone detoxification policy" and "The majority of prison officers are in favour of a methadone detoxification policy for prisoners"

STATEMENT	N	VSA,SA,A%	UNDECIDED %	D,SD,VSD %	MEAN
The majority of prisoners would be in favour of a methadone detoxification policy in prison	177	69.5 (n=123)	21.5 (n=38)	9 (n=16)	2.98 (SD 1.34)
I am in favour of a methadone detoxification for prisoners	177	54.8 (n=97)	22 (n=39)	23.2 (n=41)	3.72 (SD 1.62)
In general prison health care staff are in favour of a methadone detoxification for prisoners	178	36 (n=64)	46.1 (n=82)	18 (n=32)	3.78 (SD 1.16)
The general public would be in favour of a methadone detoxification policy in prison	178	28.7 (n=51)	36.5 (n=65)	34.8 (n=62)	4.22 (SD 1.42)
The majority of prison officers are in favour of a methadone detoxification for prisoners	178	21.9 (n=39)	44.4 (n=79)	33.7 (n=60)	4.28 (SD 1.29)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

Table 5.31 displays the responses to statements regarding support for a methadone detoxification policy. The rows are arranged in ascending order from most acceptable to least acceptable. The general perception was that prisoners would find a methadone detoxification policy most acceptable amongst the groups identified (mean 2.98) followed by the respondents own views on methadone detoxification (mean 3.72). Health care staff, the general public and prison officers elicited a majority of undecided responses to the statements, the means being respectively; health care staff 3.78, general public 4.22, prison officers 4.28.

There were no group differences in the responses from the predictor variables of age range, type of prison and job discipline.

The Cronbach's Alpha score for the 5 item normative belief scale concerning methadone detoxification is: $\alpha = .7579$.

5.7.8.5 Management of opiate detoxification regimens in prison

Figure 5.23 Responses to statements; "If a methadone policy were operational inside a prison it should be managed by the prison health care staff", "If a methadone detoxification policy were operational within a prison it should be managed by discipline staff", "If a methadone detoxification policy were operational in a prison it should be managed jointly by discipline and health care staff" and "If a methadone detoxification policy were operational inside a prison it should be managed by outside agencies" - analysed by different types of prison

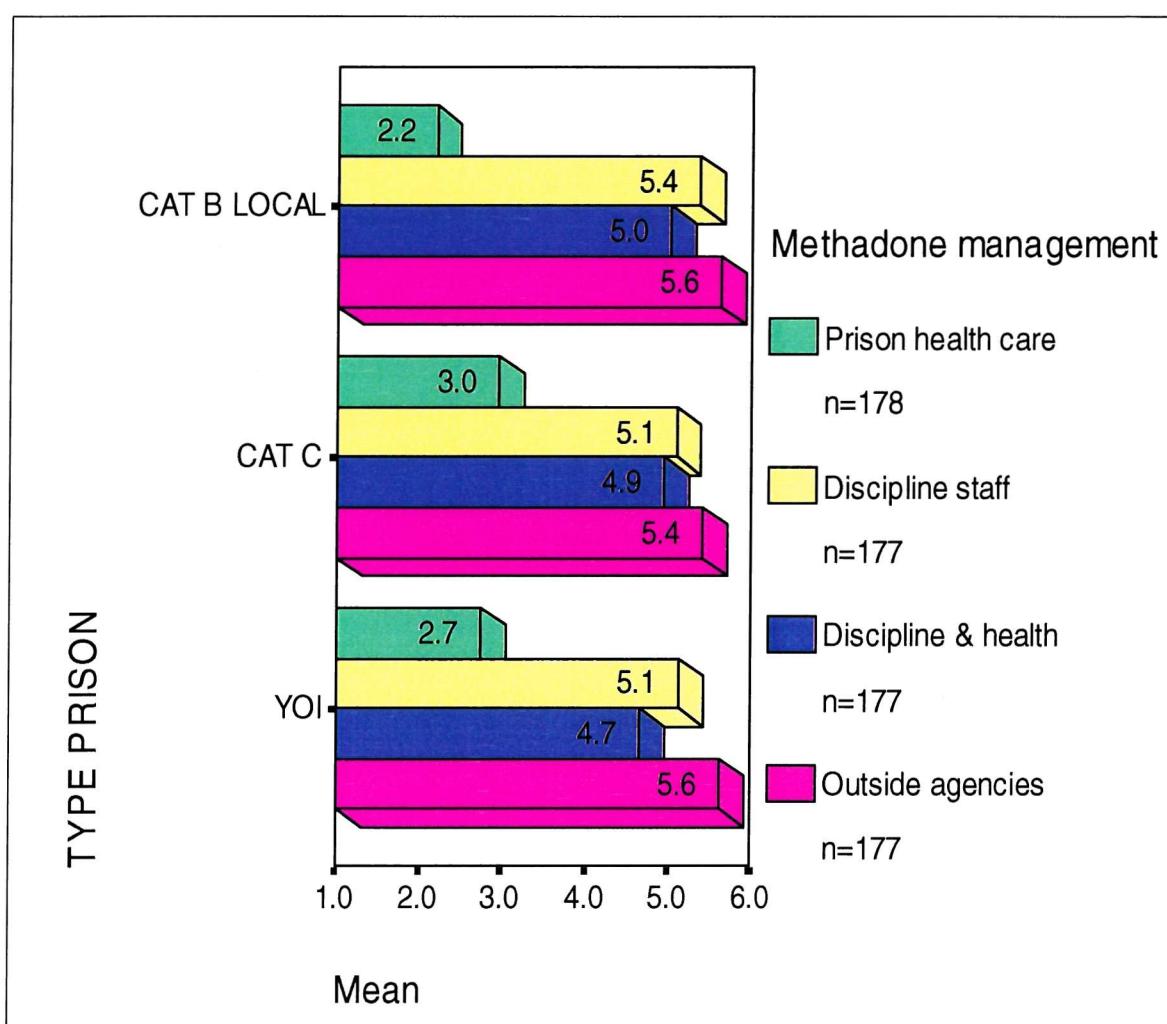


Figure 5.23 shows the responses to the statements by type of prison; this shows that the group perceived as most appropriate to manage a methadone detoxification policy is health care staff. The total group responses are outlined below:

- 83.1% of respondents agreed with the statement, "If a methadone policy were operational inside a prison it should be managed by the prison health care staff" (mean 2.58, SD 1.26)
- 76.3% of respondents disagreed with the statement, "If a methadone policy were operational within a prison it should be managed by the discipline staff (mean 5.21, SD 1.24)
- 65.5% of respondents disagreed with the statement, "If a methadone policy were operational in a prison it should be managed by discipline and health staff (mean 4.86, SD 1.47)
- 80.8% of respondents disagreed with the statement, "If a methadone policy were operational inside a prison it should be managed by outside agencies (mean 5.58, SD1.30).

χ^2 tests for the predictor variables of age range, type of prison and job discipline showed no group differences in responses.

5.7.8.6 Stated intention to implement opiate detoxification policy

Figure 5.24 Responses to the statement, "If methadone detoxification were in place I would fully implement the policy"

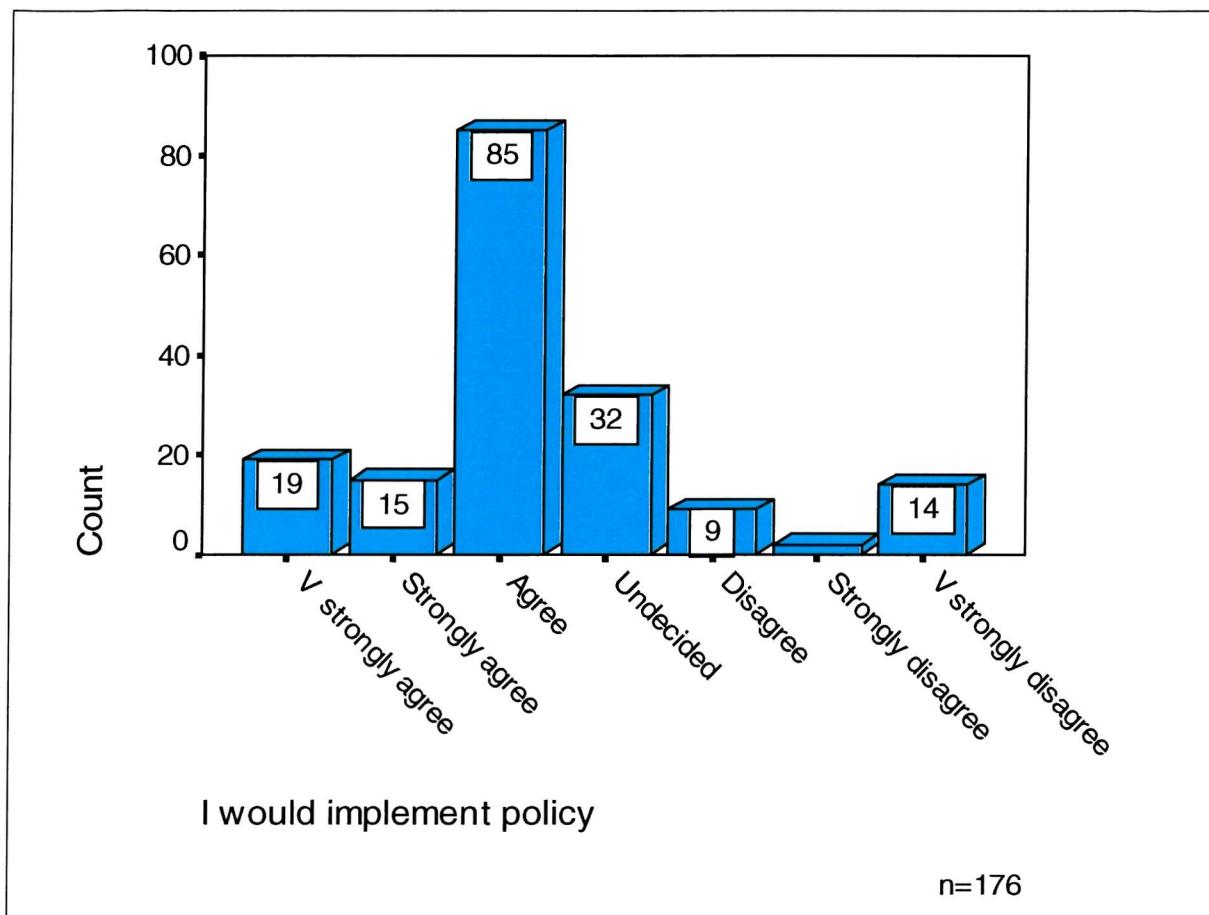


Figure 5.24 shows that 67.6% of the sample indicated that they would fully implement a methadone detoxification policy, 18.2% were undecided and 14.2% indicated that they would not implement the policy (mean 3.34, SD 1.48). The result is unremarkable because the majority of the sample felt the policy was a good one.

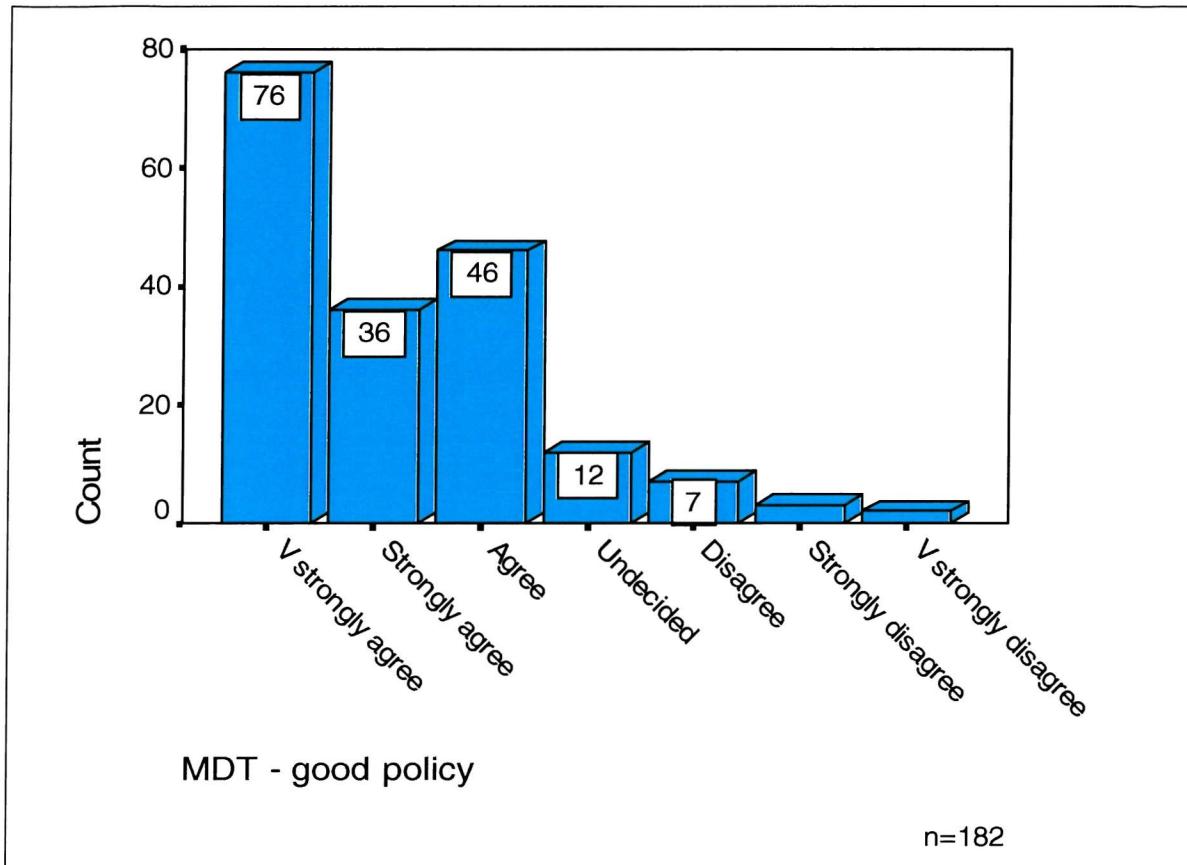
χ^2 tests for the predictor variables of age range, type of prison and job discipline showed no group differences in responses.

5.7.9 MANDATORY DRUG TESTING

5.7.9.1 Mandatory drug testing policy evaluation

86.8% of the sample agreed with the statement, "MDT is a very good policy development; figure 5.25 illustrates the number of respondents in each of the categories.

Figure 5.25 Responses to the statement, "MDT is a very good policy development"



The mean of 2.20 (SD 1.34) is influenced by the predominant response of 76 who very strongly agreed with the statement (1 equals very strongly agree and 7 relates to very strongly disagree).

χ^2 tests for the predictor variables of age range, type of prison and job discipline showed no group differences in responses.

5.7.9.2 The effect of mandatory drug testing on drug use

Figure 5.26 Responses to the statement, "MDT has changed the pattern of drug taking in prisons, increasing the amount of 'hard drugs' taken"

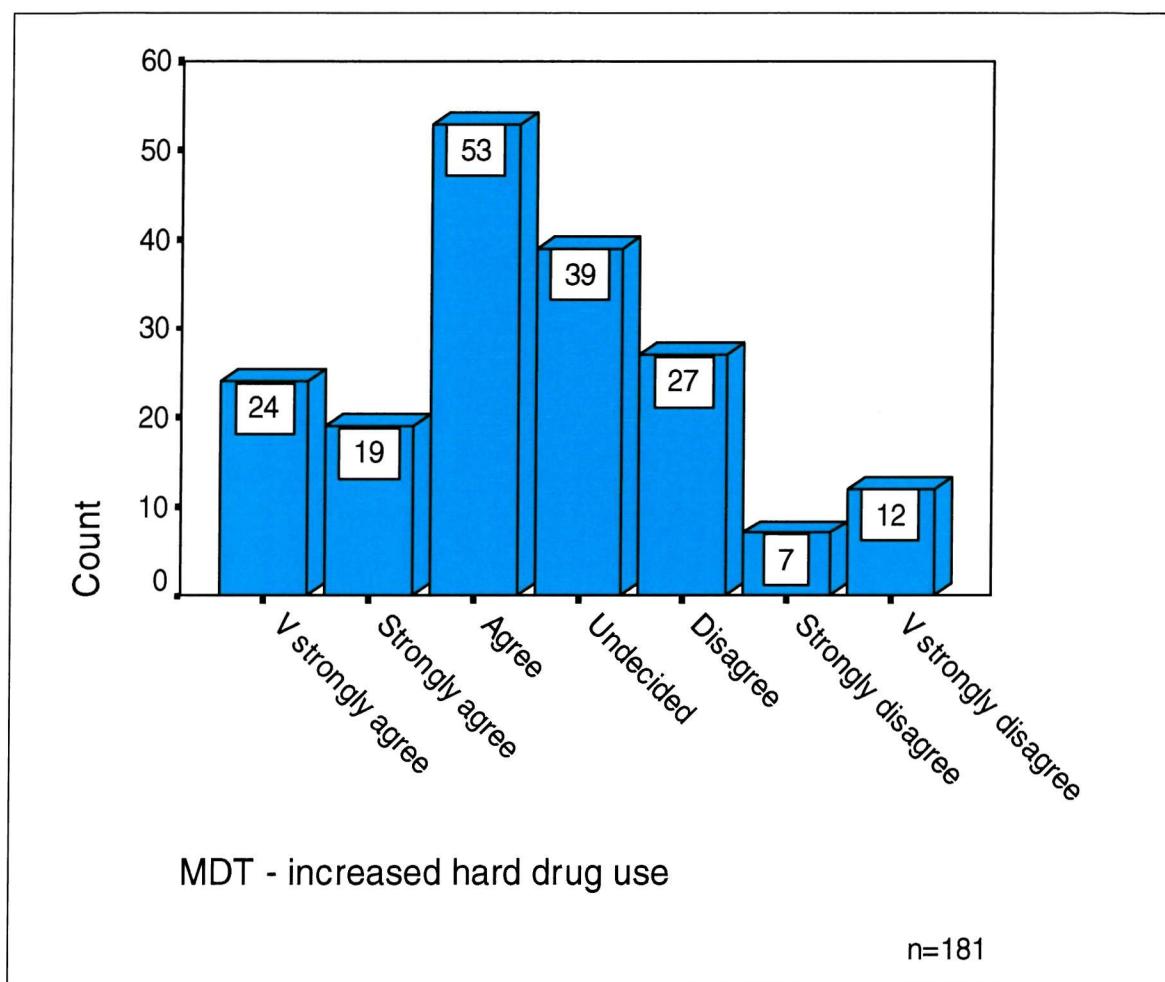


Figure 5.26 shows the response to the statement, "Mandatory Drug has changed the pattern of drug taking in prisons, increasing the amount of 'hard drugs' taken"; the mean was 3.52 (SD 1.61). 53% agreed with the statement; 21.5% were undecided and 25.4% disagreed.

χ^2 tests for the predictor variables of age range, type of prison and job discipline showed no group differences in responses.

5.7.9.3 Should the mandatory drug testing policy be reviewed

Figure 5.27 Responses to the statement, "If MDT precipitates changes to the pattern of drug use in prisons then the policy should be reviewed"

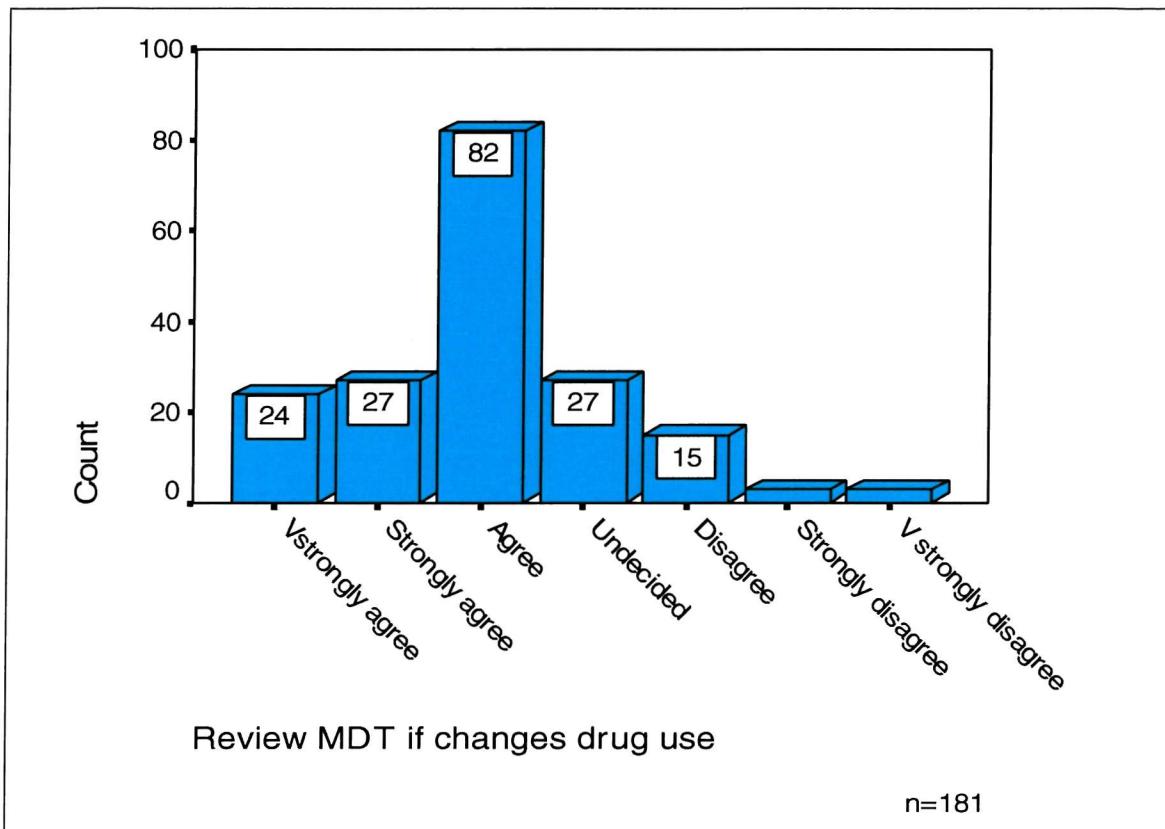


Figure 5.27 illustrates the majority agreement with the statement; 73.5% agreed with the statement, 14.9% were undecided and 11.6% disagreed. The mean was 3.02 (SD 1.26) where 1 is equivalent to very strongly agree and 7 relates to very strongly disagree.

χ^2 tests for the predictor variables of age range, type of prison and job discipline showed no group differences in responses.

5.7.10 INFLUENCES ON POLICY DEVELOPMENT

This section explores issues of personal feeling of control over policy, and the perception of how the public and politics influence policy development.

5.7.10.1 Personal control over policy development

Figure 5.28 Responses to the statement, " I feel I have little control over the way policy is developed"

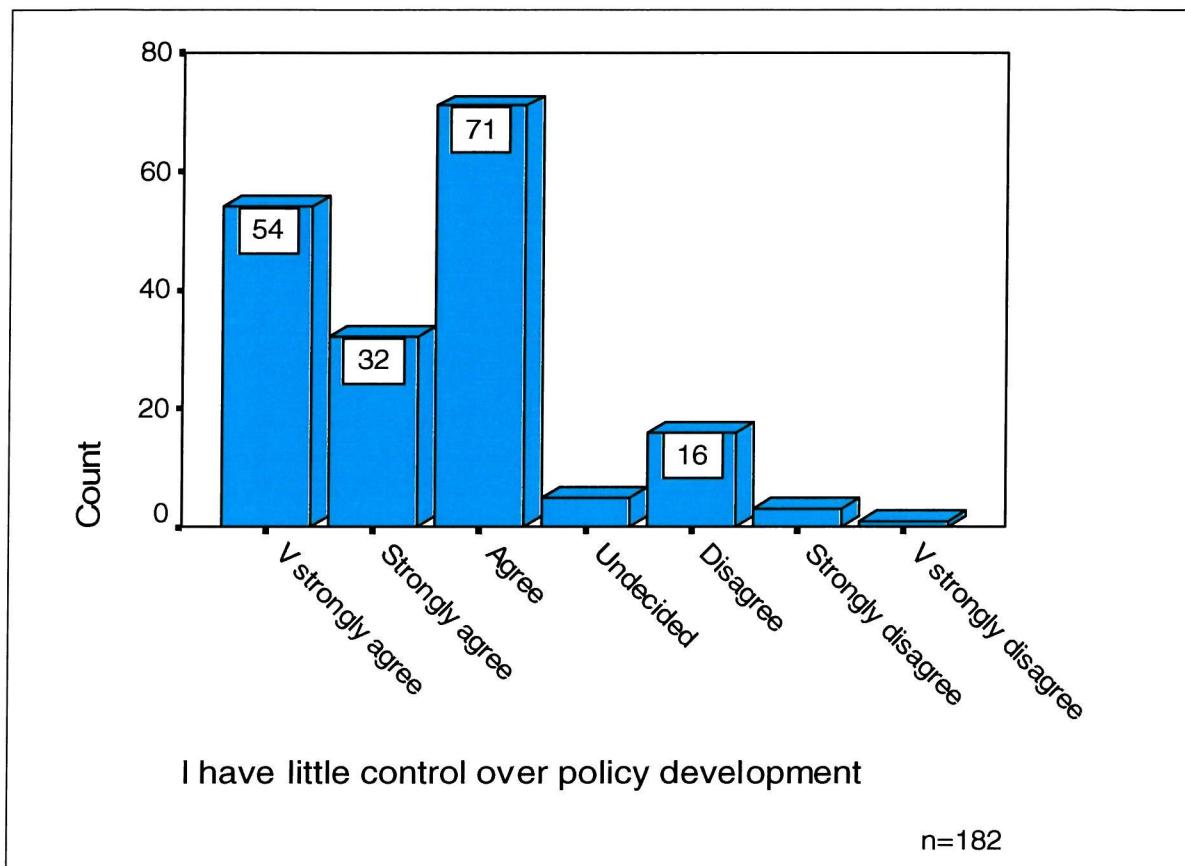


Figure 5.28 illustrates a strong agreement with the statement, with a mean of 2.51 (SD 1.32), where 1 equates to very strongly agree and 7 relates to very strongly disagree. 86.3% of the sample agreed with the statement, 2.7% were undecided and 11% disagreed.

χ^2 tests for the predictor variables of age range, type of prison and job discipline indicated no group differences in responses.

5.7.10.2 General public influence on policy

Figure 5.29 Responses to the statement, "The general public view of policy in prisons influences policy development"

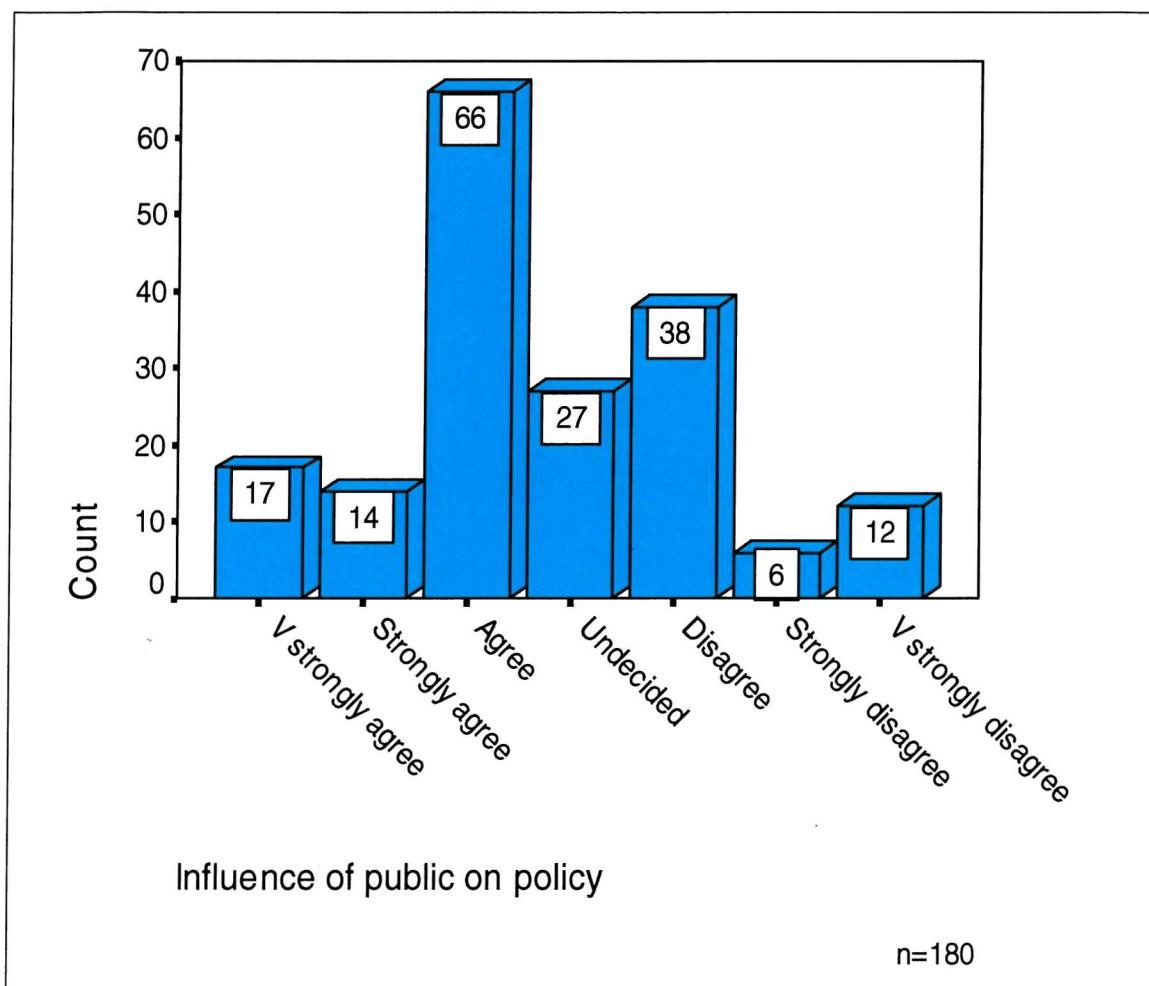


Figure 5.29 outlines the number of responses to the statement, "The general public view of policy influences policy development". Over half the sample, 53.9% agreed with the statement, whereas, 15% were undecided and 31.1% disagreed (mean 3.67, SD 1.54).

χ^2 tests for the predictor variables of age range, type of prison and job discipline demonstrated no group differences in responses.

5.7.10.3 Political influence on policy

Figure 5.30 Response to the statement, "Prison policy can sometimes be made because of political will rather than for the good of prisons"

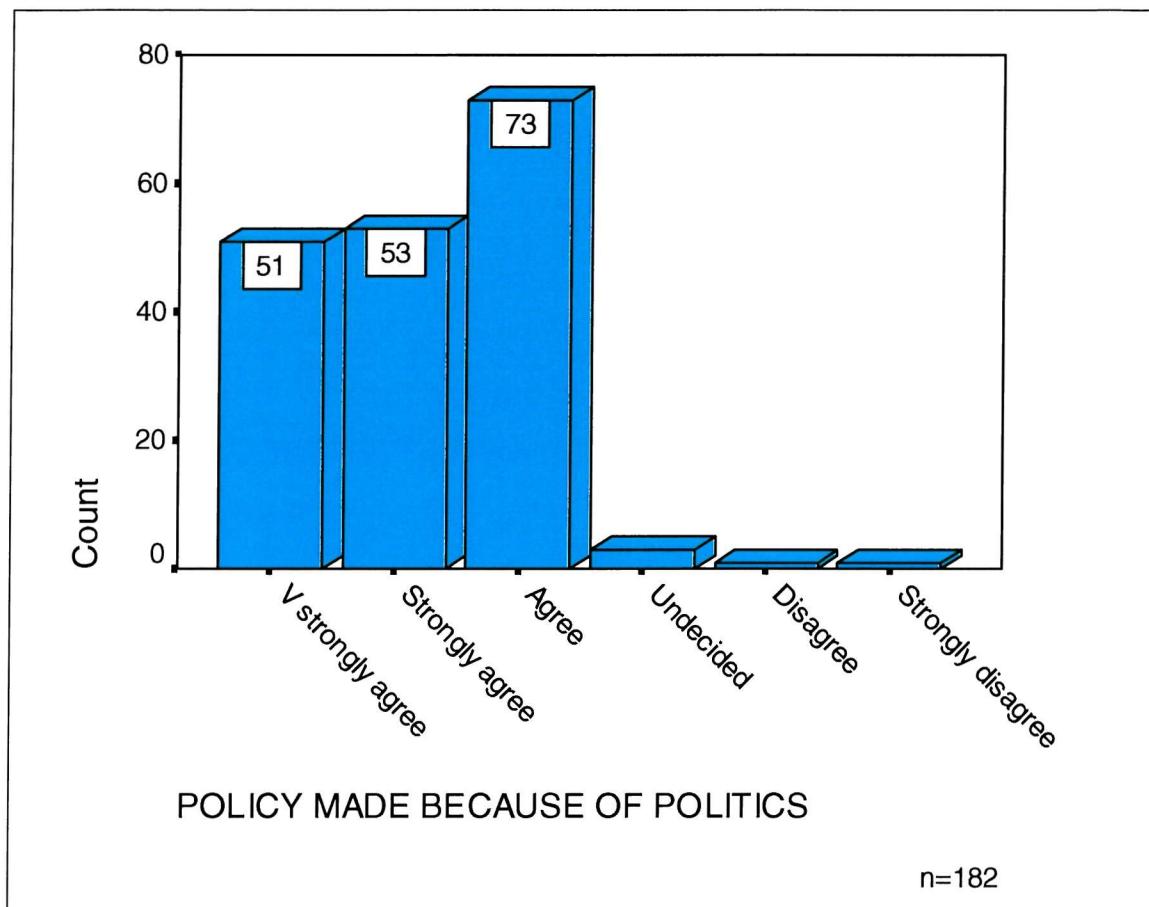


Figure 5.30 shows a very strong endorsement of the statement (mean 2.19, SD .92), with 97.3% of the sample agreeing with the statement, 1.6% being undecided and 1.1% disagreeing.

χ^2 tests for the predictor variables of age range, type of prison and job discipline showed no group differences in responses.

5.7.11 THE IMPORTANCE OF DEVELOPING PREVENTION POLICY IN PRISONS

Figure 5.31 Responses to statements; "I feel that HIV and hepatitis prevention is an important issue" and "I feel that HIV and hepatitis prevention is a priority area for policy development"

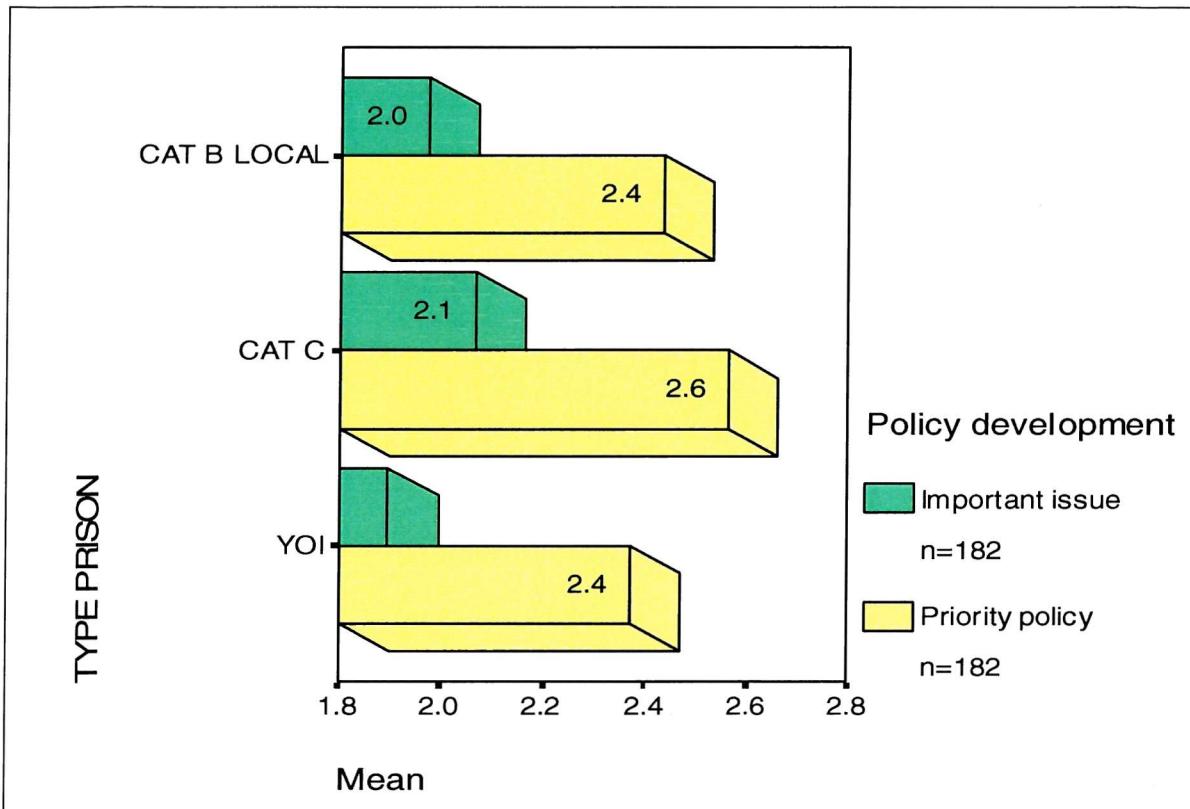


Figure 5.31 outlines the responses to the statements:

- I feel that the prevention of HIV and hepatitis B and C is an important issue
- I feel that HIV and hepatitis prevention is a priority area for policy development

There is no difference in the response from different types of prisons and the responses are quite strikingly in agreement with the statements. The overall responses were that 97.3% agreed with the statement concerning the importance of HIV and hepatitis B and C prevention (mean 1.97, SD .91). In terms of HIV and hepatitis B and C being a priority area for policy development, 85.7% agreed with the statement, 9.3% were undecided and 4.9% disagreed (mean 2.45, SD 1.14).

χ^2 tests for the predictor variables of age range, type of prison and job discipline revealed no statistically significant group differences in responses for either statement.

5.7.12 WHO SHOULD MANAGE THE DEVELOPMENT OF PREVENTION POLICY

The Health Care Directorate act at national level to set policy and standards that are devolved down for implementation to the governor of the prison who is primarily responsible for health care (Joint Prison Service and National health Service Executive Working Group 1999). In prisons where an AIDS Management Team is in operation, the role of the team is to consider and advise the governor about the relationship and impact that prevention of HIV and hepatitis policy would have on security matters (Sexton 1997). Figure 5.30 outlines the responses to statements about managing the overall policy development in prisons.

Figure 5.32 Response to statements; " Policy for the prevention of HIV and hepatitis B and C should be developed by the Health Care Directorate", "Policy for the prevention of HIV and hepatitis B and C should be developed by the governor", "Policy for the prevention for HIV and hepatitis B and C should be developed by the health care staff" and "Policy for the prevention of HIV and hepatitis B and C should be developed by the AIDS management team" analysed by different types of prison

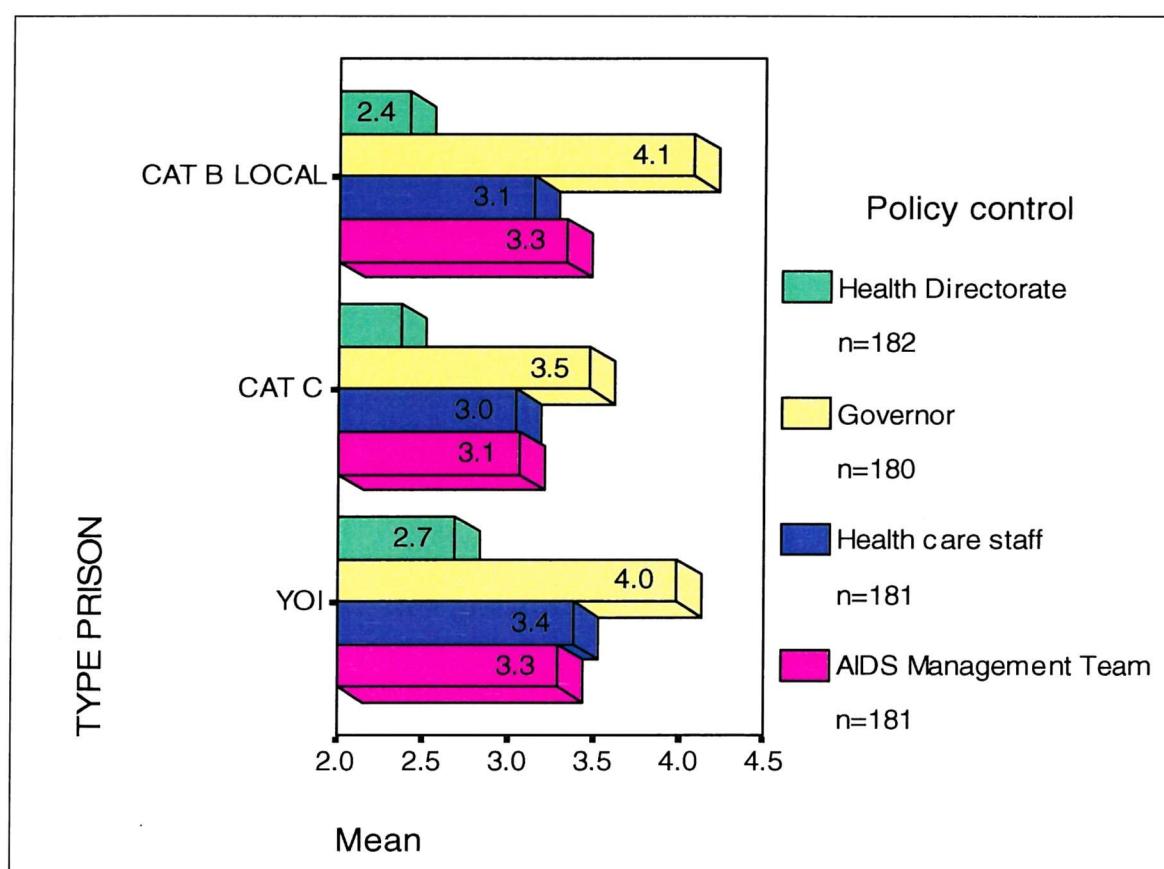


Figure 5.32 illustrates that, in terms of policy development for HIV and hepatitis B and C, the respondents feel that overall policy should be driven by health care; however, most preferred was the Health Care Directorate. This result supports the preferred

management responses for the individual policies of condom access, needle exchange, bleach distribution and methadone detoxification. The whole sample results are summarised below in ascending order of most acceptable:

- In response to the statement, "Policy for the prevention of HIV and hepatitis B and C should be developed by the Health Care Directorate", 85.7% agreed, 11% were undecided and 6% disagreed (mean 2.49, SD 1.17)
- In response to the statement, "Policy for the prevention of HIV and hepatitis B and C should be developed by the Health Care staff" , 63.5% very strongly agreed, strongly agreed or agreed, 23.2% were undecided and 16.6% disagreed, strongly disagreed or very strongly disagreed, mean 3.19 (SD 1.32)
- In response to the statement, "Policy for the prevention of HIV and hepatitis B and C should be developed by the AIDS Management Team", 60.2% agreed, 23.2% were undecided and 16.6% disagreed (mean 3.25, SD 1.29)
- In response to the statement, "Policy for the prevention of HIV and hepatitis B and C should be developed by the governor" 40% agreed, 21.1% were undecided and 38.9% disagreed (mean 3.89, SD 1.56).

The results indicate that the respondents believe that there should be a strategic leadership for HIV and hepatitis prevention from the Health Care Directorate. Health care staff and the AIDS management team were clearly perceived to have an important role in policy development. The governor's role was less certain in HIV and hepatitis prevention and had less support than the other options; however, a slight majority of respondents generally agreed with the view that the prison governor had a development role in policy.

χ^2 tests was performed for all the statements for the predictor variables of age range, type of prison and job discipline however, no statistically significant group differences in responses were revealed.

5.7.13 HIV AND HEPATITIS B AND C TRAINING

Table 5.32 Response to statements; "I feel it is necessary for me to have further training in HIV/AIDS awareness", "I feel it is necessary for me to have further training in hepatitis B awareness" and "I feel it is necessary for me to have further training in hepatitis C awareness"

STATEMENT	N	VSA,SA,A %	UNDECIDED %	D,SD,VS D%	MEAN
I feel it is necessary for me to have further training in HIV/AIDS awareness	181	91.7 (n=166)	4.4 (n=8)	3.9 (n=7)	2.10 (SD 1.15)
I feel it is necessary for me to have further training in hepatitis B awareness	181	92.8 (n=168)	3.9 (n=7)	3.3 (n=6)	2.04 (SD 1.11)
I feel it is necessary for me to have further training in hepatitis C awareness	181	92.8 (n=168)	4.4 (n=8)	2.8 (n=5)	1.99 (SD 1.11)

Key

VSA = very strongly agree, SA = strongly agree, A = agree, VSD = very strongly disagree, SD = strongly disagree, D = disagree

The responses to the statements in Table 5.32 powerfully indicate that staff regard further training in HIV, hepatitis B and hepatitis C as necessary.

χ^2 tests were performed for all the statements for the predictor variables of age range, type of prison and job discipline however, no statistically significant group differences in responses were revealed.

5.7.14 SUMMARY OF QUANTITATIVE RESULTS

The strength of the study is its multimethod approach, utilising qualitative interviews to explore the policy issues concerning HIV and hepatitis B and C prevention, and to formulate the most common issues into a structured questionnaire that was administered to a second, and wider, population. Within this context; the questionnaire has fulfilled its aim of exploring these important policy issues and concerns in a wider population and from the perspective of a greater number of the different types of prisons. The responses to the Likert-scaled statements confirm the qualitative data in all areas except for the statements regarding training and the priority and importance of HIV and hepatitis prevention policy. In the questionnaire

sample, over 90% of respondents felt it was necessary to have further training in HIV, hepatitis B and hepatitis C awareness. 97.3% of the sample felt that HIV and hepatitis B and C prevention was an important issue and 85.7% felt that HIV and hepatitis B and C policy development was a priority area. This presents a slightly different picture from the qualitative analysis because, although all interview participants felt concern about HIV and hepatitis education, few felt that in the competing demands of prison life it should be a policy priority. A number of interview participants felt that they would not benefit from further training on HIV or hepatitis B however, there was consensus about the value of training in hepatitis C awareness. The higher rating given to issues of policy priority and importance and desire for further training may well reflect a response bias in the questionnaires returned. Despite all efforts, the questionnaire response rate was poor and questionnaire distribution problems were experienced. This essentially means that the questionnaire findings are not generalizable and would not be valuable as a stand-alone study; however, when used in conjunction with the qualitative findings they allow a much broader view of the research questions.

The policy statements concentrated on areas where introduction of HIV and hepatitis B and C prevention measures was difficult or controversial; therefore, areas such as education and training for prisoners, where good progress has been made, were not explored. Statements on the questionnaire focused on policy development in the areas of condom access, needle exchange, bleach for cleaning intravenous injecting equipment and methadone detoxification for opiate withdrawal. Additionally, risk, mandatory drug testing, influences on policy development, and the importance of policy development and training were explored.

The results for policy related responses can be summarised broadly as follows; staff acknowledged that there is risk behaviour in prisons and therefore, the benefit of prevention policy can be appreciated in terms of its impact on reducing transmission of the viruses, except in the instance of methadone detoxification treatment. It is apparent that the role of methadone in harm reduction is not well understood. This could be because there is less awareness that the prescription of methadone as a substitute opiate drug helps the drug user avoid the harm related to injecting and with using less 'pure' illicitly obtained drugs. There was however, a positive response to

methadone detoxification being available in all prisons this seemed more related to its association with the drug strategy.

Needle exchange and bleach provision are not viewed as acceptable by the majority of respondents, whereas condoms and as stated methadone treatment are viewed positively by the majority. There was profound conflict with all the policies explored, except for methadone detoxification, expressed in terms of believing that the policies condone risk behaviour, compromise security, cause a conflict for the law and order role of prisons and cause a conflict for the discipline and security role of prison officers. When the normative beliefs were explored the only group believed by the respondents to favour all policies were the prisoners; otherwise the only other favourable response was to the statement, "I am in favour of a methadone detoxification policy for prisoners", there was a majority undecided response for health care staff favouring methadone detoxification. When respondents were asked if they would implement the policies, despite the deep concerns expressed, the staff overwhelmingly stated that they would indeed implement the policies. Health care staff were favoured to manage all the policies explored individually with an overall strategic direction preferred from the Health Care Directorate.

The questionnaire results revealed that 56.6% of staff felt that their job put them at high risk of HIV, 72.5% felt that their job put them at high risk of hepatitis B and 68.9% felt their job put them at high risk of hepatitis C. The fear of communicable disease risk in the workplace should be countered by training to increase knowledge and understanding of how prevention policies would reduce risk in the environment for themselves and for the prisoners. The perception of staff of the benefit and usefulness of compulsory virus testing may in part be a result of the risk felt in the work environment, and partly because of a lack of understanding about the surveillance difficulties related to testing for seroconversion.

The results show that staff are more concerned about policies that have not been implemented; this can most strikingly be seen where respondents for category C prisons were more likely to favour methadone detoxification treatment in category B local prisons; this position reflects the current policy position. On the other hand the responses from the types of prison that were likely to have a methadone detoxification policy were more likely to endorse a widening of the policy to include all prisons.

Mandatory Drug Testing (MDT) was believed to be a very good policy development but it was perceived to have negatively impacted on the use of 'hard drugs' in prison. Therefore, the majority of respondents felt the MDT policy should be reviewed.

The issues summarised will be discussed and developed in conjunction with the results from the qualitative interviews in Chapter 7.

5.7.15 CRITIQUE OF QUESTIONNAIRE DESIGN

The questionnaire covered many factors associated with prevention policy and its length reflected the important issues that emerged from the interviews with staff. However, the comprehensive coverage of the issues may have seemed daunting and thus discouraging to potential participants. An additional factor may have been that because some of the earlier questions in the questionnaire were knowledge based some respondents may have found this section challenging and possibly off-putting; for example, one of the respondent's stated that the questionnaire,

"Made me think".

Some of the issues explored in the questionnaire are controversial in a prison setting because the principal focus of attention is on security and law and order. Therefore, this level of complexity may have resulted in some ambiguity of beliefs and so had an additional detrimental effect on the response rate. One statement that was included in each policy section asked about the necessity of the policy because of risk behaviour, for example, "A condom policy is not necessary because same sex sexual activity is not a problem in this prison" this statement does in fact address two issues and may have been confusing for the respondent.

Control over questionnaire distribution and the timing of the distribution were also factors in the low response rate. The distribution problems were a feature of the particular secure environment of prisons and the researcher was unable to control both the number of questionnaires distributed and the timing of the distribution, in one prison there were three other questionnaires distributed at the same time.

Finally, using the Theory of Planned Behaviour to guide item selection burdened the questionnaire with additional conceptual questions; for example, the questions concerning normative beliefs and intention to perform the policy were asked in relation to each type of policy. Although this approach added to the length of the

questionnaire, issues about the views of others affecting policy had emerged as a theme in the interviews so this approach seemed worthwhile. However, the addition of what appeared to be repetitive questions may have been off-putting to a number of potential respondents.

Some of these response factors may have influenced a respondent bias; so that only people interested in HIV and hepatitis B and C, or are interested in policy development would have taken the time to complete the questionnaire.

CHAPTER 6

Study Three: Interviews with prisoners

6.1 CHAPTER OVERVIEW

Chapters Four and Five explored the policy issues from the staff perspective and Chapter Six presents the third study, the interviews with the prisoners. The aim of study three was to explore prisoner perceptions of HIV and hepatitis B and C prevention in prison. The background literature review in Chapter Two revealed only one Canadian pilot study which explored in depth the prisoner perception of HIV and hepatitis B and C prevention in prison. It is likely that prevention programmes will only be effective if the beliefs of the target population are known, considered in policy development, and acted upon.

The methods used and the analysis of the interviews are presented and the Chapter concludes with a summary of the results.

6.2 METHODS

Face-to-face, in-depth interviewing was the method used to address the research aim in this phase of the study. The method was chosen to identify the problems from the prisoner perspective and the approach to the interviews and the analysis of the interviews was influenced by a combination of case study method, ethnographic method and the theory of planned behaviour.

6.2.1 DESIGN OF PRISONER INTERVIEW SCHEDULE

An interview schedule was designed to help guide the discussion; its development was influenced by the themes that emerged from the staff interviews, the staff questionnaire and from the related literature. A discussion about risk behaviour was necessary to be able to contextually identify and have a meaningful discussion about the appropriate prevention policies. Policy issues discussed were condom access, needle exchange, bleach provision for cleaning shared injecting equipment, opiate detoxification, drug free wings and therapeutic communities. However, the interview design was to enable exploration of HIV and hepatitis prevention policy from the prisoner perspective therefore; participants were reassured that their own views of

what was relevant and important were most important. The interview schedule was designed to address the following research questions:

- Is HIV and hepatitis B and C prevention necessary?
- How do prisoners perceive HIV and hepatitis B and C prevention policy?
- Would prisoners take up the HIV and hepatitis prevention policies?

6.2.2 INTERVIEW SCHEDULE

The interviews were semi-structured and focused on policy issues and related risk behaviours. The flexible schedule of questions (appendix 3) asked about the prisoner's perception of risk behaviour in prison; therefore, drug use in prison, intravenous drug use in prison and perceptions about the amount of sexual activity in prison were discussed. Also addressed were HIV and hepatitis B and C prevention policies and how they would be received or accepted by prisoners and prison staff.

At the end of the interview, the participant was asked if he had any new ideas for HIV and hepatitis prevention policy development. The participant was also asked if there were any issues he wished to discuss that had caused concern during the interview.

6.2.3 GAINING ACCESS TO PRISONERS

Access to prisoners was organised by the staff member who had facilitated the staff interviews in study one. A request was made for all interviews to take place in a private place. This request was observed; however, on some occasions if a member of staff wanted to enter the room they did so without knocking and on these occasions the interviews were suspended briefly whilst the member of staff was in the room.

All participants were approached by a member of staff and given brief details of the study; however, before each interview the participant was fully informed by the researcher about the purpose of the interview and reassured that involvement in the study was purely voluntary and they could withdraw at any stage.

6.2.4 PARTICIPANTS

Purposive sampling was used for 18 prisoner interviews. 6 were conducted in a category C prison, 6 were conducted in a category B local prison and 6 were conducted in a young offender institution. The research sites were the same as the prisons used for the staff interviews because it was anticipated that the different categories of prison might have shown important differences from the perspective of the prisoners. All participants were male as all the prisons were male establishments. The prisoners were chosen because they were identified by staff or by the prisoners as key informants, they were believed to have an understanding of the topics to be discussed. For example, people who were in a therapeutic community, on a drug programme, known to have substance-related experiences or were perceived to be gatekeepers because of their confidential supportive role towards other prisoners, such as, listeners in the suicide awareness programme. All prisoners approached for interview agreed to participate.

6.2.5 PROCEDURE

At the beginning of the interview, a crib sheet was used to ensure that the participants understood and felt comfortable with the following points:

- the nature and purpose of the interviews
- that the researcher was independent of the prison service and had a background in nursing and communicable disease control
- that the content of the interviews would not be discussed with staff
- to ensure that anonymity and confidentiality were explained and assured
- to give an explanation about the length of the interview
- to obtain written consent for the interview
- to obtain written consent for audiotaping the interview.

6.2.6 ETHICAL ISSUES

The Prison Health Research Committee and the Psychology Department of the University of Southampton examined the ethical issues and gave approval for the

study. However, the Prison Health Care Research Committee gave approval subject to the following points;

- the prize draw offered in the study two, the staff questionnaire, should not be extended to prisoners
- the consent form should include the following aspects;
 - a) it should be made clear that the prisoners can withdraw at any time
 - b) the consent form should explain the purpose of the research
 - c) the consent form needs to make clear that the transcription of the interview will be kept and that the audio-tape will be wiped clear (see appendix 5 for letter from the Prison Health Care Ethics Committee).

These requirements were included in the consent form (see appendix 6 for prisoner consent form). The consent form also gave reassurance about anonymity and stated that the participant was not obliged to answer any question. These points on the consent form were also stated verbally at the beginning of the interview and at times during the interview if the interviewer felt it was necessary to reinforce any one of these points.

Approval, from each of the governors of the prisons involved in the study was also required. The researcher was given permission to use the Prison Health Research Ethics Committee letter as the official confirmation to governors that the required ethical approval had been obtained.

The participants were informed before the interview started that personal descriptions of risk behaviour were not necessary and that policy issues could be discussed generally, although, if the participant felt that a personal account would illustrate a particular point, and they felt comfortable about it, then it may be useful for clarification.

Research that focuses on sensitive issues may stir up emotions and concerns about the subject under discussion or the confidentiality of information (Alty & Rodham 1998). To try to alleviate this all respondents were asked at the end of the interview if there was anything that he would like to discuss in more detail or if there was

anything in the interview that required clarification. Details of how to contact the HIV co-ordinator or an appropriate member of the health care staff was given so that any concerns the participant had after the interview could be dealt with appropriately.

Confidentiality of information was restated at the end of the interview.

6.2.6.1 Consent, anonymity and confidentiality

Written consent was obtained from all participants before the interview. Participants were informed that no identifying information would be used in write up of the research. Permission was sought to audiotape the interview. The participants were informed that the audiotapes would be erased after they had been transcribed and the transcriptions would be stored securely and only used for research purposes. It was emphasised that nobody would hear the participant's individual views apart from the researcher.

6.3 DATA ANALYSIS

6.3.1 TRANSCRIBING THE INTERVIEWS

The interview tapes were listened to as soon as possible after the interview. The interviews were transcribed verbatim and entered into Ethnograph version 4.0. All identifying information was removed and the transcripts given numerical identifiers. To aid later analysis the identifiers described the participant as a prisoner, the type of prison, and the interview number. Each type of prison was assigned a range of numbers according to the type of prison; so for example, the first interview in the young offender institute was numbered PRYO100; a prisoner (PR) in a young offender institute (YO) with the first number in the range assigned to the prisoner (100).

6.3.2 THEMES IDENTIFIED FROM THE DATA

Ethnograph was used to aid coding and identify relevant issues in the prisoner interview data. Categories were assigned if a number of prisoners raised the same issue (see appendix 7 for example of coding process). However, the same forty-six categories used for staff interviews were found to be useful and appropriate for coding the prisoner interviews, although not all categories were utilised for coding data. When the coding of all transcripts was complete the data compilations of these

categories were used to identify major themes in the data and four themes were identified:

- 6.4.1 Education
- 6.4.2 Risk behaviour
- 6.4.3 Prevention policies
- 6.4.4 Barriers to policy development.

6.4 RESULTS

This section describes an overview of the four themes that conceptualised the beliefs of the prisoners about HIV and hepatitis B and C risk behaviour and prevention in prisons.

6.4.1. EDUCATION

Most respondents said that they had a general understanding of the transmission routes of HIV; however, the consensus was that they had received very little education and more education would be beneficial. There was particular concern expressed about lack of knowledge and education concerning hepatitis. The following extracts illustrate this viewpoint.

A participant from a category C prison expressed his viewpoint in the following way,

"I mean they should, people should get told in prisons more about it [hepatitis] if you ask me, I mean the only time you get told about it is if you take a drug course and then they throw a bit in about hepatitis diseases, but other than that you don't know anything I mean there's a few naïve people like still don't know how you can catch it, it's still why oh, it's like you've got hepatitis like oh keep away from him don't even talk to him you know what I mean."

(PRC83)

This response was from a participant from overseas in a category C prison when asked if he had received any education relating to HIV and hepatitis B and C,

"Any information [HIV or hepatitis] no. I know that if you go to the hospital you can get information but no because they have come to me and they say, or to us, we are doing this, you know what I mean, we don't have any training about this. I don't know much about hepatitis or HIV"

(PRC84)

A participant from a local prison who felt he had enough knowledge about HIV but had a concern about transmission of hepatitis B and C said,

"Hepatitis B and C hasn't been you know broadcast as much as HIV has it so it hasn't been as known as much but umm, it can be as deadly can't it.... Since I've been in here, I've heard it a lot more than I have when I've been on the outside, The only thing worries me about catching it through saliva."

(PRL95)

This response about HIV and hepatitis education comes from a participant in a young offender institute, who is currently on a therapeutic community programme for substance misuse,

"No [not enough education] with the therapeutic, like when you come on to these communities, I think they should do a group like once a week, every week, for like AIDS, contraceptives and hepatitis and all that, I think they should do different subjects on that a week, so then people do start to learn more about the problems, the way that you can catch it."

(PRYO100)

A participant from a young offender institute responded to the question concerning HIV and hepatitis education, had he received any and was it enough, in the following way,

"Well we had someone that came in, a talk for about half an hour, twenty minutes. It was useful yeah."

When he was asked if he had understood the transmission routes of HIV and hepatitis prior to the talk he said,

"I didn't really, I mean I knew people had it, but I didn't really like ask them, you know what I mean."

(PRYO104)

Often discussion about education relating to HIV and hepatitis prompted questions that participants had about transmission of the viruses.

A participant from a local prison responded to a question about education by asking,

"The only thing I worry about is umm, I don't know much about B and C [hepatitis] but I just wondered if umm, say you're walking round the gym and umm, made an injury and you had blood on yourself you had contact with a person with blood and can you actually spread anything?"

(PRL94)

A participant from the category C prison responded to the question about hepatitis education by saying,

"No I don't really know much about it [hepatitis] it don't mean nothing."

(PRC85)

Some participants were very positive about the education that they had received but it appeared not to operate to the same standard across prisons.

A participant from a category C prison said,

"We had an induction when I first went into prison umm, and that lasted for two hours and that was purely on umm, hep C, hep B umm, how to prevent it and that was on a video and a lecture and as I said on an induction that lasted two hours which for an induction is good umm. That was at the prison I first come in but after that as far as that prison was concerned that was it, you've seen it, done it, got the t-shirt, go away, do you know what I mean anything else is down to the hospital, this prison has a tendency to have it ongoing, you do it on induction here umm, I don't think it's as comprehensive as what it was at me last prison, the induction bit but it's ongoing here umm, as you say again it's more open conditions you have easier access and recourse to people here than what you had at me old prison umm, but again I don't

think they can ever do enough anyway so it's where do you draw the line but I would say generally umm, yeah on the induction at that other prison I think by the time they'd done it most of the guys take it in and have a good idea about what it's about anyway."

(PRC80)

Discussing how different prisons have different approaches to HIV and hepatitis education this participant from a category C prison said,

"Some prison yes [have training], some prisons no, some prison you go in and you never hear anything at all, other prison they have special umm week long classes where they take you in and they show you videos on umm, intravenous drug use, AIDS, hepatitis, how you can catch it, how you can't catch it, what's safe what isn't umm and other prisons you know you can be in prison for years and not be told anything, I have seen umm, something up on the wall in my wing about hep C but all it says is if you know somebody who is using to tell the officers, which you know really speaking is not going to happen, not in a prison."

Later in the interview, he went on to say,

"Umm, it's well, for me it seems to have been drummed into me at the start of my sentence and then nothing else, like when I first went into prison I have say six months of just sitting around waiting and when I went to my next prison they show us on induction a video and umm, a couple of prison videos about tattooing and things like that and then since that nothing else you know it's not everybody that does the induction if you see what I mean, if you've been to prison before and you go back into the system if you're known in that prison then the education part of it it's oh you've been here before you know you don't have to come."

(PRC81)

A participant from a category C prison also commented on the variability and nature of HIV and hepatitis education in the induction programmes,

"I went to the induction but I didn't really do it that much I got myself a job as soon as I come here so I was only on the induction for about a day and then I got myself a job."

(PRC85)

A participant from a local prison had this to say about his experience of education,

"No. I've done education courses but that was only on cooking."

(PRL92)

A participant from a young offender institute when asked if he had received any education at the current or remand prison he said,

"No. None at all".

(PRYO103)

The following extract was from a participant in a local prison responding to the question regarding attending HIV and hepatitis B and C education or training,

"Umm, I just read what was available in the health care, no not training."

When asked if he thought education or training would be a good thing he replied,

"Yes I do yeah."

(PRL94)

When given the opportunity to ask questions at the end of the session some participants took the opportunity to ask questions, for example, a participant from the young offender institute said on the conclusion of the interview,

"Umm, is there any chance of leaflets."

(PRYO105)

The delivery of leaflets to the participant was arranged through the liaison officer that had organised the interview.

Another participant from the young offender institute asked the following question,

"How would I actually go about getting tests [for hepatitis and HIV seropositivity] in this prison."

(PRYO103)

There were a number of questions concerning hepatitis, particularly hepatitis C. The following question is from a participant from the local prison,

"Alright, okay, can hepatitis C be umm, caught by saliva and that, cause I've heard a lot of it can be caught by saliva or whatever."

(PRL95)

6.4.2 RISK BEHAVIOUR

The theme risk behaviour comprised the categories of illicit drug use particularly intravenous drug use, same sex intercourse, and tattooing. In addition, change in behaviour perceived to be attributable to context specific policy such as Mandatory Drug Testing was described.

6.4.2.1 Reflections on drug use in prison

All participants talked about illicit drugs being easily available in prison. Most participants talked about the social and personal pressure to take illicit drugs in prison. The pressure to take drugs was expressed in two ways; firstly, in terms of how prisoners tended to relate to each other on a day by day basis. Secondly, and more generally, how prisoners coped with imprisonment. The following reflections from participants will explain some of the pressures that prisoners experience and how it relates to illicit drug use.

A typical response from a young offender on the therapeutic community shows how this particular participant dealt with the pressure to socially conform:

"Umm, yeah, but if, it is hard, if you go into gaol and you wanna stop drugs, there's always somebody there that's actually got drugs and at first if you wanna fit in and everybody, you've got say five people on your case, cause they're all doing drugs

and you don't wanna, then you'll feel a bit of a, left out. But if you can stand up to them and say no look I'm here to sort my head out, you know".

(PRYO103)

Discussing the social pressure to take drugs a participant from the category C prison said:

"Yeah it's a lot, it's going on a lot on the other wings taking drugs and that so I mean you're going to go on to a wing and then you're going to like become mates with someone and then next, he's taking drugs and you know what you might be mates with who's taking drugs and the next thing you know it's you and that's it with a lot of people they just get dragged into it you know what I mean".

(PRC83)

Similar social pressure was observed by a participant from the category C prison:

"Heroin, yes, yeah what you seem to find is sometimes you're sat in the gaol and everybody around yeah you might have say a hundred blokes on a landing, only ten of them are straight yeah and the ninety are all scratching and you know all got their habits going so when, when I've, I don't take heroin but when I've asked people why they take heroin they say it's a day out of gaol, and you know it's carefree so of course cause it clears so fast from your system unless the prison start drug testing every other day then your not going to catch anybody so you know sooner or later you're thinking well everyone else is doing it yeah why should I be any different, you know and umm, you know your friends start doing it and then before you know it you haven't got any friends because they are running off to their cells to do what they're doing and the only way to be in with them people sort of thing is to do the drug with them and before you know it, I know umm, quite a few people that have left prison with heroin habits and before they have gone into prison have never touched the stuff and the Home Office try to say oh that's rubbish yeah they smoke cannabis and then it progresses, it's not the case with some people".

The participant went on to explain the pressures of not having recourse to commonly used stress alleviation measures such as being able to leave the stressful situation or being able to go for a social drink or discuss problems with a general practitioner:

"More than every other person [in gaol] that I've met, you know well, more than every other person has at some stage tried or taken heroin you know because they can't, the prison officers don't realise when your in a prison it's umm, they go home every night yeah, they seem to think that we're still normal people in here but if you're having problems you know or your wife is messing you about or you haven't seen your kids for a while, you can't go and get anything from the healthcare people they won't prescribe you anything obviously, so sometimes you know I don't know people out there they have a drink or they do something you know, they'll do something to get away from it for a minute they might go out and get drunk so they you know that day's gone, and you know the problems are still there in the morning but in prison you can't drink so obviously you're take something else, take drugs or whatever."

(PRC81)

A number of participants described the stress of imprisonment. To illustrate this point a participant from the category C prison said:

"I've done an awful lot since I've been in you know studying wise and whatever else you know but there's always times when umm, you know I mean outside if you're stressed you know you can go for a swim or have a glass of whiskey or something you know something to relax you to get you to sleep that night or whatever umm, whereas in here there's very, especially I mean it's getting better now you know but certainly in my earlier days it was very difficult you know and the culture was that people took cannabis I mean heroin has become is overtaken that, you know umm, tenfold now you know".

(PRC82)

A participant from the local remand prison described the pressure of prison 'drug talk' and its effect in the first week of being imprisoned:

"I was surprised you know I came in here the first night last Friday night and I was petrified I'm not joking, and I'm not joking, and I'm not a coward, I was petrified. I didn't know what to expect, you know I've seen it from the outside and heard about it and God, and I was locked up in the cell, bloody hell you know you're joking, you expect me to stay here you know, know nothing, you know locked in behind a snotty little cell as big as this you know and that's it. But it gets better the second day you

get to know a couple of people and now you know people come up to me and say, fancy a fix for a, a couple of fix's for a 'phone card, couple of fix's for half ounce of baccy you know it goes on and on".

The participant appeared to get some comfort from the approaches of other prisoners even if they were wrapped up in communications about drugs. He goes on to say:

"It's hard for me because they, you know the conversations in the daytime when we're locked up which we are, well yesterday you, most days if we're not on exercise, we're locked up for 22 hours a day. Well I haven't been on work duty, you can't go on work first week, I start work, I can start a work programme which involves drugs and alcohol and tai chi and what have you on Monday but the first week you can't. So they talk about so and so and B does a good fix, a good deal with cocaine and heroin and this, that and the other, I don't come in to it cause I don't take drugs, I take Valium but I don't call that a hard drug. I'm listening to it, you know they're sat in the cell and that's all they're talking drugs, drugs, drugs, drugs and it's on their brains full of it and mine's full of it".

When asked how he was finding being surrounded by people talking about drugs he responded:

" I feel a bit under pressure myself".

(PRL90)

Another participant from the local prison also described the way drug taking became a focus for conversation and communication:

"There's total euphoric recall in prison, as soon as I got here there's people saying about how great it was when they were younger on the acid trips and the mushroom trips and the good old days and a lot of people do feel sorry that you are into smack and that's only because they got caught, in my opinion".

When he was asked if the drug talk created any pressure to take drugs he said:

"No I don't think there's a pressure, I think it's the majority of people in prison have been in those circles".

(PRL91)

Some people talked about taking drugs as a way of getting through the experience of being in prison; for example, a participant from the category C prison said:

"Well there's a lot of people taking drugs in here cause you get I mean technically like you do drugs and you get a different feeling, you just forget about everything, people like to, they like to take drugs just to forget about where they are."

(PRC85)

A further reflection from a participant from the local prison on taking drugs to alter the perspective of time:

"In prison you've got a lot of time on your hands and heroin is a time waster....and also to take away from their self, from their feeling of guilt, their feelings of pain".

(PRL91)

Another extract to illustrate the view that illicit drugs help prisoners through the time component of their prison sentence was from a participant in the local prison; he said:

If you've got a long term prisoner there's more umm, if you like sleeping drugs, you get time to travel faster so your smack and your umm, Valium and all sorts in a prison."

(PRL93)

A participant from the young offenders institute explained the time factor associated with taking drugs:

" I mean you get a lot of time off, like people in prison if they've got [opportunity] to use a needle they will, you know what I mean, you can get them and obviously they will share that."

(PRYO104)

Some prisoners talked about how some people progressed from taking cannabis to taking other more harmful and addictive class A drugs such as heroin.

A participant from the local prison responding to a question about drug progression to 'hard drugs' in prison expressed his reply in terms of how drugs alter the perception of time:

"No. No, I've known loads of cannabis smokers come into gaol start buying bags [heroin] with the canteen. See what I mean, known loads, I know loads in here, that's life isn't it see what I mean if you have drugs and the day flies, see what I mean without drugs you're just sitting there on your bed thinking, see what I mean you have the drugs and the days gone like that".

(PRL92)

A participant from the category C prison described the perceived progression to 'harder drugs' in terms of a progression to injecting drug use:

"In a closed prison yes umm, because umm, you're locked up all the time so when you're locked up all the time people find things to occupy themselves really so umm, once they start using like heroin or something like that they start injecting umm, they can only get hold of umm, say one needle so that needle gets passed around and umm, really speaking because they're not being kept occupied they find other things to do."

Later in the interview the participant was talking again about progression to injecting behaviour,

"When they start smoking it, I would think personally umm, you can only get so much out of anything can't you, yeah and the best way to, the best hit out of the drug is to inject it so, sooner or later somebody's going to say well if you like that obviously you've built up an addiction for it then, and if you like it like that you try it like this yeah, it's twice as good so then they think well if it's twice as good I'll have a go and as soon as they realise it's twice as good, that's it they'd stop smoking it and then start injecting it."

(PRC81)

The young offender institute was seen as a place that was less likely to have access to class A drugs such as heroin, particularly in the therapeutic community however

the next few comments show that this impression is very much influenced by the supply of drugs:

"From my experience in here, this prison is a strict prison. They do have like prisoners in order and everything, they've got them all set to like, like a lot of people don't mess the prison up here, they don't bring drugs and that in..... I'd say this wing's gone a bit funny cause like there's people bringing in heroin and people bring in cannabis and they had to shut the wing down for a couple of weeks to sort it all out".

(PRYO100)

One participant from the therapeutic community in the young offender institute described what it was like when he heard that some heroin was on the wing:

"I mean, cause when they hear about, it starts them thinking of it and it's just temptation. I was on here for like nearly two months, I mean, and someone brought it on the house, and like my stomach went all horrible and that, you know, like it's all twisted, just couldn't think of anything else"

(PRYO105)

Another participant from the therapeutic community in the young offender institute said:

"I think if it weren't that strict then I think they would probably be taking more drugs than they are at the moment, so."

(PRYO101)

Some participants from the young offender institute (YOI) compared their prison to other security types of prison in terms of the YOI having a stricter regime as these extracts explain:

"Slacker at [adult local prison] isn't it. It's a remand centre like you say, this place is where you do your gaolbird and that, but at [another adult local prison] they just doss around in it, walk round and do what you like. The screws are there to lock your door and nothing else really."

When discussing drug supply into prisons participants generally agreed that drugs got into adult prisons successfully but described the young offender institute as more difficult to penetrate with illicit drugs. These beliefs are illustrated in the following quotes.

In response to a question about illicit drugs getting in to prisons a participant from a young offender institute said:

"It is harder to get in but it still comes in."

The local prisons were believed to be easier to penetrate with supplies of illicit drugs.

One participant from a local prison described illicit drugs getting into the prison:

"yeah, there's drugs all over this gaol, all over and that's down to the visiting rooms, the visiting rooms are diabolical like I was in here about two months ago, me brother came up to see me and I got in here on the Thursday, on the Friday I comes out seeing the doctor and 35ml of methadone off the doctor, about half two - three o'clock the officer came for me and said I had a visitor and I said to him I haven't even sent a visiting order out yet he said well you've got a visit. I went down and me brother and me two mates came and the visiting room is just like a container know what I mean whereas other prisons have got like big rooms know what I mean full of cameras and everything, this is just a little blue container and umm, and two officers standing at the front door to let them in and that's it, and it's so easy to get anything in".

To explain why local prisons appeared to have a greater illicit drug supply one participant from a local prison said:

"Because you've got remand people here they can get visits every day, so there's a probably more chance of having more drugs in the remand nick than you would have in long term nicks".

Many prisoners talked about their motivation to stop illicit drug use. Typical of the remarks is the following response from a participant from the local prison:

"Me personally I've been in and out of prison, six years out of seven, umm, I've had drugs, in all I've been on drugs ten, twelve years umm, I've only injected nine of them, and it's only now that I want to stop, really due to I've got a little girl on the out but secondly it's because I don't need it really, you know.

When asked if he had managed to stop taking drugs, the participant responded:

"Yeah, yeah there's drugs going around here, there's needles going around, I don't do it it's not me".

Having established the availability of illicit drugs in the prisons, discussion then focused on the amount of intravenous injecting that took place. The majority of prisoners said that the predominant way of taking opiates and other drugs in prison was smoking rather than injecting. Although, there are other health implications from smoking drugs, blood-borne infection is not one of them and therefore, will not be discussed further in this thesis. However, while there was not frequent intravenous drug use, sharing was described in a number of interviews and this is cause for concern in respect of the transmission of HIV and hepatitis B and C.

A participant from the local prison said:

"I would say umm, a reasonable percentage of people would smoke or snort it [heroin] rather than use intravenously but then you've also got people who have needle fixations and they're not treated with any sort of respect they're just umm, bundled in with everybody else, when a needle fixation can become a very powerful and it can become a bigger addiction as the heroin itself. I have heard recently of umm, needles being in prison, people getting them out of sharps bins which diabetics have used and offering them to people, selling them, so it umm, there is a situation that needs to be dealt with in my opinion".

A participant from the young offender institute said in response to a question regarding route of administration of drugs:

"Yeah, I've seen a couple of people inject, done it myself a couple of times".

The participant was asked if his injecting had taken place during the current sentence; the participant confirmed that it had. When asked about obtaining the needle the participant said:

"It's like you can't go over and ask from, you've got to see a diabetic and then that's the risk of them using it first, I mean you don't know if it's clean, you don't know if it's not"

When asked about how many people would share one needle the participant said,

"Oh, one needle. About three maybe four".

He went on to explain his reflection on his own risk behaviour:

"It's like when I first come in, it didn't really bother me and then I thought I'd shared, sleep with people unprotected and it's just bobbing about in my mind. It's like a person went over, I mean he had a test and it come back positive hep C and like I mean, he was gutted in a way, he's glad now he knows."

(PRYO105)

The participant confirmed that he had shared injecting equipment with the person who was hepatitis C positive.

Further HIV and hepatitis risk behaviour was described by a participant from the local prison:

"But the two guys I'm in with [sharing a cell] I can't say who they are, they're both been doing the needle, I have never."

(PRL90)

A participant from the category C prison described his perception of injecting behaviour:

"You know as I've already stated I've been inside a long time so you know you get a sort of grasp of what is actually going on you know within the confines of the prison and umm, and although people are aware, lets say sharing needles for instance you know umm, it doesn't seem to, the impact of what they're doing doesn't seem to strike home you know enough really because certainly I don't know, I imagine a lot of people have been, have contracted hepatitis C or whatever or even AIDS through sharing needles you know."

(PRC82)

Another report of a number of people sharing injecting equipment came from another participant from a local prison,

"Yeah, yeah because when people are round medication and gaols they, some people who are on insulin get needles off the doctor, they're supposed to keep them in their cells but they don't they give them out, see what I mean you can get up to ten people sharing a needle."

He went on to say,

"Do you know what I mean and there's a big risk of getting it. That's evident in myself personally. I'm no angel do you know what I mean."

(PRL92)

A further illustration of sharing drug injecting equipment in a prison was given by a participant from the category C prison:

" Yeah, I mean the time that I knew like about one getting shared it wasn't this prison or anything it was when I was in [another prison], like you say about it, they do get passed around I mean God knows how many people have used that one syringe I mean it got blocked up and everything and they were actually burning the needle off the end, unblocking it and then mounting it back on again which you know isn't safe at all, know what I means it's all, yeah a few people could have caught it that way off that one, but it does go on I mean when I'm in prison myself I keep myself in working groups you know what I mean I'm here to come off not to stay on while I'm prison".

(PRC83)

Another participant from the category C prison described his experience of injecting behaviour:

"I mean people do tend to you know live for today and have got, if they can get hold of drugs then they will use it in the way that everybody else is using it, their friends you know their clique, or whatever they're in how they use it then umm, and I mean I've taken drugs in prison, I've never taken heroin I've never used a needle or anything you know or anything you know it's just been cannabis but umm, I've been in situations where I've left because people have said right we're going to do this or that you know umm, and it makes you, but I think I'm more aware that a lot of other people so umm, but certainly a lot of people tend to live for the moment you know."

(PRC82)

One participant from the category C prison described his perception of reduced injecting drug use in prison:

"Well like myself I was into drugs for years for about sixteen years, I mean that's what I'm in for, supplying drugs, but it's not all the times I've ever been in gaol I have never well only once seen someone using a needle in goal they've always just smoked it or something".

(PRC83)

6.4.2.2 Reflections on same sex intercourse in prison

Penetrative intercourse with a same sex partner frequently mentioned when talking about HIV and hepatitis B and C transmission but tended to be described in the prison context as hidden or suppressed because of the machismo culture.

A participant from the young offender institute distanced himself from any involvement by saying that he did not know anything about sexual relationships in prisons, but acknowledged that the culture that would probably suppress any such relationship:

"I know there's a rule for it in this prison. It's not to be done in this prison, but I don't really know much about the sexual side of prisons. Yeah, it's like a lot of people in prison do put up a front to their mates, be like a big person to them."

(PRY0100)

A participant from the local prison said that same sex relationships would be unlikely in a short term local prison:

"It doesn't happen in here it's too short term."

(PRL93)

Another comment on the nature of the length of sentence on the possibility of forming a sexual relationship came from a participant from the local prison:

"In remand nicks no, Yeah in long-term nicks. When you're doing eighteen years it's an awful long time so obviously there are umm, people that turn queer in there I suppose."

(PRL93)

A participant from the category C prison described the difficulties that prison culture would have on being open about a same sex relationship:

"Well I think it's covered up more because of the culture in prison, you know if you're known to be a homosexual or something like that you get a lot of stick off people."

(PRC81)

Another participant from the category C prison also described the need to demonstrate masculinity:

"My experience is that there are certainly a number of men who get involved in that activity you know umm, they're normally pretty quiet about it you know it's not something they broadcast you know, umm, that's the culture you know what I mean they're not going to come out of the closet or whatever for that reason, simply because of the ridicule they'll get or umm, maybe violence against them you know umm, but I mean obviously I've been in situations where umm, certainly in the earlier part of my sentence where you were with guys who were locked up for a long, long

time, umm, and they took part in those activities you know umm, I was very young when I came away so umm, I was actually a target you know for older men you know which wasn't really a problem because once you made it, you know sort of drew a line umm, they wouldn't cross it you know."

(PRC82)

This view that same sex relationships would be stigmatising was again revealed by a participant from a category C prison:

"I would think it's probably more the umm, macho side of it umm, for I'm in prison with a bunch of hard men like, you know what I mean, I'm not effeminate like that isn't my thing, umm, so I think it's more the stigma attached to it."

(PRC80)

A participant from a category C prison echoed the beliefs of a number of participants when he described how different levels of acknowledgement or acceptance of same sex relationships occurred in different prisons:

"Umm, right in this prison I've not actually seen it, like anything like going on, but [another prison] I was in it went on there a fair lot, know what I mean, I thought it did I mean but like then say [another different prison] which is a bigger prison I never seen it happen in there, I mean I never heard anything about it in there so I would say so it depends on which gaol."

(PRC83)

A participant from the local prison expressed concern for himself when same sex relationships in prison were discussed:

"I don't even want to think about it, I'm not exactly ugly I don't want to think about it, fucking frightens the life out of me, condoms in here, condoms it would be the end of my life if somebody did that to me anyway."

(PRL91)

Some participants wanted to distance themselves from any knowledge or experience of sexual relationships in prison.

One participant said:

"It happens but not with me but I think that it happens because, I don't know, certain of the people but not with me."

(PRC84)

Another participant from a local prison responded in a similar way that sexual relationships could not be happening on his wing:

"No, no not in this wing no they wouldn't have none of it, no there's none of that sort of stuff down there no."

(PRL95)

Some participants believed that same sex relationships would only occur if the partners were sex offenders.

A participant from the local prison expressed this belief:

"It might be like you know on other wings where the sex offenders are but not on the other wings it's not."

(PRL92)

It was observed by many participants that the most important risk behaviour for transmission of HIV and hepatitis B and C in a prison is sharing injecting equipment.

"The other big thing [in terms of transmission] in prison is homosexuality which is umm, I wouldn't say it was a big thing at this prison but obviously it does go on. I would say its probably hidden more umm, I know this prison has gone a long way on the confidentiality side i.e., for condoms and what have you, you can actually get them issued in this prison umm, if you're that way inclined but I would say it's probably the tendency this it's buried more, it's sort of pushed to one side, all that doesn't exist whereas in fact it does, it's as, I am, obviously through word of mouth I know it goes on and it goes on in here umm, but to what degree, how long is a piece of string."

(PRC80)

6.4.2.3 Reflections on tattooing behaviour in prison

Most participants said that they had seen very little evidence of tattooing in prison and those that gave examples believed that there was very little sharing of tattoo equipment. This participant from a young offender institute illustrates this with his own tattooing experience:

" I done that one [tattoo] with indian ink, that one there with clothes dye, but all these [pointing to other tattoos] I done when I was out and it's stupid. There was, when I come in here I was issued with a needle and thread like. I know it ain't safe to do it that way, I always make sure I burn my needles before I do it. I know it still isn't exactly safe to do it that way."

When asked about sharing tattooing equipment he responded:

"I think most of them know the dangers of doing it, like, some of them, well they don't exactly find it, they get one off an officer or something and use a different needle."

(PRYO100)

Although burning the needle would not sterilise it and therefore localised infection was a potential risk however, there would be no risk of virus transmission without sharing an infected needle. There was an acknowledgement that people generally knew and avoided the potential for transmission of bloodborne virus from sharing tattooing equipment.

To further support the position that the potential for virus transmission from sharing tattooing equipment is well recognised came from another participant from the young offender institute:

"I've had mates who've come to prison before me and come out again and I've seen them get tattoos when they've been in. I wouldn't do it, you know what I mean, cause of the needles, I don't want other peoples stuff in me, you know what I mean, I want myself to myself. But I can't even see why they wanna tattoo to be honest."

(PRYO102)

A participant from a category C prison described how prison discipline had deterred tattooing:

"Not much goes on these days really, we had a spate of it here last year and it was jumped on from a great height."

(PRC80)

A participant from a category C prison explained his understanding of why there is not a large amount of tattooing in prison:

"It just died [tattooing], I've never actually seen it happen in a prison someone get tattooed know what I mean, it takes too long doing it, to tattoo someone and the amount of time it takes there's bound to be some officers come past and caught you doing that."

(PRC83)

A participant from a category C prison, described how behaviour had changed over time:

"It doesn't happen no more, I used to hear of umm, tales with a Walkman you can make a tattoo gun and you could umm, electric pairs of scissors, take the scissors rings out and put a needle in, and you can make a tattoo gun but it doesn't happen no more it's umm, I think it was all back then you know."

(PRL93)

The following extract, from a listener in a category C prison, shows the level of concern and understanding of risk shown by the prisoners:

"The listeners here are very good with that although we always keep confidentiality you know yourself the same as I do there's ways and means and there's ways of whispering. Well this tattoo artist that thought he was on to a right good thing here lasted two days and he was gone. He started his business up Monday dinner time, Wednesday he was out the prison and that wasn't the prison staff that was inmates."

(PRC80)

However, there were some reports of situations which would have potential for risk behaviour, as this extract from a participant from a young offender institute shows:

"Somebody was trying to build a tattoo thing out of a bloody Walkman the other day, so I know that goes on in prison."

(PRYO101)

However, even when tattooing machines are used it may not necessarily mean that the needles on the machine are used by more than one person, as this prisoner in a category C prison explains,

"That's different with a tattoo because from my experience of being in prison when they are going to do a tattoo they use a wire, a little wire so that every time you want a tattoo they cut just a little bit of tattoo wire, you burn it put into the machine and they start to draw it, after that they throw away."

(PRC84)

6.4.2.4 Concerns relating to other potential routes of transmission

Fighting or aggression was frequently described as an area of potential transmission of virus when contact with blood was the issue of concern.

A participant from the young offenders institute explained:

"Blood to blood, you know what I mean. You're always going to get a fight in prison, you know what I mean, it's unlikely that you're going to fall on top of someone when you're whatever, there's always blood spilt in a fight".

Further describing fighting as a risk factor for virus transmission, he went on to say:

"I mean at the end of the day, these fights, cut your hands, someone's cut their hand, only something like that you know what I mean, minor thing really. That's the only way I can imagine it happening"

(PRYO102)

6.4.2.5 Reflections on change in behaviour in prison

Some participants described they had had a change in attitude and were now less fearful of HIV and AIDS; the following extract presents an account from a participant from a category C prison:

"Yeah, when AIDS first came out everyone was petrified you know if you caught HIV that was it, you know you were more or less three years to your grave umm, but now umm, people are just, they're more laid back if you see what I mean they're just oh, if I'm thirty now and I contract AIDS I'll live till I'm forty and forty's not a bad age you know even though it is you know some people just you know they just turn round and say umm, all the hysteria about it has disappeared yeah because you know obviously they're bringing out new drugs that can slow down this that and the other."

He went on to relate this attitude to condom use,

" Oh a couple of years back it was like everybody umm, in the street in the prisons were saying use a condom no matter what you do use a condom, even if this has been your regular girlfriend for four months use a condom, and now everyone's back to oh you know I'll take my chances."

(PRC81)

Mandatory drug testing was most often cited as the reason for change in drug taking behaviour.

One participant from a local prison echoed the perceptions of many participants:

"Go back a year or so before mandatory drug testing came in and it was hash, that was all anybody wanted was hash. As soon as they brought mandatory drug testing in, because hash is twenty eight days to get out of your system, smack is only three days, that's where it came in about if you want to come off smack it only takes three days. And a lot more people are going to do it... there's hardly any hash in here, its all smack, all little bags of smack".

(PRL93)

One of the unintended consequences of changing drug use due to the Mandatory Drug Testing programme was described by a participant from a category C prison:

" Yeah, that's definitely happened that I mean I've seen that myself in well all three prisons I've been in on this sentence where somebody's come in and I've actually known one of the people on the outside he's come in and he's smoked cannabis when he's come in and then he's had a test and it's come back positive so he's

thought and someone's said to him like well if you took heroin it's not going to come back positive cause it only stays in three days all that and the next thing you know he's a raving junk addict like and he's gone out and straight on to heroin and I think he's still on it now to this day so and having seen that and that happen a lot where people never touched it before in their lives and now they're heroin addicts".

(PRC83)

There were positive changes in drug taking behaviour reported and these were attributed to being sentenced and taking stock of life and being in a challenging drug programme. Underpinning these changes were being given a lot of support and or family responsibilities. The extracts from interviews below illustrate these beliefs.

This quote is from a participant on a therapeutic community at a young offender institute:

"In a way I had a drug and alcohol problem, but before I was sentenced I didn't really see I had a problem. It's only since I've been on this wing, I haven't been here long, I've only been here just over two months, but them two months I've learnt a lot. I've had a lot of time to think. I can now, I can see now here I was going wrong. That I did have a problem and that I'm always going to have that problem."

(PRYO103)

This participant from a category C prison described how he changed his behaviour in response to the length of his prison sentence:

"Well yeah like I mean I've been in like prison a few times but they've all been like short sentences apart from this one, this one I got done for like possession with intent to supply so they give me four years so I've been in longer this time than any other. In the other sentences I carried on taking drugs but I was smoking it I weren't injecting it and umm, but this sentence at the beginning of my sentence right I carried on taking it, like smoking it, but then I thought what's the point I mean about time I come off it, I've got long enough to do it so now like I've been clear for a very, what sixteen month or so now, know what I mean, so which is good but yeah but I mean on the out yeah I used to inject it, I used to bang up so I know like what can be caused through it you know what I mean."

(PRC83)

A number of participants described their beliefs about how the change in drug use had affected the prison discipline staff:

"You know cannabis is a prison drug, it's excellent, it keeps people calm, it is stress free umm, the prison offices will have less work on their hands, where smack comes into it, when people can't get smack umm, they go off their heads, they go into someone else's cell and attack anything, which causes more problems for the prison staff".

(PRL93)

One participant described how he perceived that the progression from smoking heroin to injecting heroin could occur in the prison situation:

"So if you're smoking and smoking and smoking [referring to heroin] yeah, sooner or later somebody's going to say well if you like it that obviously you've built up an addiction for it then, and if you like it like that you should try it like this yeah, it's twice as good so then they think well if it's twice as good I'll have a go and as soon as they do it once and they realise it's twice as good, that's it they'd stop smoking it and then start injecting it".

(PRC81)

Generally though participants tended to disagree that there would necessarily be a progression to intravenous drug use. Typical of this belief is this extract from a participant from a category C prison:

"Most people who take heroin umm, they it's called they boot it, they chase the dragon, alright, umm, which is it can be addictive but it's not as dangerous as fixing up you know you can't overdose on it because obviously you pass out before you anything went, you know before you took too much umm, so and the other thing of course is that you actually don't get much for your money in here you know."

(PRC82)

One 20 year old from a local prison who was on a methadone detoxification programme said:

"When people come into prison off the streets and they use drugs for many reasons and the bottom line is the psychiatric reasons, deep down there's problems in maybe childhood it may be umm, a self loathing it may be you know not being able to come to terms with their life, if you take this away I think the suicide rates in prisons will go up, you'll get more fighting you'll get more violence umm, and that's why I feel at the moment it runs itself, it does run itself in many respects I do think needles should be supplied because I think it's all very well me sitting here saying to you yes I want to make a go of it, but if I had fifty pound and I could get a needle that is when I've got to make my decision, when I've got an option to use, I don't have no money, I don't have no means, I don't have no family, you know, but if I was in a different circumstance it, I feel a temptation has got to be there you know because the ones who are strong enough will make and the ones who are not, not and that's going to be the same on the outside".

(PRL91)

However, it was stated by many of the participants that intravenous use in prison often reduces as this extract from a participant from the category C prison shows:

Umm, I would say the biggest problem of anybody catching it in prison would be the same as what it is on the out, which is drugs umm, obviously there's probably less chance in prison of getting it because they've got less access to needles which is the most common way of catching it umm, and again the big thing in prison is homosexuality which is umm, I wouldn't say it was a big thing at this prison but obviously it does go on so there is common connections here but I'd say drugs wise there's less chance of catching it in prison that way."

(PRC80)

6.4.3 PREVENTION POLICY

6.4.3.1 Access to condoms:

Some participants did not know that condoms were available in prison or did not know how to get hold of them. Of those that did some said that they had reservations about the way they were currently distributed, as the following extracts will show.

A participant from the category C prison described his lack of knowledge of condom availability in this way:

"Yeah and I thought I had my finger on the pulse you know of the day to day life of this place umm, you get the odd guy who comes in and umm, you know I mean they're camper than a row of pink tents if you like I mean they're out they're not, they're straightforward they tell you exactly what they are, umm, and that's fine you know most people then, people can accept them for what they are, they get their stick but you know they've had that all their lives you know umm, but umm, yeah, I'm surprised that they actually do it [distribute condoms] but I think it's definitely a very good idea."

(PRC82)

The current policy is obviously not clearly communicated to prisoners as this extract from a participant from a category C prison shows:

"Well I only ever heard this on the news saying that they are I have never seen."

(PRC83)

In response to the question about condom distribution there was some negative attitudes expressed towards same sex relationships in prison.

This response was from a participant from the local prison:

"I don't like the thought of homosexuals anyway to tell you the truth. Yeah, yeah if they want to go, if they're like that way and they want to go ahead and you know catch diseases you know let them go and do it, they deserve it, it's a nasty way but you know that's my views on it."

Later in the discussion about condoms he said:

"Yeah, oh yeah, do you know what I mean that's what I mean like over on [another wing] I've heard there's a few nones [sex offenders] and that over there I mean it's up to them keep them on a separate wing keep them out of it, have as many condoms as they like, it's not over our area."

(PRL95)

A participant from a young offender institute expressed a similar attitude towards same sex relationships but could see the benefit of access to condoms:

"As far as I can see it, it just encourages people to do it, dun't it, the people that's dirty, that's dirty. It's like I don't understand why people can even do that, even if they're doing life know what I mean, it's sick. But if they've got a do it then it's a good idea [condoms], if they really have to do it, then know what I mean."

(PRYO102)

A participant from a young offender institute displayed a lack of tolerance when he said,

"But if you've got two people that are gay, umm, they wanna do that sort of thing yeah, but I think it would, it could provoke other things as well. Could provoke attacks and things like that. By prison giving out condoms, they're saying yeah, go and have sex with another man".

(PRYO103)

To further illustrate that condom distribution is not always acceptable to prisoners , a participant from a local prison expressed his viewpoint in this way:

"No I don't think it's a good idea cause that's just telling people isn't it, know what I mean you know we've got condoms if you want to go and fucking have the relationship I think it's wrong, see what I mean you shouldn't have that at all, that's my personal viewpoint."

(PRL92)

A participant from a young offender institute felt that condoms should only be distributed if a need was demonstrated:

"Really, I'm an open person I wouldn't really. I don't think it would bother me that much, like I say , if somebody, two blokes wanted to, let them get on with it, you know, just the same as a bloke and a women doing it, but would probably be against it if they were giving it out to people that were getting them for the wrong reasons, You know if people were getting them for genuine reasons, they're using them if say somebody had a disease and they didn't want to pass it on to their boyfriend or

whatever, then yeah that's when they should give it out. But only if they know that person has got the disease, you know they shouldn't just give it to anyone."

(PRY0103)

Despite many expressions of the stigma of same sex intercourse in prison there is a general acceptance of the moral imperative for condom distribution in prison, as the following extract from a participant from a local prison shows:

"I personally think it's a good policy umm, for the simple reason is anything that you can stop a deadly disease which I mean it is absolutely deadly has got to be a good thing umm, I would think if you asked seven hundred blokes and said right, do you think it's good, they'd probably say yeah but if you got them in a discussion group they'd probably go no because the barriers would come up and go oh, hang on a second like I'm not interested in this sort of thing but I personally think it is a good idea, I think they should have as much umm, paraphernalia for want of a better way of putting it then they can, cause I don't think you can have it heavy enough, so I mean I'm all for it."

(PRC80)

With regard to condoms being used to smuggle drugs into prison this was generally not accepted by the prisoners:

"In condoms, ha. I've never heard of that before miss, you know what I mean, so I wouldn't know."

(PRY0101)

The following extract from a participant from a category C prison further exemplifies this position:

"I think that by saying oh if we give them condoms they will just use them to umm, what we call plug yeah, keep things inside and for years and years prisoners have been you know concealing things and they've never had condoms before so if they introduce condoms I don't think you would be encouraging they can still use other things you know there's a whole load of things that they'd need to get rid of in gaol and at the end of the day they'd have to just really speaking leave us with our plastic

razors and clothes to stop us doing anything you know, it just can't be done they'd never be able to stop umm, so saying condoms you know would help doesn't matter, condoms I'm not saying they wouldn't be used but what I'm saying is umm, it wouldn't make any difference you know because prisons have done it anyway in the past."

(PRC81)

Exceptionally there were descriptions of concealment of drugs as this extract shows from a participant from a young offender institute:

"Yeah, umm, about 4 weeks ago one of my friends from.....prison, one of his friends brought him up some heroin inside a condom and he swallowed it and before he could get it out it burst in his stomach, and like he died, through something wrong with his stomach, it done something to his liver, kidneys and he died over that."

When asked if he thought that having condoms would increase the supply of drugs into prison or the concealment of drugs in prison, he replied:

"It comes in everything, cling film, I mean, tin foil, it can come in anything. Depends what the person on the out does with it."

(PRYO105)

On the same issue of concealment of drugs a participant from a local prison explained the way condoms are used:

"Gets the drugs off the visit, do you know what I mean, they get back to the bed they get the drugs out, they put it into the condom, they tie it into a knot and then they cut it with a razor blade do you know what I mean no just put, you know see what I mean and the officers come in and search and they can't find it, do you know what I mean so I don't think it's good at all, no. You see it only comes in thin cellophane bags, you know like when you go and get your fruit and veg, them little bags they come in, then they wrap it up in that once, cut it, tie it and then put it again in the other corner, cut it and tie it, yeah so if they swallow it you know what I mean the acid in your stomach would burn the plastic yeah so they've got to get back to the pad, drink loads of water throw it up and then conceal it into something else like a condom it will not burst, do you know what I mean...So that's why they're against it, I'm against it as well."

When asked if he was against condom distribution because of the potential to conceal drugs or because of the potential for same sex relationships, he replied:

"Both."

(PRL92)

The hidden nature of some same sex relationships in prison has been discussed; however, it will be referred to again here because of its effect on condom distribution.

A participant from a category C prison explained the hidden nature of sexual activity in prison and thus the need for confidentiality:

"I would say it's probably hidden more umm, I know this prison has gone a long way on the confidentiality side i.e., for condoms and what have you, you can actually get them issued in this prison umm, if you're that way inclined but I would say it's probably the tendency that it's buried more, it's sort of pushed to one side, all that doesn't exist whereas in fact it does, it's as, I am, obviously through word of mouth I know it goes on in here umm."

(PRC80)

A participant from a category C prison who had been in prison in another country described a much more open distribution of condoms in prison:

"I think, well it's covered up more because of the culture in prison, you know if you're known to be a homosexual or something like that you get a lot of stick off people umm, in a [prison in a different country] they issue umm, your toilet roll, your toothpaste like they do over here but in a [prison in a different country] you get condoms with your monthly."

(PRC81)

A number of the participants were in favour of condoms being distributed via the health centre or the doctor, principally because it was felt that it would be more confidential.

A participant from the young offender institute said,

"I don't think if somebody was going to use them they would like them on the landing in front of the other prisoners. It needs to be confidential"

(PRYO104)

Finding a way of obtaining condoms confidentially seemed important to the participants. Most respondents favoured obtaining condoms from the health centre, although there were a few participants that felt confidentiality would be compromised or access would be difficult. The following quotes explain the reasons for this point of view.

A respondent from a category C prison explained his reservations:

"Yeah, well if everyone's issued them yeah then whoever uses them like here in this prison if you want condoms you can get them but you've got to go down to the medical centre and ask for them in front of whoever else is there so if there's no, you know they don't say right these, that's you know if you use them or if you don't they're there they just you know you've got to go down and say can I have some of them and everyone's looking at you as if to oh yeah."

(PRC81)

Another participant from the category C prison explained his objection to the policy of going over to the health centre to ask for condoms:

"I don't think it's a good policy to have them in prison but saying that I don't think it's a good policy where you've got to go over and ask for them, I mean they should stick them in a box or something like that on a landing then if someone wants them they can take them."

(PRC83)

The difficulties perceived to be related to obtaining condoms from the health centre led to some support for condoms being available on the landings as this extract from a participant from overseas shows:

"They have to have an appointment [for condoms from the health centre] maybe they are quite embarrassed but I mean for them its they're rights in that they go to the hospital and just ask for them or have, for example like, a box that they can pick

them up from. Yes you know, because many people they are shy and they don't want to go and ask for them"

(PRC84)

When asked if the distribution of condoms would be a conflict for discipline staff the majority of participants felt it would not. A participant from a category C prison explained this viewpoint in this way:

"Don't think the officers would have a problem with it, I mean at first like I say inmates would probably just take it as a joke and go start throwing them all over the place and everything, but then eventually like everything they get sick of that and they'd just be stood there then let's use them you know what I mean."

(PRC83)

6.4.3.2 Needle exchange

There was a great deal of ambivalence about needle exchanges in prisons, although some thought that a needle exchange would be a good prison health policy there were concerns expressed by the majority of the participants, and there was a small number who were totally opposed to having a needle exchange. The concerns centred on personal safety, fear of being identified as a drug user and targeted for drug testing and fears about encouraging intravenous drug use.

Some of the participants acknowledged the complexity of the issues as this extract shows from a participant from a local prison:

"If you said yes there should be clean needles or needle exchanges, then you're saying there is drugs in the prison and there's guys taking it and somebody's bringing it in and getting it in, aren't you? And on the other hand if you're saying somebody's using a dirty needle and they're passing it round then you're passing on HIV so, I wouldn't like to say. Difficult one to answer that is a difficult one to answer."

(PRL90)

Another participant from a young offender institute, voicing similar difficulties with a needle exchange, said,

"I think it's a good policy but there is like the dangerous sides to it, like the bleach and everything and the needles. Say, like with the needles in like, after prisons that have been banned from dartboards where people have been getting stabbed in the face and that with darts and I think that would go on like the same way with the needles, like people would be getting stabbed."

(PRYO100)

A further illustration describing ambivalence towards a needle exchange in prisons was from a participant from the young offender institute:

"Two minds, I mean, it could stop spreading diseases but they could use it as a weapon I mean, you know. And that's why you know what I mean it would encourage people to use drugs though, in this particular wing you get off drugs, you know what I mean."

(PRYO104)

When specifically asked about the possibility of needles from a needle exchange being used as weapons most said it would not be an issue.

A participant from a category C prison responding to this question said:

"Well there are weapons anyway, you can make a weapon from a toothbrush."

(PRC84)

When participants were asked if the potential for using needles from a needle exchange as weapons would be a barrier to policy development most responded by saying that there were many weapons in prison anyway.

This extract from a participant from a category C prison illustrates this viewpoint:

"Not really, there's loads of weapons you can use in prison."

(PRC85)

Some participants recognised the difficulties that prison officers may have with a needle exchange:

"I think they [prison officers] would have a hell of a job coping with it, umm, for the simple reason is I think that would put the old barriers back up, us and them, them and us and I think they would probably just stand back and say well, right that's it if they're prepared to go that far how far are they going to go like, we're trying to stop them using drugs and they're saying oh, it's alright if you're using we'll exchange your needles for you. In prison it just wouldn't work, at least I don't think it would anyway."

(PRC80)

Concern was also expressed in terms of a needle exchange scheme promoting more intravenous drug use in prison. An example of this concern is expressed here by a participant from a category C prison:

"Umm, well it would be acceptable to the inmates that are using but umm, I think the majority of inmates that don't inject would have more of a chance to inject if they gave out needles, yeah umm, even though they say out on the street, you can go to a needle exchange, that's what you do as an individual, if you want to go but if you're sat here and somebody says well you know if you're worried about catching anything it's not a problem I'll go and get you a clean needle you know I don't think they'll ever give a needle exchange in a prison."

(PRC81)

For those prisoners that are using intravenously prison is a particular concern because of the lack of sterile equipment. This extract, a view from a participant from a category C prison who has never taken illicit drugs, illuminates a contrary view to those expressed against needle exchange:

"I advocate needles, actually issuing needles to people going to fix up you know because I've seen some contraptions made up and out of pens and things which you know is, just makes me shudder."

(PRC82)

Describing the difficulties of specifying how the policy will operate and responding to individual need, a participant from the category C prison said:

"You know because that people, maybe if they start with these they say you can only have two needles but if you are a hard consumer you will need four or six so what would happen or you would steal for another one or you borrow for other ones or you start going to asking for more there will always be a problem."

(PRC84)

Promoting and encouraging drug use was mentioned frequently by the participants; a few illustrations of this view are given below.

A participant from a category C prison described his concern that having a needle exchange in a prison:

"I think it would be a case of umm, you've got a known addict for a kick off there's a kick back down the line, where do they get the stuff from in the first place, he's got the stuff he's a known addict he can have a needle exchange, his mate's not a known addict fine, I'll use your needle, then his mate says, oh you've got some gear right I'll use your needle. I think in a prison, particularly in a prison situation it would give a knock on effect."

The concern expressed by some participants, that a needle exchange may encourage intravenous use, also came from one participant from the local prison who had only previously smoked heroin. He said that during his rapid detoxification programme:

"I'd have used one, I wouldn't have thought about it, I'd have just used it straight away for the heroin."

(PRYO100)

A participant from the young offender institute said:

"No, If you'd have a needle exchange then you'd have more people taking drugs."

(PRYO103)

Of those that disagreed with a needle exchange policy the following extract shows a typical response from a participant from a young offender institute:

"When I was on the out, I used to smoke my heroin I never used to use [inject] it, but when I was on remand, if I had the chance to I would probably took a needle, cause I wouldn't have cared how I'd got my heroin as long as I'd have got it."

(PRYO100)

Extracts from interviews showing disagreement with a needle exchange policy,

"I'd probably think it [needle exchange] shouldn't be there in the first place, I don't think they should be there."

(PRYO101)

Some participants felt that to have the facility of a needle exchange for people who are on a drug free wing and trying hard to stop their drug habit would present difficulties.

A participant from the young offender institute, in a therapeutic community illustrates this point:

"Umm, well I suppose it would be like, cause like you mean somewhere like they give you needles, clean needles, umm, not really actually cause like if someone gets smack in here yeah they're on a drug free wing they're here apparently to sort out drug problems, yeah, sticking a needle in their arms, I mean, what is the point of being on this house, you might as well go somewhere else, know what I mean. Don't know smoking it, I think it would be better to just to let them carry on smoking it myself rather than have them sticking needles in their arms."

(PRYO102)

One participant from a local prison suggested a way to develop a needle exchange policy that would try to prevent the potential for promoting injecting drug use:

"I feel people who would want to use intravenously would have to prove that they've used intravenously in the past umm, by showing track marks recent needle marks, so therefore, people aren't going to be picking up needles who haven't used them before."

(PRL91)

A further policy suggestion that would help prevent the promotion of injecting drug use came from another participant from the local prison:

"There should be I'd say umm, there should be more strict rules about giving it out and they should be able to like separate people who knows they are umm, [going to use] needles from other people."

(PRL94)

Some participants suggested that there could be specified 'injecting areas' that would allay the fears about needles being in circulation in the prison:

"They [injecting equipment] were used in a confined space in their own facility or something and the needles returned or whatever."

(PRL95)

6.4.3.3 Bleach

The means to chemically disinfect injecting equipment was generally welcomed by the participants. However, there were concerns expressed about the use of chemical disinfection without also having access to a needle exchange, the efficacy of bleach and related safety issues.

Some participants described HIV and hepatitis B and C risk behaviour simply because they had misconceived knowledge about chemical disinfection of needles; an account of this is outlined below. Some of the participants also felt some scepticism about bleach being used correctly by prisoners and also concern was expressed about the efficacy of bleach for killing viruses. The following extracts were selected to represent the responses to questions about cleaning injecting equipment.

A participant from the local prison said:

"Cause people think oh no, I'm not going to catch it I clean, I clean your needle with this do you know what I mean, that'll be all right you know I've seen people get a needle just suck water up into it twice and squirt it out, know what I mean that's not going to kill any disease."

(PRL92)

The following explanation came from a prisoner from a local prison who clearly did not understand the process of decontamination and, therefore, thought the introduction of bleach as a harm reduction measure was an excuse to increase the budget:

"I used to clean my needles out with washing up liquid, Umm, antiseptic, anything that cleans really, umm, I've known some prisoners to use the umm, stuff you've got on the inside, the scratch cleaner, put that inside and clean them, anything really, but introducing bleach pills umm, I think it's all, all umm, politics really on the prison side of things, it's umm, how can we umm, spend more money to get a bigger budget really, umm, but if you're worried about needles then umm, if people want to inject they will inject whether it's a dirty needle, they will inject, it's up to the person individually really."

(PRL93)

A little later in the interview the participant gave more detail about the way he cleaned his injecting equipment. Although the participant was in contact with a needle exchange scheme in the community, he clearly had misconceptions about the sterilising properties of hot water and about whether cold water had bactericidal properties:

"Mmm, well know what I mean it's if when you're cleaning the needle you're supposed to put hot water through it and cold water, cold water kills bacteria, hot water sterilises it through the needle, now if you do it that way, the risk of hepatitis or bacteria is umm, there is no risk it cleans it one hundred percent, you don't need bleach, you don't need washing up liquid".

When asked if he thought that people generally knew how to clean needles, he replied:

"I think if you are a drug addict yeah you do. It's when I've been on the out I used to pick up my needles every week from the drug umm, place and umm, come the end of the week I've used all me needles and I need to go through the dirty bin and clean them so I would do that with hot and cold water and umm, it doesn't matter whether you're a drug head in here or even on the out you soon learn from other people that's how injecting came about".

Another concern that was expressed frequently was concern about the safety of bleach, both in its potential for being used as a weapon and in its effectiveness as a decontamination agent for injecting equipment. The following extracts exemplify these concerns.

A participant from a young offender institute said:

"People'd get bleach in for the sheer sake of it, to make it as a weapon. If it's the same bleach as what I think it is, you get that chucked in your eyes, you know what I mean. There would be a hell of a lot of violence, I know for a fact there would be. There would be people trying to get high off it, you know what I mean. They'd be drinking it whatever, they're weirdos in there I tell you they're desperate."

Another participant from a young offender institute expressed similar fears:

"You can fling it in somebody's eyes couldn't you. You know what I mean, unless they can get bleach that doesn't harm you, your eyes, but I don't think they can, can they?"

The safety issues most expressed by prison staff in study one were different from those expressed by prisoners, they were concerned with the possibility of bleach tablets being combustible and used for setting fires and the other concern was to do with maliciously putting bleach into food or drink.

Most participants raised the issue that provision of bleach for cleaning injecting equipment would conflict with the prevailing focus on the drug strategy in prisons. Some examples illustrating this viewpoint are provided below.

A participant from a young offender institute explained:

"I think it would be best to keep it discreet, but at the same time you've gotta find a way to stop the drugs coming in then you're gonna have no problem, but at the same time you're gonna have, they have to have something sterile, just in case the drugs

do come through, But then they could turn round and say, right drugs are banned, do this sterilising kit, but if you're caught taking 'em then you lose days, simple as that."

(PRYO103)

Bleach for general issue to prisoners had officially been withdrawn from prisons to undergo testing at a Health and Safety laboratory for its potential as a fire hazard. Testing showed this not to be the case and as a result there is a limited pilot programme to introduce bleach into a specified number of prisons for evaluation. However, none of the prisons in this study were pilot sites for bleach; however, it was apparent that access to bleach was still available in some of these prisons.

A participant from the category C prison said:

"I mean I'm one of the cleaners on our wing I give like give all the stuff out to the lads who clean the landings and that, that's my job and many times they've come down and said is there any bleach to put in the buckets so they can mop their cells out like so I've said yeah, I've always had a bucket full if they say they want some I just give it them, not thinking what they want it for or anything."

(PRC83)

Distribution of bleach in this way though is a cause for concern because bleach should be at the right strength and concentration for effective chemical disinfection.

The majority of participants recognised the potential conflicts that distribution of chemical disinfection for cleaning intravenous injecting equipment may cause for the Prison Service; it was explained to me in the following ways.

A participant from a category C prison said,

"I mean if you are going to advocate it you know, okay they know it goes on so therefore, you know the political head in the sand job you know they know it goes on but they're not going to admit it goes on and umm, therefore, there's no cure you know it's not going to think of a cure or ways of prevention really, so you know it's, I think it would be better then these guys who gave got a needle can then, at least you know they can clean it you know and umm, there's certainly been a, I've seen big

posters on the wall about using detergent to clean needles you know three times or whatever it was."

(PRC82)

Another participant from the category C prison said:

"That's a very clever back door way of saying well we know it goes on this is the best we can do without somebody hitting the headlines saying oh, they're encouraging them to take drugs in prison."

(PRC80)

Concerns were also expressed about bleach being watered so that it alters efficacy of the chemical as a disinfectant. Reflecting this concern a participant from a category C prison said,

"If somebody's going to use yeah, umm, and they're going to inject then they should be able to get hold of some sort of cleaning agents you know but the thing is you can't go to an officer and say I want some bleach you know you can say I want some bleach to clean my cell yeah, but then you get a little jar and it's watered down so much that you can practically drink it."

(PRC81)

A number of participants stated that a needle exchange scheme would be a better option than chemical disinfection, some because they challenge the effectiveness of bleach and others because it was felt to be morally right. The following extracts from interviews have been chosen to explain from the prisoners' perspective.

A participant from a category C prison explained it in this way:

"Once you are injecting drugs you don't think about cleaning needles. So maybe you will once or twice but no.... A needle exchange, I think that's much better than bleach or something like that."

(PRC84)

This was the response from a participant from a local prison:

"I think if you're prepared to give bleach you should be prepared to give clean needles. Cause I mean you're saying look clean them up, use them, so you might as well say here you are here are some clean ones."

(PRL91)

6.4.3.5 Opiate detoxification

The category C prison and young offender institute did not have a systematic opiate detoxification programme. However, the local prison did and most of the participants from the local prison were on or had been on a detoxification programme. All of the participants from the young offender institute were on a therapeutic programme for drug or alcohol related problems.

Most of the participants were in favour of a methadone detoxification programme.

A participant from the young offenders institute talked about equivalent policy with the community methadone programme:

"Cause they would get that [methadone] on the outside you know what I mean. Yeah it's got to be, definitely gotta be. If somebody's a heavy user and then goes in to prison they can't just take them straight off."

(PRYO104)

A further comment on equivalence was from a participant from the category C prison:

"To bring people down umm, off drugs, umm, well I think anything is it's a proven thing outside you know where drug addicts use it to come down then fine, yeah."

(PRC82)

One or two participants felt that methadone was not helpful and that what would be most effective would be medication to aid night-time sleeping and living through the symptoms of withdrawal.

Comparing his methadone programme in the community to his methadone

programme in prison, a participant from the young offender institute said:

In a way I feel it helped me a bit [prescribed methadone in the community] cause my heroin slowly went down, but when the methadone went down I think the heroin started going back up again so, it was when I come to prison that I just sorted my drug problem. All I had was two pills I got when I went in there [remand], that was it, the first two days I was in there, just had two tablets. I was just then banged up in my cell. I didn't come out. I didn't feel like I was safe in there cause being my first time in prison like, being ill from doing drugs, I just sat in my cell all day and just sweated everything up. Just cold turkey in you cell's, a lot better. With the sleeping tablets, is it's a lot easier when you're in prison to like, to do your cold turkey or go without, on the out it's just a lot harder to turkey."

(PRYO100)

A participant from a local prison expressed his feelings about methadone in this way,

"I don't think they should have a methadone treatment at all here no. Methadone on some basis is worse than smack itself, It umm, it makes you feel cold, see and if you don't have the methadone there then your cold all the time and the cluck just carries on. They call it clucking when you come off smack cause you're literally like a chicken, you cluck but umm, if they did away with it, it takes three days to come off a cluck, you know just give them sleeping pills for the night and that would be enough you know.

This participant was currently involved in a methadone programme. To explain this apparent double standard he went on to explain:

"See, I don't, a lot of it is needle fixation, it's to do with umm, I used to be able to inject hot water and get a rush off it because it was mentally there."

(PRL93)

A participant from a local prison described the need for more psychological support to withdraw, this time from alcohol, he said:

"Umm, Librium I done an eight day detox on Librium which helped a lot and then after that I complained about everything and then someone suggested acupuncture so I

found the nurse, put me name down and since I've been having it it's been quite good well the first day I had it I had the best nights sleep I've had in a long time in here so I don't know what it was, I think it might, I don't know if it's psychological or what but I don't know."

(PRL95)

A participant from a local prison related his own experience to compare community and prison methadone programmes:

"Well I can only talk from personal experience, I was on a slow reduction methadone prescription, I've been to treatment I've tried it that way and I've done twelve months in treatment and I've ended up using again and I used the methadone and I was a very slow reduction, two ml reduction every two weeks which is something you don't notice, and I think it's umm, a better way of going about it than people who are on a reduce, people who are on methadone to come in here and just to be reduced over ten days, because psychologically you haven't got the strength or I personally wouldn't have the strength or the willpower to stay clean if I reduce quickly rather than doing it slowly."

Later in the interview the participant went on to describe his level of drug use in the community before going into the local prison:

"I've been using a gram and a half every day of Valium, ten Valiums a day, a gram and a half of heroin a day and I'm now on 25 milligrams of methadone and that's just ridiculous, if I had money now I would probably use, I probably would because I feel vulnerable I feel unhappy, scared you know and that would take that away."

(PRL91)

Another participant from the local prison described how his current detoxification compares with his experience in the community:

"I came in yesterday about three o'clock, and told the nurse that I was depressed and she brought me over here [prison health centre]. Last night she give me some tablets but they didn't work I didn't sleep at all and they just give me some methadone then so hopefully that'll help. In [community programme] you start off at 50milligrams

and every four weeks they take you down five but here they start you off at say 25/30 and take you down five every three days."

(PRL92)

One participant from a young offender institute described his experience of withdrawal from crack cocaine:

"When I first went to [another prison] I'd just taken it [crack] the day before I went to court as well, so when I went to [another prison] the first night I was just like I wanted it and stuff like and then it got a bit worse after, I was like sweating, waking up during the night and stuff like that and I went to see somebody about it, look can I get something for it, They said couldn't do nothing about it.

When asked how long he experienced withdrawal symptoms, he said:

"About a month. It wasn't as bad as you see it on the TV and stuff like that, but I was shaking, I was sweating all the time, getting a bit nervous and a bit wary and stuff like that."

(PRYO101)

A participant from a young offender institute had been prescribed Valium for his withdrawal from alcohol and drugs. He describes his experience below:

"When I came to this prison, I had them [Valium] for like my depression and it was to like calm my anxiety down a little bit, They made it a bit stronger in [another prison] cause when I was first in there I was a little bit shocked in there. When I came here, I said to them can I, I don't wanna get hooked on Valium but is there anything I can have to help me come off, cause I know what it's like to come off, cause I've come off it before, and he said yeah I can help you, you're not having it, simple as that. So I spent a week just in a state. Still got on with it, I never got in any trouble or anything, no reports, but huw, I was in a state."

When he was asked how he could have been helped he said:

"Umm, well I don't think they should have just like taken, like, I don't mind about it, but I don't think they should have just taken me off it and left me to deal with it. I think I should have, I don't know, had to see a doctor each day, just to make sure I

was all right, Because at one point I honestly thought I was dying you know, felt so bad."

(PRYO103)

A participant from the category C prison also described alternative treatment to methadone:

"They give you some stuff in [another prison] for coming off [heroin], DF118, but I took it I got it off them like a couple of days and then that was it after that I didn't bother any more cause it's just a pain the DF118s know what I mean. Yeah it's for pain relief I mean the majority of people who come in like on heroin, like I only know about heroin, on heroin they come into prison and they're raging junkies like when they come in, and that withdrawal of heroin is, oh it's the worst thing that anyone can go through, now the worst part of it is the night-time when like they can't sleep, they're up all night tossing and turning just walking about you can't sleep at all, and it lasts for about sixteen days know what I mean, so I mean after so long you're drained, you're just now like I said to them in [another prison] I went on a course, the best for them to do if they want people to stay off drugs is to give them something to go to sleep, I said not that DF118 it don't do anything but go onto something, put a wing separate give them something to go to sleep then yeah like that's the worst part over if they can sleep at night.

(PRC83)

Most participants told me their own experiences of drug and alcohol detoxification in prison and many issues were highlighted through the use of their own personal experience, some of the extracts below give an overview of some of the issues.

Some of the participants from the young offender institute stated a case for detoxification programmes in young offender establishments as this extract from a participant from the young offenders institute shows:

"I reckon there should be a detox wing for like YOs [young offenders] and like for younger generations. In [another prison] there's kids like 14 to 21 and that all going in

there, where they're so young I don't think they're getting enough of a chance to do their change, if they wanna try."

(PRYO100)

There were mixed responses about Methadone use; one heroin user on a methadone programme in a local prison said:

"The majority of people are in prison for either alcohol, which I consider a drug, related crimes or umm, drug related crimes, you know robbery to get the money for the drugs, or the thieving, that's why I believe there should be a proper support for people outside umm, I'm not sure of the actual terminology, I think it's diamorphine umm, the natural derivative of heroin, rather than the chemical produced one and your crime rates will go down, people won't need to use gear with their methadone doesn't do anything apart from (pause) it helps you maintain your sanity".

(PRL91)

One participant from a local prison was on remand and was on a methadone programme and anticipated being released before the detoxification programme was complete, disagreed with the use of any drugs in prison, he said:

"I don't think there should be drugs in gaol at all, do you know what I mean, cause you're here getting punished do you know what I mean and if you can come into gaol and still have your drugs it's a waste of time isn't it, do you know what I mean, to block things out that's what I do it for anyway, to block things out of what's happened in the past especially now that me girlfriend's just fucked me off, do you know what I mean, if I can get drugs in here I will do, know what I mean.

People wouldn't be bothered coming into gaol if they're on drugs on the out, they get it in gaol do you know what I mean, and just get a drugs script off them do you know what I mean, I got off the streets robbing everyday, I think I'll go and get caught by the police so I can go to gaol and get it off them for nothing, see what I mean it's wrong, they should come here they should be on cold turkey and let them feel what it is like, know what I mean and that way they might not do it again".

When asked if that was the case wouldn't he be going through cold turkey at the moment, he replied:

"Yeah, I would but I'd be happy to do it, I would I've done it before see what I mean it's just that with them doing the detox programme but I know when I get out I'm still going to use cause I'm still going to be on the detox programme so".

When the researcher asked if the participant would feel a little differently if he were sentenced to a period of time in prison, he responded:

" Yeah very much".

(PRL92)

What at first appeared to be a paradox can in fact be explained by realising that the participant was seeing the issue completely from his own current situation and that the beliefs he was expressing may be influenced over time depending on his own circumstance.

One person talking about the rapidity of the detoxification regimen in prison said:

"Yeah I think detox is a good idea but it's with the methadone programmes again they're not prescribed to the people that really need them like some people will come in and they'll say look I'm an addict I need a methadone programme and they say alright we'll start you off on 25 ml of methadone well that doesn't touch some people so they're getting their methadone and having to get heroin to you know just feel okay, they're not giving the proper junkies the recognition that they've got a bad addiction, you know they're saying well, it's like saying if you need four gallons of petrol to get to work we'll give you a litre and you know you'll have to walk the rest of the way and for some people it helps them but for other people you know they find that by the time they've had their methadone it's just not good enough for them you know they're having to find other drugs, they're having to run round finding Valium and umm, what's the other one they give them umm, I can't remember, they give them something else in prison proper addicts, little pills, they're what get sold to the proper addicts and swapped and changed so and another thing a junkie has to want to come off you know if the prison knows somebody is purposely using heroin they can put them down the block where they can't get anything right, but alright the guy will be ill for a week, two weeks, then they think well he's cured well he's not cause he's coming straight out of the block yeah and his first objective is to find that heroin again, even though he doesn't you know he's not in pain any more. They don't give

enough attention to the mental side of the addiction yeah, I've heard people go on and on and on about it took me three weeks to get off the heroin and six months to stop thinking about it you know so."

(PRC81)

Some remand prisoners talked about the detoxification regimen being pointless because they would go back to court, not be sentenced to prison and perhaps be back on the street before the course ended without any real help and support for the withdrawal from drugs.

A lot of participants talked about the need for much more support to help drug users, most felt that Methadone and detoxification would have a place in this sort of prevention programme.

Drug-free wings, units or therapeutic communities are set up to help people with substance misuse problems. They are usually separate from the main prison but have varying degrees of access to the rest of the prison. There is usually intensive counselling and support, these were valued and praised by the majority of participants who had had experience of them. Drug-free wings are also referred to as voluntary testing units (VTUs). The drug-free programmes in the participants' prisons were voluntary and the majority of participants had requested a place on one.

Examples of the beneficial effect of the units are described in the extracts below.

A participant from the category C prison described his experience:

"I was drug free completely in me last place and I've been drug free here, a lot of people say why go on to a VTU which is a voluntary testing unit, if you've never took a drug in your life it shouldn't affect you, but my attitude has always been but if you get everybody on one wing that are trying to get off drugs, they have got no support [of people who are drug free] in this wing."

(PRC80)

The need for ongoing support was described by a number of participants. The following example was from a participant from the category C prison:

"It's like a lot of people will stay on even though they've not touched drugs for ages they'll stay on the same wing because they've got used to like everyone and the people on there and that umm, and some will stay on because they'll say like well if you send me back to another wing and they're taking drugs on that I could get tempted to take it."

(PRC83)

Also describing the need not to be with illicit drug users, but for a different reason a participant from a local prison explains:

"People are in for drugs or whatever it might be best to be put on a certain wing cause they possibly might be users some of them aren't but umm, and other people in for different matter you know should be on some other sort of wing. You know I mean I'm only in for like a few driving offences so you know me doing, you know I mean shared cells with like heroin addicts and stuff like that doesn't work out."

(PRL95)

There were many comments about illicit drugs in drug-free areas and programmes. One example is the following extract from a participant from the young offender institute who is on the therapeutic community:

"I've heard people say in the groups before that they're changing, they're changing, and then I've gone upstairs and they're speaking in the hall, I can't wait till I go home, get home leave, because it's so easy to get home leave by joining this wing. They go like can't wait till I get home I'll bring enough puff [cannabis] and all this and I'm going to bring that back, do you know what I mean."

(PRYO101)

However, although some abuse of the drug-free areas was reported that did not detract from the value for the majority of participants and this extract from a participant from a category C prison shows:

"Umm, well yeah I'm on a drug free wing, like, but like they work okay but you still get daft people who are still on drugs like but I mean to me it's stupid cause all they can get, you get voluntary tested you know what I mean so I can't see the point in

someone coming on to a drug free wing who's going to carry on taking drugs anyway because you might as well go on to a normal wing and then just hope he doesn't get picked out for a mandatory test at random like."

(PRC83)

A participant describing the value of the intense therapy programme he had received on the therapeutic community said:

"You need therapists to make you look at things. They do all the work for you really in a way, know what I mean, They just point things out and you just look at them, yeah, yeah that's a problem, and then once you've found out what the problem is you've got to deal with the problems know what I mean and they're there to keep on at you, they make sure that you do deal with the problem. And if there wasn't any therapists about you might just get to the point of recognising a problem but no one's going to be there to push you to deal with it, do you know what I mean, You've got no support, you've got no encouragement to deal with, no reason to deal with it."

(PRYO102)

Another participant from the young offender institute described similar benefits:

"Since I've come over here, I've learnt loads, like drugs and what it's done to me; Wasn't just like your drugs, it's the problems that you are covering when you're using the drugs and that, other things like, other ways of to stop thinking of crime and to stop thinking about drugs and all that."

(PRYO100)

The staff working on the drug free unit and therapeutic community were highly praised by the majority of respondents who were on either of these units. The staffing of these units are a mixture of prison staff and independent drug counsellors or therapists.

Most of the participants who had been on therapeutic or drug free units said that they particularly valued counsellors, particularly the independent counsellors, that had experienced the similar problems to their own problems. The extracts that follow illustrate this belief.

Commenting on the independent workers in the therapeutic community a participant from the category C prison said:

"I would say it's probably at the initial start of it it's better to have an independent counsellor because you've still got the hang up in prisoners he's got a prison uniform on."

(PRC80)

A participant from the young offenders institute commented on the support gained from someone who understands the problems being experienced:

"It does help if someone's, they you know what you're going through, do you know what I mean, they can give advice how they dealt with it, what to do, to sort it out, do you know what I mean."

(PRYO101)

On the same theme of counsellors understanding the problem, a participant from the young offender institute said:

"They understand, they understand, do you know what I mean. They don't have to go to prison, but as long as they have done bad things, do you know what I mean. They've had, you know what I mean, they've, I don't know how to put it. All through the years like till say twenty or whatever you've played up roughly do you know what I mean. I've had a rough upbringing, you've done plenty of drugs, you've done crime, you know what I mean, and then you sort of look back on it and thought what the fuck am I doing and changed. I listen to someone like that, I've got respect for them, they've done what I am doing. If it's someone that's never done it before, you know what I mean, completely different to me, I can't really, you know what I mean, I'm not on their wavelength at all. They don't know what I'm doing and why I'm doing it."

(PRYO102)

Another participant from the young offender institute described his preference for an independent counsellor:

"I prefer someone outside, do you know what I mean, It seems a bit difficult talking to someone in the uniform do you know what I mean."

(PRYO101)

A number of prison discipline staff have counselling roles both within the individual prisons and in the drug free or therapeutic units. The issue of discussing confidential problems about drugs or HIV with the prison discipline staff was raised by the participants. Although the majority of participants were suspicious of the perceived conflict of confidentiality that discipline staff may have with problems discussed drug taking or risk behaviour a few were really positive about their own personal experience.

A participant from the category C prison explained:

"I've never had a problem with the uniform, I know a lot of guys do but like I said I would think in this prison I would think in this prison I would have to say yeah, and it does work because these guys are approachable umm, for virtually anything, I mean I've been to them for all sorts and I've yet to have a whisper come back from anywhere else and that's usually what you get in prison, if somebody comes up to you and says oh I see you had a problem, you start thinking how did he get hold of that it can only come from a confidential source and I can honestly say I've never had that in this prison, so from a personal point of view I would say yeah it does work."

(PRC80)

A participant from the therapeutic community in the young offender institute explained how he felt:

"It does make a difference, you know what I mean, still even though the prison officers aren't the same as on a normal wing you're still a wee bit edgy about them, you know what I mean."

(PRYO104)

A participant from the category C prison who is also a Samaritan listener explained his perception of why there was suspicion about prison discipline staff:

"well I think if you've got a problem you'd be prepared to talk to anybody, if you want to talk I don't really believe that you know the clothes they're wearing would make a difference you know, from my point of view but obviously there are people here who would you know, there's still that us and them label you know which they sort of have and umm, and there's no way on this earth they would talk to an officer you know a screw about their problem, you know they would probably be more likely to talk to me than they would a screw you know umm, and there are listeners in gaol now."

(PRC82)

Prisoners have recourse to speak to health care staff about confidential issues related to health care; again however, although most participants would be happy to talk to the health care staff some barriers were highlighted. One of the perceived barriers is illustrated in the extract below:

"It's prison policy they won't umm, you have to go at specific times they have to be ill at the certain times if you're, if I had a migraine at two o'clock there would be nothing I could do about it until after tea and you, in this prison we fill out medical slips and I filled out a medical slip once I'm an asthmatic and I filled out a slip cause I needed a pump, well they gave me an appointment for twelve days later so I sent the application back saying hang on a minute you're neglecting my medical needs here I don't want to see a doctor I'm a registered asthmatic all I want is the pump and I had to wait a day but in the end I had to go down there myself and say look I'm not leaving until you give me a pump you know, so when you've got those sort of things happening with inmates when it comes to counselling and when they've to sit down one to one, nobody wants to speak to them."

(PRC81)

6.4.4 BARRIERS TO POLICY DEVELOPMENT

The participants perceived that some of the policies discussed would conflict with the current drug policy or current attitudes about sexual behaviour. One important problem identified was suspicion felt about the motives of the prison authorities for introducing policies that would also identify the drug users and therefore leave them vulnerable to targeting for the drug strategy. Participants also mentioned being fearful that some of the policies may lead to violence or loss of discipline, and

highlight for example, negative attitudes to same sex relationships or in the potential for using needles as weapons. These frequently expressed fears are expressed in the following accounts.

A participant from the local prison expressed his fears:

"You can go down and ask for a needle and what happens is it goes on your record then when you go to another prison they say oh, you've got needles it's on your record they they're like classing you as a drug addict and when you're in prison you don't need that, you have people coming in and searching your cell every week, I've been burgled on the out before and it's exactly the same as being burgled inside, people are going through your personal possessions every week it's not nice."

When asked if getting a needle from the prison is confidential, he replied:

"The prison will know about it, they have to know about it, they have to know about it really you know, they've got a prisoner on the wing with a needle I mean you don't want it going round the wing which it does and they sharpen them on matchboxes and everything, you know."

(PRL93)

A participant from a category C prison echoed the same sort of concern when asked if he could see a time when there would be a needle exchange in an English prison:

"No. Because they wouldn't do it for the simple reason like no one's going to go over and exchange their syringes are they cause they're going to be targeted."

Further on in the interview he went on to say:

"If they did start one I mean the prisoners would get a way round it whereas they got the syringes from the needle exchange, right tell us someone who don't take drugs and get one, know what I mean. If they're going to come and grab this guy he's not doing anything he's not worried to get tested and he haven't took none anyway, know what I mean so that's the only way to do it but it would cause like trouble that would, they'd get, people would be stabbing each other with everything in here."

(PRC83)

To further exemplify this point, a participant from a category C prison said:

"If they go round there swapping needles they're going to get MDT tested and everything and they're going to lose days."

(PRC85)

Another factor that would stop policy developing to the required level would be if the risk behaviours remain largely hidden and therefore, not enough resources will be allocated. This extract from a participant from a young offender institute illustrates this point:

"Sometimes they [prison officers] turn a blind eye, depends what it is. I mean if you're injecting, I mean you just wait until the night, wait until they all go off duty and it's just one officer, I mean then do it. Then get rid of it the next day, so there's no evidence and officers don't find no pin what's broke up, I mean, so they don't know very much what goes on."

(PRYO105)

6.4.4.1 Mandatory Drug Testing

Mandatory Drug Testing forms part of the Prison Drug Strategy and is perceived by the participants as a barrier to HIV and hepatitis prevention policy. It was felt that in the light of the drug policy any policy that would mean that drug users would be identified would fail. The policy was also criticised for being costly and not very effective in identifying all the drug users.

The following extracts depict the problems from the prisoner perspective.

A participant from the category C prison said:

"If they were, well I like cannabis, if you say to somebody I smoke cannabis they go oh, you know if you say to somebody I smoke heroin they go (demonstrates disapproval) you know it's too different you know so because they're so bang on how, they're losing you 14 days for your first cannabis offence then you're losing 21, the next one you're losing 28 yeah the next one after that you're losing 42 days for a spliff they're giving you a three month prison sentence for one spliff, it's not, I don't think it's right you know but it's helping stamp out cannabis but it's only because of the time

scale that it takes to clear but it's promoting heroin and they don't realise how fast it's promoting heroin in the gaols."

Later on in the interview he went on to say:

"It's against the law [cannabis] so obviously they have to stop it if they can but they're getting one problem down and I think the worst problem is heroin because people are going out and whereas they were in for a petty theft yeah they've robbed a shop or something and they've got away with I don't know 200 cigarettes, they've given them a 12 month prison sentence, by the time they get out of prison they've got to rob three to five hundred pound a week to feed the habit that they've had and the crime rate goes through the roof and everyone's saying well we've got all these drug free wings we don't know what's going wrong you know."

(PRC81)

There were however, some positive responses to MDT as this extract from the young offender institute illustrates:

"I think it [MDT] does do some good. Random tests and that, cause I know quite a lot of people nowadays just think more about their times of getting out than smoking again, so like some people do leave it alone just in case they do get a test, but I've known people to like keep getting tests and their days have gone up like 56 days at a time and that, just for a little smoke that they could do without."

(PRYO100)

Another participant from a local prison described how the loss of days for smoking cannabis had altered his drug behaviour:

"I lost fourteen days at me last prison. Hopefully I can get them back. I stopped now can't be bothered with any of it. Made me stop."

(PRC85)

A number of the participants were critical of MDT. The following extract expresses a viewpoint typical of the responses,

"I personally think their strategy of random tests is rubbish it's absolute rubbish, if they're going to have a mandatory drug testing system in prison target people because random is such a waste of time and money."

(PRC80)

Finally, the issue that MDT promotes a change in drug behaviour to heroin has been raised in the results section 'change of behaviour'. Most participants believed that this shift in drug use was occurring.

6.4.5 THE IMPORTANCE OF DEVELOPING POLICY

There clearly has to be more help and support for prisoners with drug related problems. This would involve a much more rehabilitation centred approach to treatment and care in prison and much greater links with the community agencies to give support to prisoners going back into the community, sometimes into situations that once supported the prisoners drug taking behaviour.

One participant described the difference prevention makes:

"I went there [rehabilitation centre] and they done group therapies and you sort of sit round in a circle, thirty of you, and you talk about problems, one talks at a time the rest listen, then they give their opinions, in here, when you're locked in the cell they're talking about drugs, fixes and when they can get a fix, who's the best person to go to for a fix, when I get out this, that and the other, if they were sat in a group of ten people, twenty people in an actual group instead of sat in a bloody cell talking about their next fix and where they can get the best fix from, if they're sat in a group with a counsellor or whatever you want to call them, and they talk about it then, they could talk round it and say well, the best thing to do that fix when you get out, what's it going to do to you, you're going to lose your relationship, your girlfriend, your wife, you know you're going to be back inside here for another two months, three months".

(PRL90)

The lack of continuity of care and drug rehabilitation programmes into the community was mentioned frequently. This extract illustrates the problems when a participant from a local prison describes his last release from prison. He went back into the

same community situation without any support to continue his drug rehabilitation programme,

"Last time I was here I got fourteen days imprisonment for the hands on charge, they put me on 35 milligrams straightaway for three days then 30 milligrams for three days, then 25 for the last day I was getting out. I had drugs in my system when I got let out and as soon as I got the train home me brother and me two mates were waiting there for me with drugs do you know what I mean and it's doing me head. I want help do you know what I mean cause to be honest I can't do it, do you know what I mean I'm going nowhere, I've got nothing at all nothing whatsoever, I've got a bin bag full of clothes and that's all I own do you know what I mean, I've got a great family you know what I mean, they give me anything, as long as I get off drugs do you know what I mean and it's doing me head in staying on drugs".

(PRL92)

It appears from the interviews that participants are seizing the opportunities that are offered to them to alter their drug-taking behaviour. Some participants viewed their prison sentence as a time to take stock and address their behaviour and some risks they had taken in their lives. Anticipating their release from prison as an opportunity for a new start. The participants from the young offender institute in particular were very positive about the therapeutic community and the benefit to their life and attitude towards risk behaviour is shown in the following two extracts,

"I've been talking to some of the boys upstairs and there's like, there's four of us stood there saying, yeah, we've got to have it done. I wanna have a test before I leave prison cause I've got like my wife and my kids to think of now you know. I don't wanna, I wanna go out of prison knowing from that moment stay safe or not know and just go off the rails again."

(PRYO103)

"It's like when I first come in, it didn't really bother me and then I thought I'd shared, sleep with people unprotected and it's just bobbing about in my mind, It's like a person went over, I mean, he had a test and it come back positive hep C and like I mean, he was gutted in a way, he's glad now he knows."

(PRYO105)

This research shows that although most participants would accept condoms in prison, same sex relationships remain stigmatising. Having the opportunity to obtain condoms confidentially and without the barriers described by participants is essential to people being able to take up the means to protect themselves with some confidence and without the fear of stigmatisation.

6.5 SUMMARY OF QUALITATIVE RESULTS

Most participants viewed HIV and hepatitis B and C prevention policies favourably; however, there was a general concern that because of the apparent emphasis of the drug strategy some of the proposed prevention policies may be used to target and identify drug users.

6.5.1 EVALUATION OF INTERVIEWS

Interviewing prisoners was an attempt to complement studies one and two by generally giving a broader and more rounded view of the research question, and specifically to answer the question of how acceptable the policies discussed would be to prisoners. Some of the findings were not anticipated by the researcher and this highlights the benefit of using qualitative interviews for a research question where there has been little previous research and the issues are therefore not well understood. Throughout the interviews participants were keen to express their views and illustrated discussions with specific examples from their prison experiences that are valuable in explaining the issues from the prisoner perspective.

The responses on important issues across the three prisons were similar indicating high levels of internal validity. Differences in response tended to focus on the security category of the prison. So, for example, differences in drug supply and thus drug taking behaviour were identified due to the apparent differences in strictness of prison discipline and access of visitors to the prison.

Some participants were a little more reticent when discussing sexual and sexual health issues; some quickly reassured me that they had not had any same sex relationships in prison. However, given the 'male macho' culture described in the interviews there may have been a greater reluctance if the interviewer had been male. A second interview would have given the participant time to reflect on some of the issues and feel more comfortable with the subject matter of the interviews.

6.5.2 PROBLEMS ENCOUNTERED

All participants confirmed that they had volunteered for interview; however, there was some misconceptions about my role regarding testing for HIV and hepatitis B and C status. I explained carefully that I would not be looking at rates of HIV and hepatitis B and C infection and the participant was told how to access counselling for HIV and hepatitis testing. A further explanation was given that the research was purely about looking at risk behaviour for HIV and hepatitis B and C infection with a view to exploring attitudes and beliefs towards prevention policy.

The privacy of the interviews was on occasions compromised by a prison officer entering the room. When this occurred the interview was suspended during the interruption and conversational talk took place. After the interruption the researcher apologised and resumed the interview. Officers felt they needed to be close at hand and have access to the room for security reasons.

6.6 IMPLICATIONS FOR POLICY DEVELOPMENT

The results of study three have profound implications for the development of prevention strategies to reduce the transmission of HIV and hepatitis B and C.

Education and training in respect of HIV and hepatitis appeared to be very 'hit and miss', some participants praised what they had received others had little or no education in this respect at all. Most participants wanted more education, particularly for hepatitis. It is possibly very difficult to ensure that all prisoners receive the same standard of education when there is a great deal of movement in and out of the prisons for discharges and transfers. However, perhaps one way to overcome this problem would be to have educational records for each prisoner which, would then operate to ensure that a minimum standard, with regard to education, had been reached.

6.7 CONCLUSION

The results summarised in this chapter show that study three succeeded in its aim to gather contextual data on risk behaviour and perceptions of prevention policy from the prisoner perspective. The results show that an understanding of prisoner beliefs and potential acceptance of prevention policy would be useful for developing effective policy.

CHAPTER 7

Concluding Discussion

7.1 CHAPTER OVERVIEW

The final chapter will summarise the findings reported in this thesis. The implications of the combined analysis for policy development are considered.

The combined outcome of the three studies that comprise this thesis have added new and important information to explain why community HIV and hepatitis prevention policy has been difficult to implement in a prison context. This research explains some of the barriers to implementation of prevention policy that have not been made explicit by previous research. In particular this thesis presents:

- A more focused and in-depth exploration of attitudes and beliefs of staff and prisoners towards HIV and hepatitis B and C prevention in prisons than previously reported in prisons in England and Wales. Previously the only reported research of this nature has been in Scottish prisons (McKee et al., 1994; McKee et al., 1995).
- The case study method utilised for the study enabled an exploration of the different perspectives between three security categories of prison and the different perspectives of staff and prisoners.
- The theory of planned behaviour provided a framework for structuring the way data were managed and conceptualised.

The results of the study can be summarised as revealing deep conflicts about some of the HIV and hepatitis prevention policies, particularly those policies perceived as facilitating illicit drug use and same sex penetrative sexual intercourse. Whereas, the policies perceived as reducing or 'stamping out' such behaviours were viewed much more positively. This thesis outlines in detail the barriers and concerns about the policies that remain controversial in a prison context such as needle exchange and decontaminates for cleaning intravenous drug equipment. Participants revealed deep-seated and shared anxieties about the consequences of implementing policies such as, needle exchange, decontaminates for intravenous drug users and condoms. In summary, the concerns expressed by participants were that the introduction of

some of the prevention polices may lead to increasing the supply of weapons, drugs or condoms in prisons or that drug use in prisons would be encouraged or increased. Similar concerns were reported in a Canadian pilot study of prisoner beliefs by Calzavara et al., (1997). Also, shown in the current study and confirmed by previous research is the belief that the provision of needle exchanges, decontaminates and condoms are unlikely to be taken up because prisoners would fear identifying themselves as participating in an illicit activity (Power et al., 1994). Another anxiety described by staff and prisoners was that providing free syringes and needles to prisoners during imprisonment may encourage the use of illicit drugs and discourage those who want to abstain from doing so. The same concern has been previously reported in a study by Power et al., (1994). In addition, some staff were concerned about condoms being used to conceal illicit drugs; however, some of the staff and the majority of prisoners rejected this concern. A few staff highlighted concern about issuing condoms in a young offender institute because the legal age of consent is 18 years. Although some staff and prisoners mentioned condoms provoking homophobic attitudes most saw the benefit of having a confidential system of condom distribution.

Large numbers of individuals in the groups described in this thesis shared similar beliefs and attitudes about HIV and hepatitis B and C prevention policy. Markova and Power (1992) describe the way particular systems of values, ideas and practices are adopted by members of a particular group as 'social representations'. Social representations are formed to cope with complex, unfamiliar and threatening phenomena, they are the way social events are conceptualised and explained. These collectively formed and maintained understandings are important to inform policy makers to design effective educational programmes that will tackle the deep-seated and shared anxiety of staff and prisoners in prisons. This thesis therefore, has applied implications, in that the results of the study describe the shared beliefs and anxieties of the groups most directly involved in policy and thus provide a platform for the discussion of important educational initiatives related to policy making. An example of a pilot initiative that did not tackle and change attitudes was the needle exchange pilot scheme at Hindlebank prison in Switzerland. Staff expressed concern at the outset of the pilot project that needles would be used as weapons, that there would be a shift in the pattern of drug use to injecting drug use and that there would be spread of infection. These anxieties remained at the end of the project even though these fears were not substantiated in the evaluation (Nelles

& Furhrer 1995). Therefore, policy makers at a national level and at individual prison level, as well as health care staff working with prisons, should find the results of this research useful.

In England and Wales there is little progress in implementing the World Health Organisation guidelines on HIV infection and AIDS in Prison (1993). A survey designed to measure the extent of implementation of the World Health Organisation guidelines in Europe questioned the appropriateness of directly implementing community policies (O'Brien & Stevens 1997). The current study empirically illustrates that to simply apply equivalent community HIV and hepatitis B and C prevention policy into a prison environment would be problematic for effective policy implementation. There should be an understanding and consideration of the specific contextual barriers and complexities described by staff and prisoners in this thesis.

7.2 EVALUATION OF METHODOLOGY

The principal aim of this research has been achieved and the beliefs and attitudes of prison staff and prisoners towards prevention of HIV and hepatitis B and C in prisons were explored. A case study methodology enabled the generation of rich contextual qualitative data in face-to-face interviews with staff and prisoners, as well as permitting the findings of the staff interviews to be developed into a questionnaire to give a broader quantitative approach towards the research problem. Identification of the 9 cases that comprise this study proved useful because it enabled an exploration of the perspectives of different security categories of prison, and the different perspectives of staff and prisoners. The analysis of the data from these different perspectives helped to build a picture of the complexity of HIV and hepatitis B and C prevention in a prison context. Differences between security categories of prison and between methodologies and between staff and prisoners were identified. Local prisons were perceived as having greater drug misuse problems. Category C prisons were perceived to be more likely environment for same sex relationships. Tattooing appeared to be declining in all the prisons in the study despite young offender institutes being perceived as the most likely environment where such behaviour occurred. 'Triangulation' of data collection and analysis enabled a rounded, multilayered consideration and understanding of the research endeavour (Yardley 1999). Despite the differences identified between cases, the three phases of this research; qualitative interviews with staff, a questionnaire survey and qualitative

interviews with prisoners revealed similar and complimentary results. Finding similar patterns of results from the different data gathering methods increases confidence in their validity (Robson 1998b).

Given the access difficulties experienced in this study, due largely to the security constraints, it was an ambitious study to achieve within the timeframe.

The response rate to the questionnaire was disappointing despite every effort to achieve a higher response rate. However, the questionnaire data in the context of the case study design does add a further dimension to the qualitative data collected because it enabled exploration of the policy issues in a wider population and in a greater number of the three different security categories of prison. The responses to the Likert-scaled statements in the questionnaire confirm the qualitative data in all areas except the apparent greater level of importance given to the priority and greater desire for training. The questionnaire results revealed that over 90% of respondents felt it was necessary to have further training in HIV, hepatitis B and hepatitis C awareness. 97.3% of the sample felt that HIV, hepatitis B and hepatitis C policy development was a priority area. The questionnaire results revealed that over half the respondents (56.6%) felt that their job put them at high risk of HIV, 72.5% felt that their job put them at high risk of hepatitis B and 68.9% believed that their job put them at high risk of hepatitis C. This result is in line with previous research showing that staff perceive prison as a high-risk environment (McKee et al., 1995).

This study is concerned with examining attitudes and beliefs towards HIV and hepatitis B and C prevention policies. Policy and attitudes to policy invariably change over time therefore; the results of this research should be considered a reflection of the attitudes and beliefs of this period in time.

7.3 THE CONTRIBUTION OF THE THEORY OF PLANNED BEHAVIOUR

Using the theory of planned behaviour to aid development of the questionnaire was beneficial because it essentially provided a way of organising the data. The model was only used in this way and it was not intended to measure the link between intention and policy-related behaviour. It was instead used to provide a framework to structure the complex concepts that emerged from the interviews with staff. Therefore, the components of the theory of planned behaviour were not rigidly applied to the questionnaire. For example, it seemed inappropriate to ask

respondents their motivation to comply with their perception of the belief of a significant other in relation to a particular policy.

According to the theory of planned behaviour, the personal beliefs of the participants, the beliefs of significant others and perceived behavioural control, in this instance over policy development, are important considerations in predicting the behavioural intention. Behavioural intention however, according to the theory of planned behaviour, is stated to be the most immediate predictor of behaviour. The results of the questionnaire study show that staff had negative beliefs about policies concerned with bleach, needle exchange schemes and condom distribution in prison, and they felt that some significant others also had negative beliefs. In addition, the respondents felt that politics and the general public had a greater influence over policy development than they have. Despite these findings respondents still showed a strong intention to carry out the policies described therefore, attitudes, subjective norm and perceived behavioural control seemed to have little impact on the intention to perform the policy behaviour. Ingham and Zessen (1997) have previously criticised the apparent inconsistencies in social cognitive models arguing that immediate situational factors play a larger part in determining behaviour than has previously been allowed for. Other critics have maintained that behaviour is not always guided by cognitive variables in a way envisaged by the main social cognitive models (Norman & Conner 1996) and that the social and cultural contexts are important determinants of behaviour (Markova et al., 1995). Clearly there were factors other than attitudes, subjective norm and perceived behavioural control determining intention to perform policy related behaviour; however, the reasons for this result are not explained by the data. As previously stated the operational procedures of the theory of planned behaviour were only partially applied to structure the questionnaire therefore, it is difficult to interpret the results of the study in relation to the model. However, staff having a stronger belief in the security and discipline aspect of their role may explain the apparent anomaly of staff stating they would implement the policies in the light of strong contrary beliefs. Staff may possibly believe that adherence to rules and policies help to maintain discipline in the prison. Further exploration of the issues would be necessary to explain this result.

The limitation of using the theory of planned behaviour to structure the questionnaire was that it added extra questions to the complex issues presented to the

respondents. However, the broader picture of prison staff attitudes and beliefs about HIV and hepatitis prevention that the questionnaire analysis was able to present diminished this limitation.

7.4 THE PREDOMINANT CONCERN OF INTERVIEW PARTICIPANTS

The predominant concern of the staff, particularly the discipline staff, was that the prevention policies discussed are to do with sex and drug misuse; activities considered illegal within the prison environment. The drug strategy appears to have wide endorsement from staff because it is closely aligned with their discipline role of 'stamping out' drug use in prisons. Therefore, illicit drug associated behaviours are generally met with disciplinary measures and not health measures. Previous research by MacDonald (1997), revealed a similar wide endorsement of the drug strategy from staff, she also reported that the focus of the policy was on testing and restricting supply resulting in less effort directed towards treatment. In the current study impressive staff initiatives were described, particularly the therapeutic community, the drug free programme and the methadone detoxification programme. However, these initiatives were dependent on individual staff and governors to implement them. There did not appear to be an acknowledgement of the principle of equivalent access to HIV and hepatitis prevention measures or to equivalent systems of psychological support and treatment for withdrawal from drug misuse for all prisoners.

In the current study prisoners tended to view the wide endorsement of the drug strategy as a barrier against accepting some of the HIV and hepatitis prevention policies. Some prisoners expressed the concern that the prominence of the drug strategy would cause prisoners to mistrust policies such as bleach distribution and needle exchange. They said prisoners would be suspicious about prevention measures that could be used to identify drug users and target them for subsequent discipline measures.

7.5 EDUCATION

The three studies in this thesis highlighted that most staff and prisoner participants were concerned about the lack of periodic updated HIV and hepatitis education. Some participants were particularly concerned because of recent advances in understanding and treatment of HIV and hepatitis viruses. In addition, some

participants expressed concern at the lack of training about hepatitis generally and specifically about hepatitis C. Some participants, prisoners and staff, described variability in the length and type of training offered in different prisons.

7.6 RISK BEHAVIOUR

The questionnaire and staff interviews showed variability in the perceived levels of same sex relationships in prisons. The young offender institute was perceived to have less sexual activity because of age and vulnerability of the prisoners and the local prison was perceived to have less sexual activity because of shorter sentences. These beliefs may have contributed to lower staff acceptance of condom policy in these types of prison. Category C staff showed a greater acceptance of condom access policies for prisoners, ($\chi^2 = 10.586$, $df = 4$, $p=0.032$). The prisoner interviews showed the same patterns of beliefs about variability of same sex relationships in different types of prisons. Staff and prisoners described same sex relationships as hidden because of the social unacceptability of these relationships. Although there has not been any previous studies reported that investigate the variability in beliefs about same sex relationships in different security categories of prison, results of previous research suggests low rates of same sex sexual activity generally in prison (Koulierakis et al., 1999, Strang et al., 1998, Curtis & Edwards 1995; Turnbull, Dolan & Stimpson 1991). However, as shown in this study and supported by Calzavara et al., (1997) and Power et al., (1991) the socially stigmatising nature of same sex relationships may serve to hide the true extent of same sex relationships in prisons. The current study shows that there appeared to be little take up or provision of condoms by prisoners and little recognition by staff of the need evaluate the policy because prisoner sexual relationships were not considered to be commonplace.

Staff and prisoners described high levels of illicit drug use in prisons and this finding is in line with previous research (MacDonald 1997; Turnbull et al., 1994). Prisoners in the current study explained the high prevalence as being attributable to a number of factors; the social pressure to conform, the high number of drug users in prisons and because drug use helped to distort the perception of time in prisons. References to time were also made by prisoners in a study by Turnbull et al., (1994) when the use of drugs in prison was explained as a strategy to help sleep and to relieve anxiety and boredom. Some prisoners in the current study explained that at times of psychological distress they did not have the usual recourse to stress reduction in

prisons as they would have in the community. Therefore, they suggested illicit drug use in prison may fulfil a role in reducing stress. A prisoner explained that prisoners were not able to leave a stressful situation or not be able to go for a drink or discuss problems with a general practitioner. It was suggested in the current study that drug use is much higher in local prisons because of greater prisoner movement in and out of prisons and a higher-level of visiting allowed for remand prisoners. Young offender institutes are believed to have lower levels of drug use because of age and less experience of knowing how to obtain a drug supply.

Reduced levels of drug injecting was described principally because some prisoners understood the high risk involved in sharing injecting equipment. This finding is supported in a number of research studies (Koulierakis et al., (1999); Strang et al., (1998); Schewan et al., (1994); Power et al., (1992)). In addition, some prisoners described a change in their own injecting behaviour because they viewed their imprisonment as an opportunity to address their drug taking behaviour. Using a prison sentence in this way to motivate positive behaviour change has been described previously by Turnbull et al., (1994). However, in contrast some prisoner participants in the current study described personally sharing injecting equipment in prison. There was a consensus that injecting use was reduced in prison but that where injecting occurred injecting equipment was likely to be shared by a number of prisoners because of the general unavailability of needles and syringes. This confirms the findings of a number of studies (Bird et. al., 1993; Dolan et al., 1995; Gore et al., 1995; Schewan et al., 1994; Turnbull et al., 1994).

Staff and prisoners generally reported a decline in tattooing behaviour in prisons, particularly in relation to sharing tattooing equipment. The reduction in this behaviour was attributed to increased knowledge of the risks of blood-borne infection. This finding appears contrary to the finding in the survey of risk behaviour undertaken in 13 prisons by Strang et al., (1998). The study reported that 11% of their sample of 1,009 prisoners had been tattooed in prison.

7.7 PREVENTION POLICIES

7.7.1 PREVENTION OF SEXUAL TRANSMISSION

When discussing condom distribution in prisons some prison staff talked about the moral aspects of same sex sexual activity. However, most were concerned with the

legal and security issues. Staff generally seemed unaware of the letter sent to the prison doctors from the Health Care Directorate in response to the concern about condom distribution clarifying that there was not a legal restriction on issuing condoms in prisons. This finding appears to support the contention by Sexton (1997) that fragmentation of policy occurs from not having clear channels of communication to both the discipline staff and the health care staff. Staff generally felt much more comfortable with the health care staff issuing condoms on prescription rather than condoms being freely available in the prison wings. This may be a result of the confusion about the legal position or it may be attributable to the perceived threat to security described in the current study; the concern that drugs may be concealed or smuggled using condoms. However, illicit drugs are currently concealed and smuggled effectively; therefore, condoms would possibly have very little impact on this situation.

Most staff believed that providing condoms was in conflict with their discipline and security role. This was principally because of the potential to conceal or smuggle drugs but also because of the possibility that the stigma of a same sex relationship may lead to aggression and bullying from other prisoners.

An important finding of this study was that although condoms could be provided in prisons on prescription from prison doctors only one doctor in the interview study said he had prescribed condoms to one or two prisoners. The doctors from the other prisons had not prescribed condoms at all.

Prisoners described how the hidden nature of sexual relationships in prison due to the 'macho' culture within prisons might negatively influence the take-up of condoms by prisoners. The stigmatising nature of same sex relationships has also been described by Calzavara et al., (1997). Most prisoner respondents in this study therefore, generally favoured confidential access to condoms through the health centre. However, a few prisoners described how potential difficulties of access to the health centre might affect the effectiveness of the policy. They described the need to make an appointment and lack of confidential access to condoms as being potential barriers to take up of the policy. A number of prisoners said that they were unaware of a condom policy in their prison.

Prisoners generally did not completely welcome policies concerned with improved access to condoms but a number of them did express a moral imperative for condom distribution in the light of the potential for HIV and hepatitis B and C transmission.

7.7.2 PREVENTION OF PERCUTANEOUS TRANSMISSION

The majority of discipline and health care staff described difficulties with needle exchange schemes. The concerns expressed by staff were remarkably similar to the concerns expressed by staff at Hindlebank Prison before the pilot needle exchange scheme was introduced; a difficulty principally with the apparent incompatibility of this preventive health measure with the illegal status of drugs. In the evaluation of the pilot at Hindlebank Prison the fears expressed with regard to increased consumption of drugs and the use of syringes for weapons were not confirmed (Nelles & Furhrer 1995). However, in the current study, the concerns expressed by staff are deep seated and needle exchange is perceived as a conflict with the staff discipline and security role and with the law and order role of prisons. In addition, concern is expressed that a needle exchange scheme would be in direct conflict with the current drugs strategy in prisons which essentially is a discipline rather than a treatment response to drug use in prisons. Some staff described the difficulty of providing a needle exchange scheme and then knowing that prisoners would then be obtaining an illicit drug supply in the prison. Some staff also believed that providing a needle exchange scheme in prisons might act as a disincentive for those prisoners who attempt to change their drug taking behaviour when entering prison.

Some prisoners were concerned that a needle exchange would compromise their personal safety and were concerned that needles may be used as weapons. They also described worries that a needle exchange may possibly encourage injecting drug use and act to tempt prisoners in situations where they were trying to give up injecting drug use. Some prisoners said that they believed that staff would use a needle exchange to identify drug users and target them for testing as required by the drug strategy. These findings confirm the results of a previous Canadian pilot study that reported similar concerns from prisoners (Calzavara et al., 1997).

Most participants, prisoners and staff, also had difficulties with bleach distribution. Some mentioned the uncertain effectiveness of bleach against viruses, a finding that has been confirmed by a number of microbiological studies (Titus et al., 1994; Vlahov

et al., 1994; Shapshak et al., 1994). In other community settings the advice with regard to bleach for decontaminating intravenous drug equipment is that it may not be effective and it should only be used as a last resort. Thus in a prison setting it becomes ethically difficult to propose that it is the only harm reduction policy available to intravenous drug users without due consideration of implementing a more comprehensive policy in line with the broader policy framework available in other community settings. The review of HIV and AIDS in Prison recommends that cleansing agents be made available to prisoners (AIDS Advisory Committee 1995). However, some prisoners and staff expressed an ethical concern about introducing a policy that had been challenged in terms of its effectiveness when it was not part of a comprehensive policy strategy that allowed access to safe injecting equipment.

Some staff mentioned that bleach tablets had been introduced into prisons and quickly withdrawn because of a safety issue concerned with the combustible properties of bleach tablets. Fire tests on bleach were conducted by the Health and Safety Laboratory and it was concluded that that particular concern was unfounded (see appendix 8).

The distribution of bleach for cleaning injecting equipment evoked responses from staff similar to the responses about needle exchange schemes. Staff generally believed that bleach distribution would also be a conflict with their discipline role, the law and order role of prisons and be in conflict with the drug strategy policies. Some staff and prisoners were concerned about the potential of using bleach in an aggressive way to throw over other prisoners or staff. Although unrestricted bleach has been available in Scottish prisons for a number of years without any undue problems reported (Power et al., 1994).

Some prisoners gave descriptions of cleaning injecting equipment with inadequate cleaning agents such as washing up liquid, believing it to be sufficient to destroy viruses. The descriptions given highlighted that those prisoners misunderstood the basic principles of decontamination. Inadequate decontamination of shared drug injecting equipment is a risk for the transmission of HIV and hepatitis B and C.

Most staff viewed methadone detoxification for withdrawal from opiates as a beneficial policy and generally favoured extending the policy to all prisons. Currently the policy predominates in local remand prisons. The methadone detoxification

policy was more associated with the drug strategy than HIV and hepatitis prevention. The role of methadone detoxification in harm reduction was not well understood. Most staff were keen to see more policy development related to helping prisoners to stop drug use for example development of support and counselling and better throughcare into the community.

One staff member when describing the benefits of the methadone detoxification policy said that there had been less 'warfare' in the prison, meaning that there had been a reduction in the bullying and violence associated with drug dealing.

Some prisoners, even ones that were in a methadone detoxification programme or had been in a methadone detoxification programme in the past, were critical of methadone. Some said that it would be easier to just stop taking drugs (cold turkey) and have night sedation and greater psychological support to help through the process of withdrawal. Other prisoners were critical of the length of the programme and the amount of methadone given and described psychological distress related to this. The rapid methadone detoxification policy in prisons has previously been questioned and it has been suggested that longer term methadone treatment be available (The Advisory Council on the Misuse of Drugs 1993).

7.8 BARRIERS TO POLICY DEVELOPMENT

This study described a prison culture where drugs are talked about constantly and illicit drugs are perceived as a way of coping with imprisonment and distressing social situations. Within this context, it will require a greater emphasis on support programmes, training and education and more general leisure activity to shift the balance of the cultural influence.

A further concern is the descriptions of same sex relationships being 'hidden' and therefore unsafe sex may be practised.

Most staff believed the drug strategy was in conflict with potential HIV and hepatitis policy. MDT was highly valued by staff, although most staff believed the policy should be reviewed because they believed that the policy had changed drug use from 'soft' to 'hard' drugs. Prisoners also believed the drug strategy would be a barrier to the take-up of policies such as needle exchange and bleach distribution.

The lack of a cohesive HIV and hepatitis policy framework will hinder prisoners having equal access to prevention policies.

7.9 CONCLUSIONS

7.9.1 Prevention measures for HIV and hepatitis B and C in prisons:

The study confirms previous research of an overall reduction in risky injecting behaviour when individuals enter prison, however, the prisoners and staff present a picture of sufficient HIV and hepatitis B and C risk behaviour to provide a clear imperative to implement appropriate and acceptable prevention strategies. However, the strength of feeling by staff and prisoners against some of the prevention policies, for example, condoms, bleach and needle exchanges should not be ignored and any policy development in this area would require staff and prisoner involvement.

It is clear that the development of HIV and hepatitis policy will affect other policies and particularly the drug strategy. The apparent incompatibility of HIV and hepatitis prevention policy and the drug strategy policies should be considered and addressed in any policy making.

Policies to promote preventive health behaviour in individuals or organisations can take many years. Change of this magnitude will require strategic direction and commitment, particularly in terms of finance for development, education and maintenance of policies. Currently the direct responsibility for health care lies with the governors and therefore prevention strategies, which have long-term outcomes, may suffer when competing against other more immediate service issues.

The National Health Service holds as a basic principle equivalent access of care for all, positive discrimination is sometimes practised for people who are in some way disadvantaged in gaining that access. Prisoners could be considered disadvantaged at gaining access to preventive health care. If a prisoner has an addiction, which in some way may relate to his or her criminal behaviour, and is unable to access equivalent addiction services, then rehabilitation of offending behaviour cannot be achieved. As some staff indicated, prison can be viewed as an opportunity that should be seized to help with addiction as well as other life skills such as literacy and anger management.

Staff were generally supportive of Mandatory Drug Testing, even with its apparent unintended policy consequences of a shift towards 'hard' drug use, because it is valued for its immediate objective of 'stamping out drug use'. However, the long-term aim of many of the harm reduction strategies also has the same objective of reducing and stopping illicit drug use. Broadening the focus of the approach in prisons to allow the prison drug strategy to incorporate the wider community public health aims might enable a way forward to helping staff and prisoners accept some of the policies with less conflict.

Staff and prisoners reported high levels of illicit drug taking in prisons. It would therefore, seem prudent to explore whether trained addiction staff should be employed to work in prisons to give additional support to prisoners and staff. In addition, they could take on some responsibility for training staff and raising levels of awareness about the underlying principles of addiction policies applied in other community settings.

Given the apparent hidden nature of same sex relationships it would also seem judicious to explore whether sexual health advisors could work with staff and prisoners to reduce stigma and raise awareness about same sex relationships. If behaviour is hidden because of social stigma then any policy development in this area may remain ineffective.

Staff and prisoners identified that they would value additional HIV and hepatitis B and C training, and they perceive policy development in this area to be a priority. Attitudes towards same sex relationships and illicit drug use will need to be addressed within the training programmes.

Prison health care staff seemed to have little direct input into HIV and hepatitis training for staff and prisoners, although there were instances described of opportunistic education by health care staff. It may be beneficial to explore if health care staff should have a greater input into HIV and hepatitis education.

There is clearly a need for careful consideration of the balance between security and public health in a prison environment; staff believe that much of the HIV and hepatitis B and C prevention conflicts with the drug strategy. As previously stated the AIDS Advisory Committee (1995) recommends a more enlightened use of discipline in this area of policy so that treatment becomes the preferred response rather than a

disciplinary response. Policies should be implemented in a way that the concerns and worries of staff and prisoners are addressed. Therefore, policies should not simply try to mimic community policies without consideration of the environment and concerns of the staff and prisoners. Prisons internationally have had difficulty in implementing the 1993 World Health Organisations Guidelines on HIV/AIDS in prisons (O'Brien & Stevens 1997) because of the complexity of the issues. However, O'Brien and Stevens (1997) state that the special circumstances and role of prisons cannot justify a lack of action and that prison policy should therefore, incorporate these circumstances into policy making. It will be challenging to develop effective HIV and hepatitis B and C prevention policy in prisons. Policy will have to address the complexity of concerns expressed by staff and prisoners. In addition, policy will have to address the ethical imperative to implement effective prevention programmes for the risk behaviour described in this thesis and provide adequate support for prisoners who express the desire to address their risk behaviour.

How does this prison compare to others that you know or have heard of?

13 Describe what more could be done? If any of the following are not described, probe what about::

Methadone programmes
Confidential access to condoms
Bleach to decontaminate IDU works
Needle exchange
Tattooing
HIV testing
GUM clinics
HIV counsellors
MDT

14 What happens when known intravenous drug users are received into prison?

15 Are people treated any differently if they are suspected to have a drug problem rather than are known to have a drug problem?

16 Does the reception process described help to reduce drug taking in prison?
If no, what more could be done?

17 Is there any specific procedure when known homosexuals are received into prison?
If yes is it different is a suspected homosexual is received into prison?

18 How could the prevention strategies be improved or introduced. Explain some of the benefits, problems and pitfalls?

Areas to cover -

Education
Methadone programs
Confidential access to condoms
Bleach for decontamination
Needle exchange
Tattooing
GUM clinics
Counselling

19 Does mandatory drug testing help in preventing transmission of HIV and hepatitis?
If yes how? If no why?

20 Is the timing of introducing the prevention strategies you mentioned important or in any way significant

21 Is there anything you feel we have not covered and you would like to tell me?

22 Are there any general comments you would like to make?

UNIVERSITY OF SOUTHAMPTON

HIV AND HEPATITIS B AND C PREVENTION IN PRISONS

STAFF QUESTIONNAIRE

STAFF QUESTIONNAIRE

1. Please give your job title and grade:
2. Please state type of prison currently working in:
3. How long have you worked in the prison service?
4. Briefly describe your prison career, indicating type of prisons worked in and for how long:.....
.....
.....

7. Have you, in a work context, known anyone with the following infections?

Please tick

HIV	Yes	No	Don't Know
Hepatitis B	Yes	No	Don't Know
Hepatitis C	Yes	No	Don't Know

8. Do you feel you understand the transmission routes of the following infections?
Please tick:

HIV	Yes	No	Don't Know
Hepatitis B	Yes	No	Don't know
Hepatitis C	Yes	No	Don't know

SERVICES CURRENTLY AVAILABLE IN YOUR PRISON

Please note: Drug detoxification refers here to a substitute drug prescribed for a specific treatment period for the purpose of helping prisoners to stop using an illicit opiate drug. It is a withdrawal treatment.

Drug maintenance refers here to an oral drug prescribed on an ongoing basis for the purpose of reducing the harms associated with illicit opiate drug use. The aim of this treatment may include a long-term goal of reducing or stopping illicit drug use. However, in the short-term this treatment is focused on reducing the prevalence of injecting drug use with the aim of reducing the risk of sharing injecting equipment and thus reduce the prevalence of HIV and hepatitis B and C infection.

9. Does your prison offer the following services for prisoners?

TYPE OF SERVICE	YES	NO	DON'T KNOW
Education and information about HIV			
Education and information about hepatitis			
Leaflets and posters about HIV			
Leaflets and posters about hepatitis			
Confidential access to condoms managed by health care staff			
Confidential access to condoms managed by discipline staff			
Confidential access to condoms managed by health care and discipline staff			
Needle exchange scheme			
Bleach provision for cleaning needles, managed by the health care staff			
Bleach provision for cleaning needles, managed by discipline staff			
Bleach provision for cleaning needles, managed by health care and discipline staff			
Detoxification on entry to prison with prescribed Methadone			
Detoxification on entry to prison with other prescribed drugs			
Maintenance therapy with prescribed Methadone			
Maintenance therapy with other prescribed drugs			
Drug-free areas			
Drug-free therapeutic community			

10. Have you attended a training session/course on the following subjects, if yes please indicate how useful you felt the course/session was:

TYPE OF COURSE	YES	NO	HELPFUL	NOT SURE	NOT HELPFUL
HIV/AIDS Counselling					
HIV/AIDS awareness					
Hepatitis B Counselling					
Hepatitis B awareness					
Hepatitis C Counselling					
Hepatitis C awareness					

11. Briefly describe the training you have received with regard to HIV/AIDS, and hepatitis:.....

.....

.....

.....

12. When did you last attend a training/updating session on HIV?

13. When did you last attend a training/updating session on hepatitis B?

14. When did you last attend a training/updating session on hepatitis C?

TRANSMISSION ROUTES

Please indicate, for each infection, the relative extent to which you believe the following activities could result in transmission of the virus:

0 = no risk
1 = low risk
2 = medium risk
3 = high risk
4 = very high risk

Example: If you believe unprotected anal intercourse is a very high risk for transmission of HIV please tick number 4

STATEMENT		0	1	2	3	4
Unprotected anal intercourse	HIV/AIDS					✓

0 = no risk
 1 = low risk
 2 = medium risk
 3 = high risk
 4 = very high risk

15. Transmission of the virus can occur:

STATEMENT		0	1	2	3	4
From Shaking hands with someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From sharing cups, plates or cutlery with someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From kissing someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
If food is eaten which has been prepared by someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From a cough or sneeze from someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From sharing unsterile tattooing equipment	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From using a cell that has previously been used by a prisoner who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From the urine of a person who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From the saliva of a person who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From the faeces of a person who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From sharing unsterile injecting equipment with someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From unprotected anal intercourse with someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					
From unprotected vaginal intercourse with someone who has the virus	HIV/AIDS					
	Hepatitis B					
	Hepatitis C					

For each of the statements that follow, please indicate your response by ticking in the appropriate box.

VSA = Very strongly agree with the statement

SA = Strongly agree with the statement

A = Agree with the statement

U = Undecided about the statement

D = Disagree with the statement

SD = Strongly disagree with the statement

VSD = Very strongly disagree with the statement

Example Statement	VSA	SA	A	U	D	SD	VSD
There should be an occupational hepatitis B vaccination policy				✓			

The tick indicates an undecided response to the statement.

16. YOUR VIEWS ABOUT TRAINING

I feel it is necessary for me to have further training in the following areas:

TYPE OF COURSE/TRAINING	VSA	SA	A	U	D	SD	VSD
HIV/AIDS /Awareness							
Hepatitis B /Awareness							
Hepatitis C /Awareness							
HIV/AIDS Counselling							
Hepatitis B Counselling							
Hepatitis C Counselling							

17. YOUR VIEWS ABOUT PRISONER EDUCATION

	VSA	SA	A	U	D	SD	VSD
HIV and hepatitis B and C training/awareness should be available for all prisoners on induction							
HIV and hepatitis B and C training/awareness for prisoners should be updated periodically							
Discipline staff should provide HIV and hepatitis B and C training/awareness for prisoners							
Health care staff should provide HIV and hepatitis B and C training/awareness for prisoners							
Discipline staff and health care staff should jointly provide the HIV and hepatitis training/awareness for prisoners							
Outside agencies should provide HIV and hepatitis B and C training/awareness for prisoners							

VSA = Very strongly agree with the statement
 SA = Strongly agree with the statement
 A = Agree with the statement
 U = Undecided about the statement
 D = Disagree with the statement
 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

18. YOUR VIEWS ABOUT RISK

	VSA	SA	A	U	D	SD	VSD
There are proportionally more cases of HIV in a prison in one year than in the community							
There are proportionally more cases of hepatitis B in a prison in one year than in the community							
There are proportionally more cases of hepatitis C in a prison in one year than in the community							
I feel my job puts me at a high risk of contracting HIV compared to other non-medical jobs							
I feel my job puts me at a high risk of contracting hepatitis B compared to other non-medical jobs							
I feel my job puts me at a high risk of contracting hepatitis C compared to other non-medical jobs							
There should be an occupational hepatitis B vaccination policy for prison staff							
There should be a hepatitis B vaccination policy for prisoners							
A prisoner is more likely to contract HIV in prison than in the community							
A prisoner is more likely to contract hepatitis B in prison than he would be in the community							
A prisoner is more likely to contract hepatitis C in prison than in the community							
Gloves should always be worn for searching prisoners							
Gloves should always be worn for searching cells							
Gloves should always be worn when intervening or dealing with blood spillage, including fights							
Compulsory testing of prisoners for HIV and hepatitis on reception would not be helpful							
Intravenous drug users can protect themselves from HIV by washing out shared 'works' with water before using them							
Intravenous drug users can protect themselves from Hepatitis B by washing out shared 'works' with water before using them							
Intravenous drug users can protect themselves from Hepatitis C by washing out shared 'works' with water before using them							
Intravenous drug users can protect themselves from HIV by washing out shared 'works' with bleach before using them							
Intravenous drug users can protect themselves from hepatitis B by washing out shared 'works' with bleach before using them							
Intravenous drug users can protect themselves from hepatitis C by washing out shared 'works' with bleach before using them							

VSA = Very strongly agree with the statement
 SA = Strongly agree with the statement
 A = Agree with the statement
 U = Undecided about the statement
 D = Disagree with the statement
 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

19. YOUR VIEWS ABOUT CONDOM ACCESS IN PRISON

	VSA	SA	A	U	D	SD	VSD
It is a good policy to allow prisoners confidential access to condoms for use in prison							
It is unlikely that condom distribution in prisons will be introduced into future prison health care policy							
Distributing condoms to prisoners for use inside prison compromises security							
Providing condoms for use in prison would cause a conflict for the law and order role of prisons							
Providing condoms for prisoners for use in prisons would cause a conflict for the discipline and security role of prison officers							
Having condoms available in a prison would be like condoning homosexuality							
The majority of prison officers are in favour of a policy to allow prisoners confidential access to condoms in prison							
In general prison health care staff are in favour of a policy to allow prisoners confidential access to condoms in prison							
I am in favour of a policy that makes condoms available to prisoners for use within prisons							
If a condom policy were in place I would fully implement the policy							
The general public would be in favour of a policy of confidential access to condoms for prisoners within a prison							
The majority of prisoners would be in favour of a policy to allow prisoners confidential access to condoms in prison							
If a condom policy were operational inside a prison it should be managed by the prison health care staff							
If a condom policy were operational within a prison it should be managed by discipline staff							
If a condom policy were operational within a prison it should be managed jointly by discipline and health care staff							
If a condom policy were operational inside a prison it should be managed by outside agencies							
A condom policy is not necessary because same sex sexual activity is not a problem in this prison							
The provision of condoms in prison would reduce the transmission of HIV							
The provision of condoms in prison would reduce the transmission of hepatitis B							
The provision of condoms in prison would reduce the transmission of hepatitis C							

VSA = Very strongly agree with the statement
 SA = Strongly agree with the statement
 A = Agree with the statement
 U = Undecided about the statement
 D = Disagree with the statement
 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

20. YOUR VIEWS ABOUT A NEEDLE EXCHANGE POLICY

	VSA	SA	A	U	D	SD	VSD
It would be a good policy to allow needle exchange schemes in prison							
It is unlikely that needle exchange in prisons will be introduced into future prison health care policy							
Needle exchange schemes for use inside prison compromises security							
Needles from a needle exchange in a prison could be used as weapons							
A needle exchange in prison would cause a conflict for the law and order role of prisons							
A needle exchange in prison would cause a conflict for the discipline and security role of prison officers							
A needle exchange in a prison would be like condoning drug use							
A needle exchange scheme would increase intravenous drug use in prisons							
The majority of prison officers are in favour of a policy to allow needle exchanges in prison							
In general prison health care staff are in favour of a needle exchange in prison							
I am in favour of a needle exchange policy in prisons							
If a needle exchange policy were in place I would fully implement the policy							
The general public would be in favour of a needle exchange within a prison							
The majority of prisoners would be in favour of a needle exchange policy in prison							
If a needle exchange were operational inside a prison it should be managed by the prison health care staff							
If a needle exchange were operational within a prison it should be managed by discipline staff							
If a needle exchange were operational within a prison it should be managed jointly by discipline and health care staff							
If a needle exchange were operational inside a prison it should be managed by outside agencies							
A needle exchange is not necessary because intravenous drug use is not a problem in this prison							
The provision of a needle exchange in prison would reduce the transmission of HIV							
The provision of a needle exchange in prison would reduce the transmission of hepatitis B							
The provision of a needle exchange in prison would reduce the transmission of hepatitis C							

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 D = Disagree with the statement
 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

21. YOUR VIEWS ABOUT BLEACH PROVISION IN PRISON

	VSA	SA	A	U	D	SD	VSD
It is a good policy to allow prisoners bleach for cleaning intravenous drug equipment in prison							
It is a good policy to allow prisoners bleach for general purpose cleaning in prison							
It is unlikely that bleach provision will be introduced into future prison health care policy							
Distributing bleach to prisoners for cleaning 'works' compromises security							
Providing bleach for cleaning 'works' in prison would cause a conflict for the law and order role of prisons							
Providing bleach for cleaning 'works' in prisons would cause a conflict for the discipline and security role of prison officers							
Having bleach for cleaning 'works' available in a prison would be like condoning drug use							
The majority of prison officers are in favour of prisoner access to bleach for cleaning 'works'							
In general prison health care staff are in favour of a policy to allow prisoners access to bleach in prisons for cleaning 'works'							
I am in favour of a policy that makes bleach for cleaning 'works' available to prisoners							
If bleach were available for the purpose of cleaning 'works' I would fully implement the policy							
The general public would be in favour of a policy of making bleach available for prisoners to clean 'works'							
The majority of prisoners would be in favour of a policy to allow prisoners access to bleach for cleaning 'works'							
If a bleach policy were operational inside a prison it should be managed by the prison health care staff							
If a bleach policy were operational within a prison it should be managed by discipline staff							
If a bleach policy were operational inside a prison it should be managed jointly by discipline and health care staff							
If a bleach policy were operational inside a prison it should be managed by outside agencies							
A bleach policy is not necessary because intravenous drug use is not a problem in this prison							
The provision of bleach in prison would reduce the transmission of HIV							
The provision of bleach in prison would reduce the transmission of hepatitis B							
The provision of bleach in prison would reduce the transmission of hepatitis C							

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 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

22. YOUR VIEWS ON OPIATE DETOXIFICATION IN PRISONS

Note: Methadone will be used here to represent all drugs used in the treatment of opiate dependence

	VSA	SA	A	U	D	SD	VSD
It is a good policy to have methadone detoxification (withdrawal treatment) for prisoners in all prisons							
It is good policy to only have methadone detoxification for prisoners in Local prisons							
It is unlikely that methadone detoxification in prisons will be introduced into future prison health care policy							
Providing methadone detoxification for prisoners compromises security							
Providing methadone detoxification in prison would cause a conflict for the law and order role of prisons							
Providing methadone detoxification in prisons would cause a conflict for the discipline and security role of prison officers							
Having methadone detoxification available in a prison would be like condoning drug use							
The majority of prison officers are in favour of a methadone detoxification policy for prisoners							
In general prison health care staff are in favour of a methadone detoxification policy for prisoners							
I am in favour of a methadone detoxification policy for prisoners							
If a methadone detoxification were in place I would fully implement the policy							
The general public would be in favour of a methadone detoxification policy in a prison							
The majority of prisoners would be in favour of a methadone detoxification policy in prison							
If a methadone detoxification were operational inside a prison it should be managed by the prison health care staff							
If a methadone detoxification policy were operational within a prison it should be managed by discipline staff							
If a methadone detoxification policy were operational in a prison it should be managed jointly by discipline and health							
If a methadone detoxification policy were operational inside a prison it should be managed by outside agencies							
A methadone detoxification policy is not necessary because 'hard' drug use is not a problem in this prison							
The provision of methadone detoxification in prison would reduce the transmission of HIV							
The provision of methadone detoxification in prison would reduce the transmission of hepatitis B							
The provision of methadone detoxification in prison would reduce the transmission of hepatitis C							

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 U = Undecided about the statement
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 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

23. YOUR VIEWS ON METHADONE MAINTENANCE PRESCRIBING IN PRISONS

(Note: Oral methadone is prescribed on an **ongoing** basis to avoid the harms associated with injecting opiate drugs)

	VSA	SA	A	U	D	SD	VSD
It is a good policy to have methadone maintenance for prisoners in all prisons							
It is good policy to only have methadone maintenance for prisoners in Local prisons							
It is unlikely that methadone maintenance in prisons will be introduced into future prison health care policy							
Providing methadone maintenance for prisoners compromises security							
Providing methadone maintenance in prison would cause a conflict for the law and order role of prisons							
Providing methadone maintenance in prisons would cause a conflict for the discipline and security role of prison officers							
Having methadone maintenance available in a prison would be like condoning drug use							
The majority of prison officers are in favour of methadone maintenance policies for prisoners							
In general prison health care staff are in favour of a methadone maintenance policy for prisoners							
I am in favour of a methadone maintenance policy for prisoners							
If a methadone maintenance were in place I would fully implement the policy							
The general public would be in favour of a methadone maintenance policy in a prison							
The majority of prisoners would be in favour of a Methadone maintenance policy in prison							
If a methadone maintenance were operational inside a prison it should be managed by the prison health care staff							
If a methadone maintenance policy were operational within a prison it should be managed by discipline staff							
If a methadone maintenance policy were operational in a prison it should be managed jointly by discipline and health care staff							
If a methadone maintenance policy were operational inside a prison it should be managed by outside agencies							
A methadone maintenance policy is not necessary because 'hard' drug use is not a problem in this prison							
The provision of methadone maintenance in prison would reduce the transmission of HIV							
The provision of methadone maintenance in prison would reduce the transmission of hepatitis B							
The provision of methadone maintenance in prison would reduce the transmission of hepatitis C							

VSA = Very strongly agree with the statement
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 A = Agree with the statement
 U = Undecided about the statement
 D = Disagree with the statement
 SD = Strongly disagree with the statement
 VSD = Very strongly disagree with the statement

24. YOUR VIEWS ON MANADATORY DRUG TESTING

	VSA	SA	A	U	D	SD	VSD
MDT is a very good policy development							
MDT has changed the pattern of drug taking in prisons, increasing the amount of 'hard drugs' taken							
If MDT precipitates changes to the pattern of drug use in prisons then the policy should be reviewed							

25. POLICY DEVELOPMENT

	VSA	SA	A	U	D	SD	VSD
I feel I have little control over the way policy is developed							
The general public view of policy in prisons influences policy development							
Prison policy can sometimes be made because of political will rather than for the good of prisons							
I feel that the prevention of HIV and hepatitis B and C is an important issue							
I feel that HIV and hepatitis prevention is a priority area for policy development							
Policy for the prevention of HIV and hepatitis B and C should be developed by the Health Care Directorate							
Policy for the prevention of HIV and hepatitis B and C should be developed by the governor							
Policy for the prevention of HIV and hepatitis B and C should be developed by the health care staff							
Policy for the prevention of HIV and hepatitis B and C should be developed by the AIDS management team							
It is appropriate that prison staff run therapeutic communities for drug reduction in prisons							
It is appropriate that outside agencies run therapeutic communities for drug reduction in prisons							
It is appropriate that prison staff to run drug-free wings/areas in prisons							
It is appropriate that outside agencies run drug-free wings/areas in prisons							

APPENDIX 3

HIV AND HEPATITIS B AND C PREVENTION IN PRISONS

PRISONER INTERVIEW SCHEDULE

Researcher will:

- ❖ Explain the purpose of the research
- ❖ Explain researcher not employed by the prison or prison service
- ❖ Explain how long the interview will last
- ❖ Explain confidentiality and anonymity
- ❖ Gain written and verbal consent for interview and tape recording

Probe questions:

1. How long have you been an inmate in this prison?
2. Have you been an inmate at any other prisons during current sentence?
3. Ask age?
4. Have you known anyone in prison with HIV or hepatitis B or C?
5. Have you known anyone outside prison with HIV or hepatitis B or C?
6. I will state briefly the transmission routes of HIV and hepatitis B and C - Sexual and blood exposure.
7. Are transmission routes more or less of a problem in prison environments?
8. Is there a lot of drug use in this prison?
9. Is there a lot of same sex sexual activity?
10. Ask how the following HIV and hepatitis B and C policies/potential policies would be/are received by prisoners in terms of:

- How received (or would be) received by prisoners
- impact of policy/potential policy on discipline and health care staff
- impact on security safety feasibility and acceptability
 - (a) Education and training about HIV and hepatitis B and C
 - (b) Confidential counselling
 - (c) HIV and hepatitis B and C testing
 - (d) Hepatitis B vaccination for prisoners
 - (e) Confidential access to condoms in prison
 - (f) Confidential access to condoms on release
 - (g) Mandatory drug testing
 - (h) Drug-free wings/areas
 - (i) Drug counsellors
 - (j) Methadone programmes - detoxification and maintenance
 - (k) Bleach distribution for decontamination of IDU equipment
 - (l) Needle exchange
 - (m) Genitourinary medicine clinics
 - (n) Tattooing

11. Is policy development necessary in any of these areas?

12. Good ideas for policy development

APPENDIX 4

CODE BOOK

TYPE	CODEWORD	PARENT	DEFINITION
Text	ACCEPTPOL	POLICY	Described as acceptable policy by interviewee
Text	BLEACH	DRUG USERS	Bleach for cleaning needles
Text	CARE	CARE	Care received in prison or community
Text	CONDOMSINP SAMESEX		Condoms issues in prison
Text	CONFIDENT	CONFIDENT	Confidentiality
Text	CONFLICOFF	POLICY	Policy causing conflict for officials
Text	CONFLICTSTA	POLICY	Policy causing conflict for staff
Text	CONTROL	POLICY	I feel I have some control over policy
Text	CULINMATE	CULTURE	Cultural aspects affecting inmates including peer pressure
Text	CULSTAFF	CULTURE	Cultural aspects affecting staff
Text	DESCRITRAN	TRANSMISS	Descriptive accounts of transmission risk
Text	DETOX	DRUGUSERS	Detox
Text	DFREEWING	DRUGUSERS	Drug free wing/area
Text	DRUGCOUN	DRUG USERS	Drug counsellor/counselling
Text	DRUGUSERS	DRUGUSERS	Prevention measures for drug use

Text	DSUPPLY	DRUGUSERS	Drug supply and availability
Text	EXPERCOUN	TRAINING	Experience of HIV counselling
Text	GUM	GUM	Genito-urinary medicine
Text	HEPATITIS	HEPATITIS	Knowledge
Text	HEPIDTRAIN	HEPATITIS	Identified training requirement
Text	INTENTION	POLICY	Intention to be involved in policy
Text	KNOWPOL	POLICY	knowledge of policy
Text	LOCALPOL	POLICY	Local policy, specific to a particular prison
Text	MAINTENAN	DRUGUSERS	Maintence treatment
Text	MDT	MDT	Mandatory drug testing
Text	NEEDLEEXCH	DRUGUSERS	Needle exchange in prisons
Text	NORMATIVE	POLICY	What significant others feel about policy
Text	OCCHEALTH	OCCHEALTH	Occupational health issues
Text	OUTVIEW	POLCIY	Outside view of policy, ie public, researcher
Text	POTENTPOL	POLICY	Areas for potential policy development
Text	PRIORPOL	POLICY	The priority given to HIV and hepatitis prevention
Text	PUBHEALTH	PUBHEALTH	Knowledge of wider public health issues
Text	RAPE	SAMESEXINT	Same sex rape

Text	SAMESEXINT	SAMESEXINT	Same sex intercourse
Text	STAFFBC	BECHANGE	Staff behaviour change
Text	TATOOING	TATOOING	Tatooing in prison
Text	TESTHIV	HIV	Issues related to testing
Text	THERAPEUT	DRUGUSERS	Therapeutic wing/prison/area
Text	TRAININMAT	TRAINING	Inmate education/training
Text	TRAINSTAFF	TRAINING	Staff education/training
Text	HEPTRAN	HEPATITIS	Transmission routes of hepatitis
Text	HIVCOUNSEL	TRAINING	HIV counsellor
Text	HIVTRAN	HIV	HIV transmission routes
Text	HIVTUTOR	TRAINING	HIV tutor
Text	INMATESBC	BECHANGE	Behaviour change in inmates
Text	TRANSMISS	TRANSMISS	Issues concerning transmission particular to a prison, fears about transmission

APPENDIX 5

HEALTH RESEARCH ETHICS COMMITTEE FOR THE PRISON SERVICE

*Room 802, Cleland House, Page Street, London SW1P 4LN
Tel: 0171-217-6145 & Fax: 0171-217-6800*

Shirley Large
19 Ringstead Crescent
Preston
Weymouth
Dorset
DT3 6PT

19th May 1998

Dear Ms Large

RP95015

HIV INFECTION AND HEPATITIS B & C PREVENTION IN PRISONS.

I apologize for the delay in writing to you, but I am now pleased to inform you that the Chair of the Ethics Committee for the Prison Service has given his approval to the above research proposal, subject to the following points being addressed.

1. The reward referred to is not to be extended beyond staff.
2. The consent form should include the following aspects:
 - a) make clear that inmates can withdraw at any time
 - b) explains the purpose of the research
 - c) if the tape is wiped clear the transcription will be retained and nothing destroyed! The consent form needs to make clear that the transcription will be kept (if that is what you propose).

The Chair is content to approve this research with the above a), b) and c) additions to the consent form.

Please be aware that this is ethical approval only, and you will need to gain the approval of governors of all establishments involved in the study. You may use this letter as official confirmation to governors that you have obtained the required ethical approval.

If at any time, you have any amendments to the above project, please inform the Ethics Committee immediately by writing to the Secretary and quoting the above reference number.

Please note that this ethical approval will expire 1 year from the date of this letter, if the study has not been started by that date.

Yours sincerely

Diana Goodger

APPENDIX 6

Shirley Large
University of Southampton
Department of Psychology
Highfield
Southampton
SO17 1BJ

HIV AND HEPATITIS B AND C PREVENTION IN PRISONS

CONSENT FORM FOR PRISONERS

This interview forms part of a research study to look at HIV and hepatitis B and C prevention in prisons. The interview will be recorded on tape, the tape will be wiped clean after it has been transcribed and the transcripts will be stored securely and only used for research purposes. Your name and consent form will be kept separate from the transcripts or any written data. I would like to stress that nobody will hear your individual views. The report will only contain summaries of views expressed by a number of prisoners in different prisons. You can withdraw from the interview at any time. If there is something you prefer not to answer then please do not feel under any obligation to do so.

THANK YOU FOR YOUR HELP

Researcher will assign ID number

ID

Please tick appropriate box and sign:

- I agree to take part in the study
- I do not wish to take part in the study

Signed:

APPENDIX 7

Coded Version of: P92

Page 1

#-TRANSMISS	#-DESCRITRAN	
problem, is there any reason why in prison they should be more of a problem than in the community or is it?		72 -#
		73
		74
		75
PRL92: Yeah, yeah because when people are round medication and gaols they, some people who are on insulin get needles off the doctor, they're supposed to keep them in their cells but they don't they give them out, see what I mean you can get up to ten people sharing a needle.		77
		78
		79
		80
		81
		82
		83
		84
I: Right.		86
PRL92: Do you know what I mean and there's a big risk of getting it.		88
		89
I: Right.		91
PRL92: That's evident in myself personally. I'm no angel do you know what I mean.		93
		94
		95
I: Do you think, umm, I mean go back to talk about intravenous drug use but do		97
		98
#-SAMESEXINT		
you think sexual transmission is an issue in prison?		99
		100
PRL92: I don't know. It might be like you know on other wings but where the sex offenders are but not on the other wings it's not.		102
		103
		104
		105

APPENDIX 8

HEALTH SAFETY
LABORATORY
Fire Safety Section

HM Prison Service
Cleland House
Page Street
London
SW1P 4LN

26 July 1996

Our Ref: C04.010.96

Dear Mr

Re - Fire tests on dichloroisocyanurate based sterilising tablets

Thank you for your letter dated 12 July 1996. I agree with the comments from Professor Brian Robinson's report.

We carried out tests using about 50 of both types of tablet. In both cases, observed concentrations of chlorine were less than the detection limit of 0.2 ppm.

For both types of tablets the gases issuing from the foil containers do contain significant quantities of chlorine. We measured concentrations much greater than 30 ppm from 1 tablet decomposing into 1000cm³ flask. However, this chlorine is reacting more rapidly with the atmospheric moisture than the characteristic time for mixing in a cell. It therefore makes little sense to attempt to calculate the notional average concentration in a cell after mixing. If one was to breathe in the plume of dense, white fumes that issue from the decomposing tablets

close to the source, one would be exposed to a toxicologically significant concentration of chlorine. It is likely however, that even in this case, the effects from HCl would be greater. By the time the fumes have accumulated to a significant extent in the cell the concentration of chlorine will be negligible.

With reference to other potential chemical species we do not have any particular recommendations. This statement was included because observation of the fumes clearly indicates that the atmosphere is likely to be particularly unpleasant. Analysis of all the products of the decomposition process would not be a trivial task and it is not clear whether it would yield any additional useful data. The apparent discrepancy between the individual masses of the components and the total mass of tablet 'W' is noted. Our calculations and results used the correct mass of 1.09g however, for the sake of simplicity the approximate weight of Ig was quoted the covering letter.

I hope that this clears up some of the confusion but please contact me if you require further information.

Yours Sincerely

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