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Illicit Drug Use Among Inmates in Ghana Prisons: A Case Study of Ghana Prisons Service

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Abstract

Illicit drug use is a considerable problem in prisons worldwide. The vulnerability of the prisons to illicit drugs and crime remains a grave concern. The flow of drugs into prisons bring with it other forms of crime and undermines security, health and control of an already overcrowded and fragile environment. Illicit drug use among prisoners in Ghana is very high and detrimental to their health and personal development. The study was undertaken to examine why, where and how prisoners in Ghana have access to drugs and the consequences on them, prisons staff and the Ghanaian society. Both primary and secondary data were collected from the prisons concerned and a total sample size of 200 prisoners and prison staff were randomly selected for interview. The primary objective the study was to examine why, where and how prisoners have access to illicit drugs and its consequences to them, prison staff and the Ghanaian society as a whole and also to know what policies and measures are in place to curb the challenge and how successful have the measures been. The main findings are that the majority of the drug users in prisons in Ghana are the youthful and those at the productive age; they are from low-income backgrounds, usually unemployed; and have previously been incarcerated for drug related offences. The data also show that the prisoners have access to drugs through visitors, family, friends and prison staff; usually concealed in food, clothing and bedding. Prisoners are motivated to use the drugs because of boredom; as a way of coping with stress; depression; harsh prison conditions lack of meaningful activities at the prisons, addiction to drugs, peer pressure and overcrowding, among others. Some recommendations made were that, the Ghana Prisons Service should develop cost- effective, standardized and sustainable drug use polices and also put effective measures in place for identification, screening and treatment of illicit drug disorders. Regular medical screening should be done for all staff to avoid transmission of infectious diseases to their families, friends and the general society and also, prisoners who are due for release should be medically examined to prevent the transfer of prison health problems into the community. Provisions should be made to install high efficiency scanners in all entry points of the prisons and the Ghana Prisons Service, the Narcotic Control Board, the AIDS Commission and the Ministry of Health should build an effective collaboration to enhance efficiency in curbing the drug-use menace in Ghana prisons.

Keywords: Illicit Drug Use, Substance Abuse, Chronic Medical Conditions, Drug Addiction

1.0 INTRODUCTION

Drug use in prison poses significant challenges given that imprisonment increases the likelihood of exposure to high-risk populations and situations. It is estimated that more than 10.2 million individuals, including sentenced and pre-trial detainees are being held in penal institutions worldwide (Prison Brief of International Center for Prison Studies Report, 2015) of which a significant number is on drug-related offences. The determination of various states to wage "war on drugs" has resulted in an increased prosecution of drug-related offences in many countries with lengthy sentences for the offenders. A 2013 United Nations Office On Drug and Crime (UNODC) study suggests that offences related to drug possession and use currently comprise more than eight out of ten of total global drug-related offences. Various studies estimate that the percentage of individuals reporting problematic substance misuse is comparatively higher in prisons than in the community. Different studies have indicated that the percentage of people in prison who have a drug problem ranges from 40% to 80% (Dolan et al, 2008).

In Ghana, the number of individuals incarcerated for drug related offences has increased from 7.15% of total prisoner population in 2011 to 11.10% in 2015 (Ghana Prisons Service Criminal Records Office, 2015). There are very few studies on substance use among prisoners in Africa as compared to their Western counterparts. This is despite literature repeatedly showing criminal activity and social disorder as a major outcome of substance use. One of the very few studies on this subject in Africa found that the

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lifetime drug use among prisoners in Uganda was 67% and that the most commonly abused drugs were tobacco (90%), marijuana (49%), khat/mairungi i.e. Catha edulis (17%) and alcohol (2%) (Uganda Prison Drug and Crime Report, 2009). Illicit drug use is growing in Ghana. Cannabis is the most abused illicit drug, but the use of hard drugs is on the rise. According to the Narcotic Control Board (NACOB), it is difficult to track abuse because there has never been any baseline study of drug environment in Ghana.

Data from the Ghana Police Service (Crime Statistics Office, Headquarters) indicate that cases involving cannabis are much more common than those involving cocaine and heroin. Drug abuse represents a great problem for societies in general, as it is a direct or indirect cause of a great number of crimes committed (SSB, Halgesen et al., 2006). There is increasing evidence for the association between substance use and criminality, including high prevalence of substance use disorders in prison population. Interventions and services for drug users in prisons are an essential component of public health care system as prisoners are part of our community. Drug treatment services in prisons, also increase such awareness., The provision of such services may encourage prison staff to examine their own use of drugs, alcohol and tobacco as well as act as peer educators among other staff, their families and wider community (UNOCD/UNAIDS/WHO, 2006).

2.0 LITERATURE REVIEW

2.1 International Conventions on Control of Illicit Drug Use and Trafficking

The many facets of drug control and the variety of other policy areas with which it comes into contact at the national level are reflected by the attribution of responsibilities to a correspondingly broad spectrum of agencies, organizations and institutions internationally. Indeed, drug control legislation may be unique in that it originated at the international level - from a confluence of world power concerns at a given historical moment - and was subsequently promulgated nationally, rather than the converse. The history of international drug control and the development of the international drug control system - including before the creation of the United Nations in 1945 - is interesting and has been explored in detail in UNODC's 2008 report.

The operation of the international drug control system is based on the principles of national control as well as international cooperation between States and with the UN bodies in compliance with the provisions of three legally binding international treaties. States not party to a particular treaty are encouraged to apply treaty provisions voluntarily. The major international drug control treaties currently in force are listed below. The World Health Organization (WHO), through its Expert Committee on Drug Dependence, is designated by the 1961 and 1971 Conventions to make recommendations as to whether a new substance should be brought under international control and to what degree of control it should be subjected. Similar responsibilities have been given to the International Narcotic Control Board (INCB) with respect to chemicals to be considered for inclusion in the scope of the 1988 Convention. The Commission on Narcotic Drugs considers factors such as extent of known abuse and trafficking and then decides whether or not to include the substance in one of the schedules of the appropriate convention.

2.2 The 1961 Single Convention on Narcotic Drugs

Member States had three principal objectives in mind when drafting the 1961 Convention: the merging of all existing multilateral treaties in the field; the streamlining of control machinery (the functions of two existing bodies, the Drug Supervisory Body and the Permanent Central Board, were merged into the International Narcotics Control Board); and the extension of the existing control system to include cultivation of plants grown as the raw material of narcotic drugs. The overall aims of control measures remained, namely the provision of adequate supplies of narcotic drugs for medical and scientific purposes and of measures to prevent diversion into the illicit market. The 1961 Convention exercises control over more than 116 narcotic drugs. They include mainly plant-based products such as opium and its derivatives morphine, codeine and heroin, but also synthetic narcotics such as methadone and pethidine, as well as cannabis, coca and cocaine. The Convention divides drugs into four groups, or schedules, in order to enforce a greater or lesser degree of control for the various substances and compounds. Opium smoking and eating, coca leaf chewing, cannabis resin smoking and the non-medical use of cannabis are prohibited. The 1972 Protocol to this Convention calls for increased efforts to prevent

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illicit production of, traffic in and use of narcotics. It also highlights the need to provide treatment and rehabilitation services to drug abusers.

2.3 The 1971 Convention on Psychotropic Substances

Growing concern over the harmful effects of psychotropic substances such as amphetamine-type drugs, sedative-hypnotic agents and hallucinogens led to the elaboration of the Convention on Psychotropic Substances. This extended the international drug control system to include hallucinogens such as LSD (lysergic acid diethylamide) and mescaline; stimulants such as amphetamine and methamphetamine, and sedative hypnotics such as barbiturates. The Convention categorizes the substances into four schedules according to their dependence creating properties and abuse potential balanced against their varying therapeutic values. Special provisions concerning abuse prevention are aimed at ensuring early identification, treatment, education, after-care rehabilitation and social reintegration of dependent persons. The Commission on Narcotic Drugs and the International Narcotics Control Board were also given particular responsibilities in the control of drugs covered by this Convention.

2.4 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988

The 1988 Convention complements the other drug control treaties, both of which were primarily directed at the control of licit activities. It was formulated specifically to deal with the growing problem of international trafficking which had only been dealt with marginally by earlier international legal instruments. The Convention includes money-laundering and illicit traffic in precursor and essential chemicals within the ambit of drug trafficking activities and calls on parties to introduce these as criminal offences in their national legislation. Its objective is to create and consolidate international cooperation between law enforcement bodies such as customs, police and judicial authorities and to provide them with the legal guidelines a) to interdict illicit trafficking effectively, b) to arrest and try drug traffickers, and c) to deprive them of their ill-gotten gains. It also intensifies efforts against the illicit production and manufacture of narcotic and psychotropic drugs by calling for strict monitoring of the chemicals often used in illicit production.

2.5 Regional and National Legislations and Policies on Illicit Drug Use

2.5.1 ECOWAS Action Plan and the Political Declaration:

In 2008 ECOWAS produced a Political Declaration and Regional Action Plan to address the Growing Problem of Illicit Drug Trafficking, Organized Crime and Drug Use/Abuse.

In 2013, the Action Plan was formally extended, and the priority was placed on the conduct of an extensive review of the existing member States' legislation with a view to achieving a common minimum standard to ensure sufficient deterrent against illicit trafficking and enhance the use demand reduction strategies to address the problem associated with illicit drug use in line with relevant regional and international conventions (UNODC, 2013)

2.5.2 The Dakar Initiative:

It is a sub-regional initiative signed by seven countries in February, 2010, which was intended to support the implementation of the ECOWAS Action Plan and the Political Declaration

2.5.3 The West African Network of Central Authorities and Prosecutors (WACAP)

It is a UNODC backed initiative aimed at improving cooperation in the criminal matters in the West African region and serving as a basis for capacity building the enforcement of illicit drug use and trafficking policies. The objective of this legislation is to fight drug trafficking and drug use in a coordinated and more efficient manner.

2.6 National Legislations

In Ghana, The Provisional National Defense Council (PNDC) Law 236 established the Narcotic Control Board (NACOB) in section 55 (under the Ministry of Interior) and the Narcotic Drugs Control and Enforcement Law of 1990. The law reflects a reasonable degree of clarity and provision and it

demonstrates a strong penchant for criminalization, with onus generally placed on people who use drugs and low-level dealers. The Criminal Offences (Amended) Act of 2012 (Act 849) strengthened penalties for narcotic crimes, making offences punishable by life imprisonment as a maximum penalty. The latter offences include, import, export, possession, manufacturing, distribution and the cultivation of plants for narcotic use (including, sniffing, consumption, injection, supply).

Regarding jurisdiction of Ghana, the Narcotic Control Board (NACOB) is the key governmental agency responsible for dealing with narcotics (section 55 of PNDCL 236). The ordinary courts in Ghana exercise territorial jurisdiction in all cases relative to criminal offences, including the aforementioned drug offences. Ghana Cooperate with other countries on criminal offences is included in the Mutual Assistance Legal Act (section 5 (scope), 8 (content) and 17 (dual criminality). Specific mention of cooperation and mutual assistance, including transfer of witnesses with regards to drug offences is included in section 42 and 52 of the 1990 narcotic Drug law. Ghana also has the extradition agreement with United Kingdom, The United States, Egypt, Greece and Canada.

2.7 Drug Use Policy in Ghana

Drug use affects all parts of society and this causes strain on healthcare system, the criminal justice system and the economy. There is a significant academic debate about decriminalization of marijuana in the country, and this has received some degree of political and public support. Some have argued that decriminalization will open a floodgate for drug use in the country, while others do not agree and see it instead as the best way to reduce drug use in the country. In practice, repressive drug laws have neither succeeded in reducing drug consumption nor put traffickers out of their lucrative business. Instead, these laws have only driven and expanded the trade underground (UNODC, 2013).

2.8 The Current Drug Policy Regime in Ghana

The current drug law/policy in Ghana is very repressive in nature, that is, Drug Control and Enforcement Law of 1990 and the Criminal Offences (Amended) Act of 2012 (Act 849). It is a control approach that has failed to consider the health and wellbeing of those who use drugs. It makes no room for people who need lifesaving harm reduction programs such as needle and syringe distribution and opioid substitution treatments. What this kind of regime has done over the years is to marginalize the majority of our citizens. Studies have also shown that the criminalization of people who use drugs is often more detrimental to their health than the drug use itself and that this approach does not lower rates of drug use (UNODC, 2013).

Moreover, some reports show that the criminal justice response contributes to a climate of stigmatization of, and discrimination against, people who use drugs, which makes it less likely that they will receive impartial treatment from police and the judicial system (International Narcotic Control Board Report, 2015). Addressing consumption through criminal justice institutions ultimately infringes on various fundamental rights of people who use drugs, including the rights to health, information, personal autonomy and self-determination. Ghana's current drug law also lacks proportionality in the sentencing of drug offenses. For instance, possession and trafficking both attract a minimum of 10 years in prison. You can see clearly that there is no distinction in the severity of the offenses. Many countries around the world have already taken steps to amend and update their drug laws - more in line with the 'Support Don't Punish' approach that civil society is advocating for (International Narcotic Control Board Report, 2015).

3.0 RESEARCH THEORY

3.1 Theoretical Framework

Theoretical frameworks are theories formulated to explain, predict and understand phenomena and, in many cases, to challenge and extend the existing knowledge within the limits of critical bounding assumptions (http://ligguides.usc.edu) .The theoretical framework is the structure that can hold or support a theory of a research. This study is guided by the following theories, namely, the social cognitive theory by Albert Bandura (1986), Cap control theory and the interactive models of non-medical drug theory.

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3.2 The Social Cognitive Theory

The social cognitive theory is a learning theory based on the idea that people learn by observing others. These learned behaviours can be central to one's personality. While social psychologists agree that the environment one grows up in contributes to behaviour, the individual person (and therefore cognitive) is just as important. The core concepts of this theory can be explained by Bandura's schematization of triadic reciprocal causation. The schema shows how the influence by interaction of the following three determinants:

Personal: Whether the individual has high or low self-efficacy towards the behaviour (i.e. get the learner to believe in his or her personal abilities to correctly complete behaviour).

Behaviour: The response an individual receives after they perform behaviour (i.e. Provide chances for the learner to experience successful learning as a result of performing the behaviour correctly)

Environmental: The aspect of the environment or setting that influences the individual's ability to successfully complete a behaviour (i.e. make environmental conditions conducive for improved self-efficacy by providing appropriate support and materials).

The implication of this theory is that, individual's behaviour is determined by the person's thought processes, the environment and behaviour itself, where in this case, were the prisoners within the prison community. This means that individuals determine their own behaviour while being influenced by the environmental factors and their own behaviours. For example, the prisoners believe that consuming illicit drugs like tobacco and alcohol will help them to cope with the challenging conditions in the prisons.

3.3 The CAP Control Theory of Drug Abuse

The cognitive-affective-pharmacogenic (CAP) control theory emphasizes the interaction of the individual's lifestyle and affective experience of drug use with the drug pharmacogenic effect. These are the basic ingredients of the cognitive-affective-pharmacogenic (CAP) control theory of addiction (Coghian et al. 1973; Gold and Coghian 1976). The cognitive style of the drug user/abuser is viewed as the pivotal factor in the individual's moving from drug experimentation to drug abuse. There is a current trend in behaviour therapy emphasizing cognitive approaches (Lazarus 1976, Mahoney, 1977, and meichenbaum, 1977). The major tenets of cognitive behaviour therapy are the human behaviour mediated by unobservable that intervene between a stimulus and response to the stimulus. Beliefs, sets, strategies, attributions, and expectancies are examples of the types of mediating constructs currently considered crucial to an understanding of emotions and behaviours.

Second, the way an individual labels or evaluates a situation determines his or her emotional and behavioral response to it. A third basic assumption is that thoughts, feelings and behaviours are causally interactive (Mahoney, 1977). To link to the cognitive approach to the illicit drug users/abusers, the CAP theory posits that the abuse process begins with the conflict as a predisposing factor. People who are having difficulty in meeting demands or expectations (in this case, the prison inmates) placed upon them by society or themselves are in conflict and a consequence of the stress of conflict is anxiety. It is not the experience of the anxiety that is crucial to the theory, but the individual's interpretation of the anxiety that is crucial to the theory. Underlying the anxiety of illicit drug user (e.g. Prisoners) is the believe that they cannot alter or control the situation; that they are powerless to affect the environment and decease or eliminate the sources of stress. They believe that, they are powerless to cope with the stress is the major cognitive distortion of illicit drug users/abusers. One consequence of this is the feeling of low self-esteem that is well known clinical entity among illicit drug users/abusers (Krystal and Raskin, 1970). Feeling of low self-depreciation, which is a form of belief that one is powerless, represents the affective component of the CAP theory.

The experience of anxiety is of course uncomfortable and means of anxiety reduction is necessary. Drug users therefore found primary pharmacogenic effect of drugs in anxiety reduction as necessary. Not only that drug provides relieve from anxiety, but the individual temporary experiences an increased sense of power, control and wellbeing. The sense of powerlessness is replaced by an exaggerated sense of being all powerful such that no task is seen as too great and no feat impossible while "high". Thus, drug can do for drug users what they believe they cannot do by themselves, e.g. to get rid of anxiety, obtain good feeling about them, as well as make them believe that they are competent, in control and able to master their environment. It is, however, important to note that, the drug effect is short lived and any

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temporary gain is turned into long-term losses. Inevitably, after the high wear off, some internal and external sources of stress rekindle the conflict and anxiety. In this way, not only do the old feelings of lack of control return but they are likely to be even stronger that before. It is this increasing sense of powerlessness with increased drug use that leads to abuse. Each time a drug user rely on a drug to relieve tension and feel good about them; they become little less capable of coping on their own. By using drugs to cope, the individual is cut off from learning more other adaptive coping mechanisms and becomes less tolerant of the pain of anxiety.

The drug user now knows that anxiety does not have to be tolerated as drug taking has been successful in the past removing tension and providing good feeling. Furthermore, the reliance on drugs to cope with stress therefore creates a vicious cycle. The more drugs are used, the more the individual believe they are necessary. Each drug experience therefore serves to confirm for drug users the belief that they are powerless to function on their own.

3.4 The Interactive Models of Non-Medical Drug Use

Gorsuch and Butler (1976a, b) came up with a multiple-model theory of non-medical drug use in an attempt to provide relatively concrete and detailed description of factors leading to specific types of nonmedical drug use. The primary focus of the models is an illicit "hard" drug abuse; such as abuse of heroin and cocaine. The models, however, are not restricted solely to "hard" drugs above but probably apply to several types of substance. The theory is psychological, focusing upon the individual, with drug behaviour as a dependent variable. Groups are important only in so far as they influence the behaviour of the members of the group. The psychological focus identifies as a major causative factor those which operate directly within the person's life space. Individuals are directly influenced only by internal processes or by that which happens in their immediate environment. Internal processes include psychological processes, the residuals of past experiences, including beliefs, opinions, expectations, attitudes, and values; and the psychological processes.

The psychological perspective defines other environmental influences as indirect factors which produce or influence the objects and events in an individual's life space. For example, a law which increases the availability of a particular drug would be an indirect influence, producing the direct influence; the presence of the drug in the person's environment.

3.5 Criticisms of the Theories

In the view of the research, these three theories have their limitations. For instance, one of the main criticisms of social-cognitive theory is that it is so broad and lack one unifying principle or structure. This means that, the different aspects of the theory may not be connected. For example, researchers cannot find a connection between observational learning and self-efficacy within the social-cognitive perspective. Currently, the theory is so broad that not all of its component parts are fully understood and integrated into a single explanation of learning and personality. The findings associated with this theory are still, for the most parts, preliminary. It does not provide a full explanation or description of how social cognitive; behaviour, environment and personality are related; though there are several hypotheses.

Another limitation is that not all social learning can be directly observed. As a result, it can be difficult to quantify the effect of social cognitive of development. Similarly, many aspects of personality are subjective and can be equally hard to measure and quantify. Another limitation of the social cognitive theory is, the theory largely ignores the influence of hormones on one's behaviour. Hormones can affect one's decision-making abilities and therefore change one's behaviour. Additionally, social-cognitive theory ignores genetic differences that could lead to disparities between people's cognitive abilities and behaviour.

The social cognitive theory also neglects maturation and lifespan behaviour changes. Advocates of the social cognitive theory assume behaviour is primary learned through observation, expectation and reinforcement. However, it ignores that as people move through life, their behaviour patterns can change drastically with little change in their environment.

Social-Cognitive theory also minimizes emotional responses. According to Albert Bandura, behaviour is largely learned. However, evolutionary psychologists such as Stephen Pinker have argued that some

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behaviour is the result of emotional responses determined largely by biological factors, which are controlled heavily by evolution and has little to do with conditioning or observation.

The final criticism of the social cognitive theory is largely related to the psychological problems. Under the paradigm provided by social cognitive theory, antisocial behaviour is a result of defects in the model of learned behaviour that an individual has received, and that they are therefore correctable via reinforcement and self-efficacy training. However, a great deal of pathological pathologies such as Schizophrenia, have more to do with neural defects or chemical imbalances in the brain. This suggest that while self-efficacy therapy can sometimes help people with psychological problems, individuals suffering from psychological disorders are not fully responsible for or in control of their aberrant behaviour. The CAP control theory of drug abuse and the interactive models of nonmedical drug use theories also have their limitations. While the two theories have unidimensional and mechanistic to begin to account for addictive behaviour, they do not correctly focus on the way in which drug user's experience of a drug's effects fits into the person's psychological and environmental ecology. In this way drugs are seen as a way to cope, however, dysfunction ally, with personal and social needs and the changing situational demands. Yet, these theories, while pointing in the right direction, failed because they do not directly explain the pharmacological role the substance plays in the abuse. They are often considered even by those who formulated them as adjuncts to biological models, as in the suggestion that the abuse uses a substance to gain specific effects until, inexorably and irrevocably, physiological processes take hold of the individual. At the same their purview is not ambitious enough (not nearly as ambitious as that of some biological and conditioning models) to incorporate nonnarcotic or nondrug involvements. They also missed the opportunity readily available at the social-psychological level of analysis, to integrate individual and cultural experiences.

Notwithstanding the above criticisms of the theories, the researcher believe the theories are relevant to the topic under study and will help in coming out with better understanding and analysis of the problem under study since all the three theories explained that, individual's behaviour is linked with external factors (the environment and the people around the individual). All these environmental factors are socioeconomic in nature.

4.0 LITERATURE REVIEW

This portion reviews literature on the definition and classifications of illicit drugs. The literature also relates to the various international, regional and national conventions and policies that regulates illicit drug use as well as the trends and nature of illicit drug use in the world, Africa and West Africa.

4.1 Definition and Classification of Drugs

Drug -This is a term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare. In pharmacology, it means any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In the context of international drug control, "drug" means any of the substances listed in Schedule I and II of the 1961 Single Convention on Narcotic Drugs, whether natural or synthetic.

Licit/illicit drugs -The United Nations drug control conventions do not recognize a distinction between licit and illicit drug, they describe only use to be licit or illicit. Here, the term illicit drugs is used to describe drugs which are under international control (and which may or may not have licit medical purposes) but which are produced, trafficked and/or consumed illicitly.

4.2 Classification of drugs

Drug types are described in various ways, depending on origin and effect. They can either be *naturally occurring, semi synthetic* (chemical manipulations of substances extracted from natural materials) or *synthetic* (created entirely by laboratory manipulation). The United Nations Conventions on Drugs classify narcotic drugs and psychotropic substances by virtue of their danger to health, risk of abuse and therapeutic values. The 1961 Convention classified narcotic drugs into four schedules. Cannabis and Heroin as well as 15 other substances are placed by 1961 convention in schedule 1, as a substance whose properties give rise to dependence and which present a serious risk of abuse and in schedule IV, among the most dangerous substance, by virtue of their associate risk of abuse, their particularly harmful

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characteristics and their extreme limited medical or therapeutic value (Cabalero et al, 2000). The five main categories of illicit drugs are - narcotics, stimulants, depressants (sedatives), hallucinogens, and cannabis. These categories include many drugs legally produced and prescribed by doctors as well as those illegally produced and sold outside of medical channels.

Cannabis (*Cannabis sativa*) is the common hemp plant, which provides hallucinogens with some sedative properties, and includes marijuana (pot, Acapulco gold, grass, reefer), tetrahydrocannabinol (THC, Marinol), hashish (hash), and hashish oil (hash oil). The common illicit forms are loose herbal material, blocks of compressed herbal material, corn-cob shaped herbal material wrapped in coarse vegetable fibre, and herbal material tied using twine around a central bamboo cane and herbal material in a small roll wrapped in paper

Certain common street names, Bongo, Buddha-sticks, Ganja, Grass Indian Hemp, Marijuana etc. (United Nations Conventions on Drugs, 1961). Coca (mostly *Erythroxylum coca*) is a bush with leaves that contain the stimulant used to make cocaine. Cocaine is a stimulant derived from the leaves of the coca bush. Cocaine is the main psychoactive alkaloid prepared from coca leaves. It can also be synthesized in a laboratory. It is generally encountered as the hydrochloride salt. Crack and cocaine freebase are cocaine base obtained from cocaine hydrochloride through specific conversion processes to make it suitable for smoking.

Short-term effects of the use of coca includes, loss of appetite, faster breathing, increased heart rate and blood pressure, increased body temperature, sweating, dilation of pupils, bizarre, erratic, sometimes violent behavior. With larger doses: hallucinations, talkativeness, sense of power and superiority, restlessness, hyper excitability, irritability which can lead to panic and paranoid psychosis (disappears if discontinued), Excessive doses may lead to convulsions, seizures, stroke, cerebral hemorrhage or heart failure. Long-term effects are, destruction of tissues in nose if sniffed, respiratory problems if smoke, infectious diseases, abscesses, if injected, malnutrition, and weight loss, disorientation, apathy, confused exhaustion due to lack of sleep, development of tolerance, and strong psychological dependence. With continued use a state similar to paranoid psychosis may develop and after stopping, there usually follows a long period of sleep and then depression; during the crash, death from respiratory failure may occur.

Depressants (sedatives) are drugs that reduce tension and anxiety and include chloral hydrate, barbiturates (Amytal, Nembutal, Seconal, and phenobarbital), benzodiazepines (Librium, Valium), methaqualone (Quaalude), glutethimide (Doriden), and others (Equanil, Placidyl, Valmid)(UNODC,2012).
The Short-term effects of depressants include, diminished emotional responses to external stimuli, e.g. pain, reduced inhibition, mental activity and alertness; drowsiness, lethargy and impairment of clarity of thought and impaired judgment may occur, but not as much as with barbiturates, initial increase of risk of accidental injury due to depressant effects, e.g. driving a car or performing other complex tasks. With larger doses, possible impairment of muscle coordination, dizziness, low blood pressure, and/or fainting. Long-term effects are, headache, nia and tremor as a result of chronic high dose use of irritability, confusion, memory impairment, depression, in some benzodiazepines.

Risks associated with injecting drugs, development of tolerance with frequently repeated doses: after approximately two weeks, benzodiazepines may become ineffective as sleeping pills, after a few months, they become ineffective against anxiety, development of psychological and physical dependence. Abrupt cessation after prolonged use leads to withdrawal syndrome which can include insomnia, anxiety, perceptual hypersensitivity, tremor, irritability, nausea and vomiting, and even mental confusion and life-threatening convulsions (after unusually high doses)

Hallucinogens are drugs that affect sensation, thinking, self-awareness, and emotion. Hallucinogens include LSD (acid, microdot, Blotter), mescaline and peyote (mexc, buttons, cactus), amphetamine variants (PMA, STP, DOB), phencyclidine (PCP, angel dust, hog), phencyclidine analogues (PCE, PCPy, TCP), and others (psilocybin), (UNODC, 2012).

Effects of Hallucinogens: The Short-term effects include, distorted perception of depth and time, size and shape of objects; movements of stationary objects; intensified colours, sound and touch; generally the user knows these effects to be unreal; true hallucinations are relatively rare, increased risk of injuries due to perceptual and emotional effects, especially when driving, or performing other complex tasks such as operating machinery, unpleasant reactions may include anxiety, depression, dizziness,

disorientation and paranoia. Physical effects are very slight compared with psychological or emotional effects; they may include dilated pupils, lowered body temperature, nausea and vomiting, profuse sweating, and rapid heart rate; occasionally convulsions occur. Long-term effects are, physical dangers attributable to long-term LSD use are not known. Rapid development of tolerance which disappears rapidly after cessation of use; no physical dependence, "Flashbacks" (i.e. short-lived, vivid re-experiences of part of a previous trip) can occur days or even months after taking the last dose, leading to disorientation, anxiety and distress. Occasionally prolonged anxiety and depression follow use of LSD

Heroin is a semisynthetic derivative of morphine. There four types: Crude morphine is sometimes called Heroin No. 1. Heroin base prior to its conversion to the hydrochloric salt: white to off-white, pale grey or dark brown, solid or powdered called Heroin No. 2. Smokable form of heroin, not as highly refined as Heroin No. 4: hard granular material from light brown to dark grey, sometimes red or pink coloured, containing 25-45% of heroin hydrochloride and other substances such as caffeine, etc. Injectable form of heroin: white powder with little odour and without adulterants, purity up to 98% heroin hydrochloride (UNODC, 2012). The short-term effects are, sometimes nausea and vomiting, constricted pupils, drowsiness, inability to concentrate, apathy, lessened physical activity, acute overdose can result in death due to respiratory depression, long-term effects include, rapid development of tolerance and physical and psychological dependence, constipation, menstrual irregularity, Infectious diseases, abscesses, if injected, damage of structures in nose, if sniffed/snorted, respiratory problems, if smoked, decreased appetite leading to malnutrition, weight loss, chronic sedation, apathy leading to self-neglect. Abrupt withdrawal results in moderate to severe withdrawal syndrome which is generally comparable to about of influenza (with cramps, diarrhoea, running nose, tremors, panic, and chills and sweating, etc.

Narcotics are drugs that relieve pain, often induce sleep, and refer to opium, opium derivatives, and synthetic substitutes. Natural narcotics include opium (paregoric, parepectolin), morphine (MS-Contin, Roxanol), codeine (Tylenol with codeine, Empirin with codeine, Robitussan AC), and thebaine. Semisynthetic narcotics include heroin (horse, smack), and hydromorphone (Dilaudid). Synthetic narcotics include meperidine or Pethidine (Demerol, Mepergan), methadone (Dolophine, Methadose), and others (Darvon, Lomotil), (UNODC, 2012).

Opium is the brown, gummy exudate of the incised, unripe seedpod of the opium poppy. "Opium" means the coagulated juice of the opium poppy. "Opium poppy" means the plant of the species *Papaver somniferum* L. (1961 Convention, art. 1, para. 1). *Papaver somniferum* L. is an annual plant growing in many countries around the world with moderate climate. It has white to red flowers and round to elongated capsules with dark violet seeds

Opium poppy (*Papaver somniferum*) is the source for the natural and semisynthetic narcotics. Poppy straw is the entire cut and dried opium poppy-plant material, other than the seeds. Opium is extracted from poppy straw in commercial operations that produce the drug for medical use. Stimulants are drugs that relieve mild depression, increase energy and activity, and include cocaine (coke, snow, crack), amphetamines (Desoxyn, Dexedrine), ephedrine, ecstasy (clarity, essence, doctor, Adam), phenmetrazine (Preludin), methylphenidate (Ritalin), and others (Cylert, Sanorex, Tenuate). The short-term effects include, loss of appetite, faster breathing, increased heart rate and blood pressure, increased body temperature, sweating, dilation of pupils, bizarre, erratic, sometimes violent behavior. With larger doses: hallucinations, talkativeness, sense of power and superiority, restlessness, hyper excitability, irritability which can lead to panic and paranoid psychosis (disappears if discontinued), excessive doses may lead to convulsions, seizures and death from respiratory failure, stroke, cerebral haemorrhage or heart failure. Long-term effects are destruction of tissues in nose if sniffed, respiratory problems if smoked, infectious diseases, abscesses, if injected, malnutrition, weight loss, disorientation, apathy, confused exhaustion due to lack of sleep, development of tolerance, strong psychological dependence. With continued use, a state similar to paranoid psychosis may develop. After stopping, there usually follows a long period of sleep and then depression.

5.0 RESULTS AND DISCUSSIONS

This chapter presents the results obtained from the data analyzed as well as the observations made from the field. It also discusses some interviews and interactions the author had with 200 selected inmates and officers on why, how and where prisoners get access to illicit drugs and its dire

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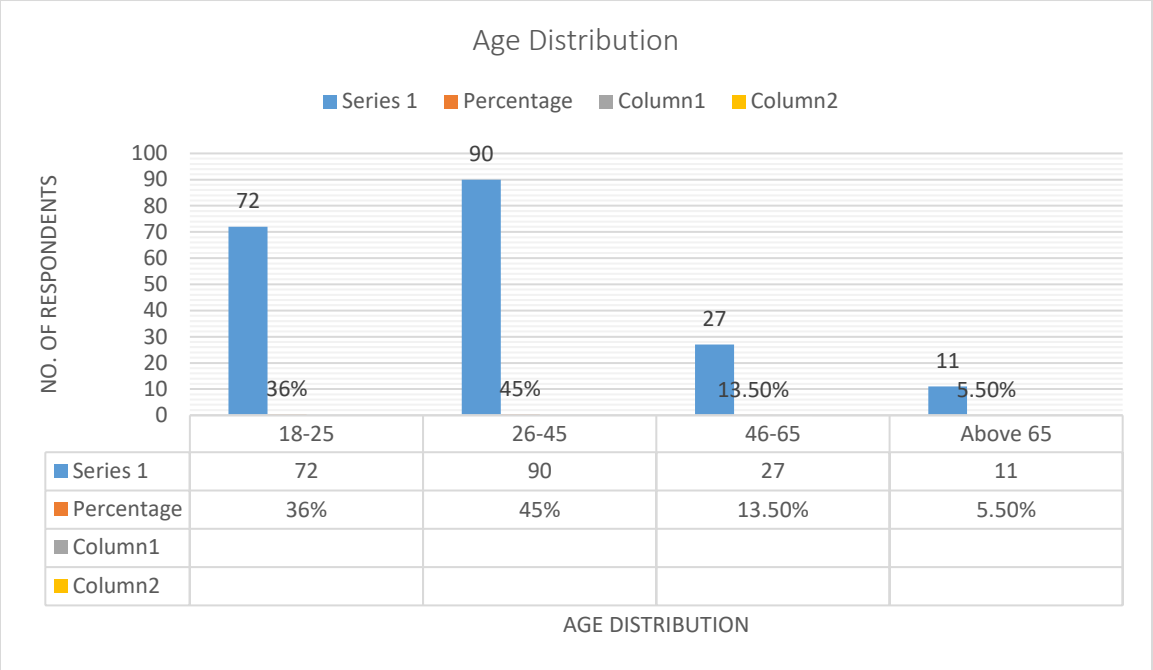
consequences on them, prison staff and the Ghanaian society, as well as some key measures that have been put in place to curb this menace and their (the measures') effectiveness or otherwise.

5.1 Socio- Demographic Characteristics of Prisoners

Demography is the study of statistics such as births, deaths, income, location etc., which illustrate the changing structure of human populations (Oxford Dictionary). Three demographic features which were relevant to this study and thus were captured are age, educational levels and employment status. According to Sickles and Tuabman (1991), age is of marginal significance when considering those who use illicit drugs. Caulkins et al (2005), however, believe that, age does not matter and new drug users are in their teens or young adult years. The results of the study indicate that in (36 %) of the respondents are in the age group of 18-25 years whiles (45%) of them are in the age group of 26-45 years. Collectively, these two age groupings form the youthful age which constitute 81 percent of the total sample. The results also indicate that 27(13.5%) interviewees out of the total sample and 11 (5.5%) are in the age groups of 46-65 years and above 65 years respectively.

Figure 3.1.1: Age Distribution of Respondents



The greatest concern to the research is the large numbers of active age groups (81%) in illicit drug use in the prisons. People in this age group (between 18 and 45 years) are supposed to be the productive period in one's life time. The researcher, based on the results of the study agreed with the study conducted by Bushmueller and Zuvekas (1998), which established that employment status (income levels) positively affects drug use for young workers, but income negatively affects heavy drug use and those with lower income use drugs more than those with higher income levels. The results as indicated in Appendix C and figure 3.1.2 show that (59%) of the interviewees were unemployed whiles (32.5%) and (8.5%) of interviewees were employed and self-employed respectively. However, looking at the cost of illicit drugs as stated in Table 3.6, one may ask how these prisoners with low levels of income managed to buy these drugs. An answer to this question in the course of the study revealed that, most of the low-income prisoners are usually supported by the wealthy and the leaders of the prisoners whom they serve.

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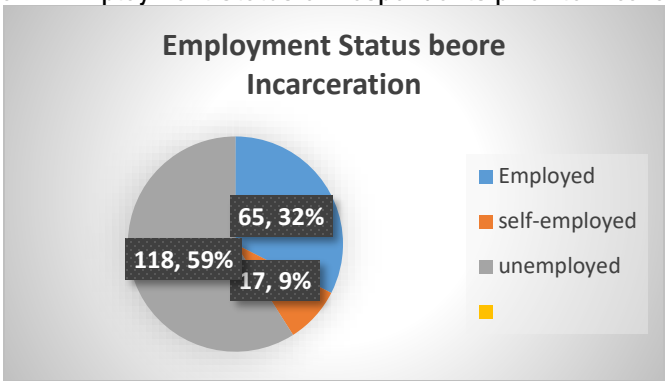
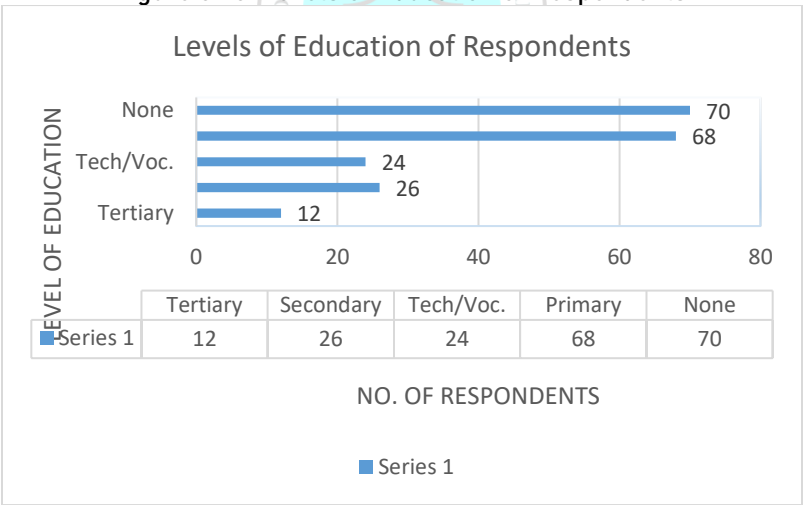
Figure 3.1.2: Employment Status of Respondents prior to Incarceration



The relationship between educational levels and drug use has attracted the attention of researchers. The social theorists believe that, dropping out of school is disengaging from the society and thus increase the rate of drug use (Krohn et al., 1995). The results of this study show that, the greater majority of the prisoners (67%) who use illicit drug have little or no educational background. That is, (35%) and (34%) have no education and primary education respectively (Appendix B and Figure 3.1.3). Also (6%), (13%) and (12%) of the respondents have tertiary, secondary and technical/vocational education respectively. According staff interviewed, the low level of education of the majority of problematic drug users affects the educational outreach the prisons authorities and some non-governmental organizations are embarking upon since most drug users cannot read to understand the dangers the use of illicit drugs pose to their life and therefore tend to believe what their fellow inmates tell them.

Figure 3.1.3: Levels of Education of Respondents



5.2 Criminal and Drug Use Records

The results in Figure 3.2.1 show that 77% out of the total sample size are recidivists and 23% have no previous prison records. Similarly, (56%) of those who have previous prison records were incarcerated on drug related offences while (44%) were incarcerated on non-drug related offences. Furthermore, interviewees, representing 51% were involved in illicit drug use during their previous incarceration whiles (49%) stayed away from illicit drugs (Figure 3.2.2). The results further indicate that, the number of prisoners who previously used drugs in prisons has increased from (51%) to (65%) whiles those who stayed away from drugs during the previous incarceration has reduced from (49%) to (35%). It can therefore be said that, more prisoners are getting involved in illicit drug use. One of the reasons given by interviewees on the increasing number of problematic drug users in prisons was that, the increasing

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overcrowding rates have made prison environment unsuitable and therefore one needs to take to these forms of illicit activities in order to cope with the harsher conditions in the prisons.

Figure 3.2.1 Criminal Records of Respondents

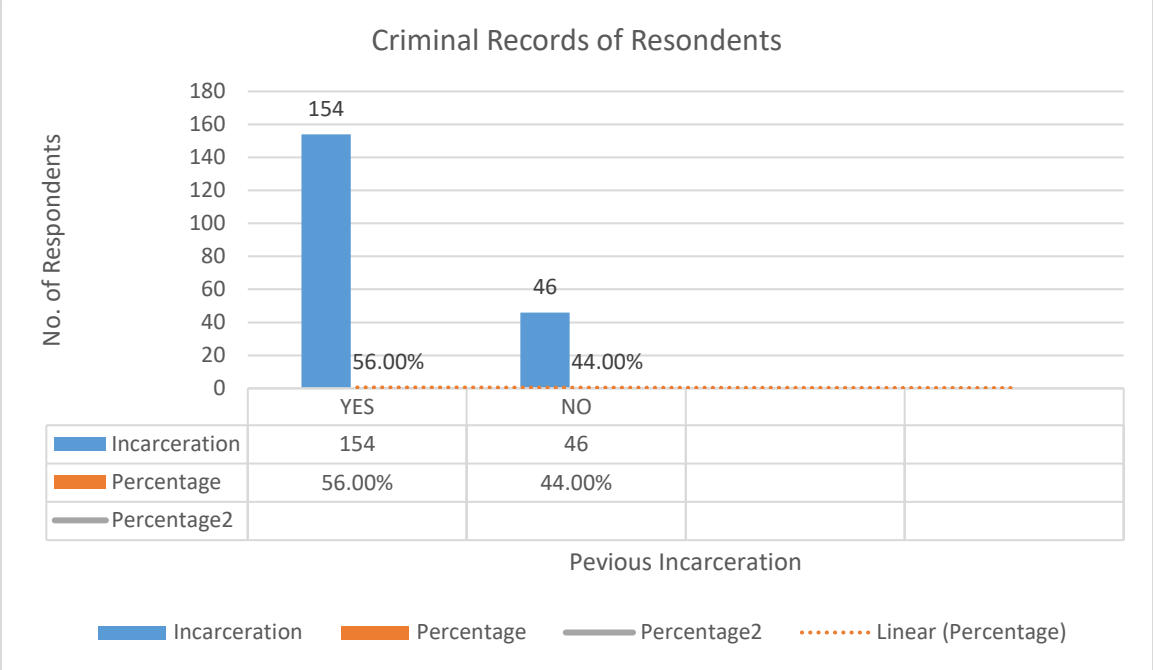
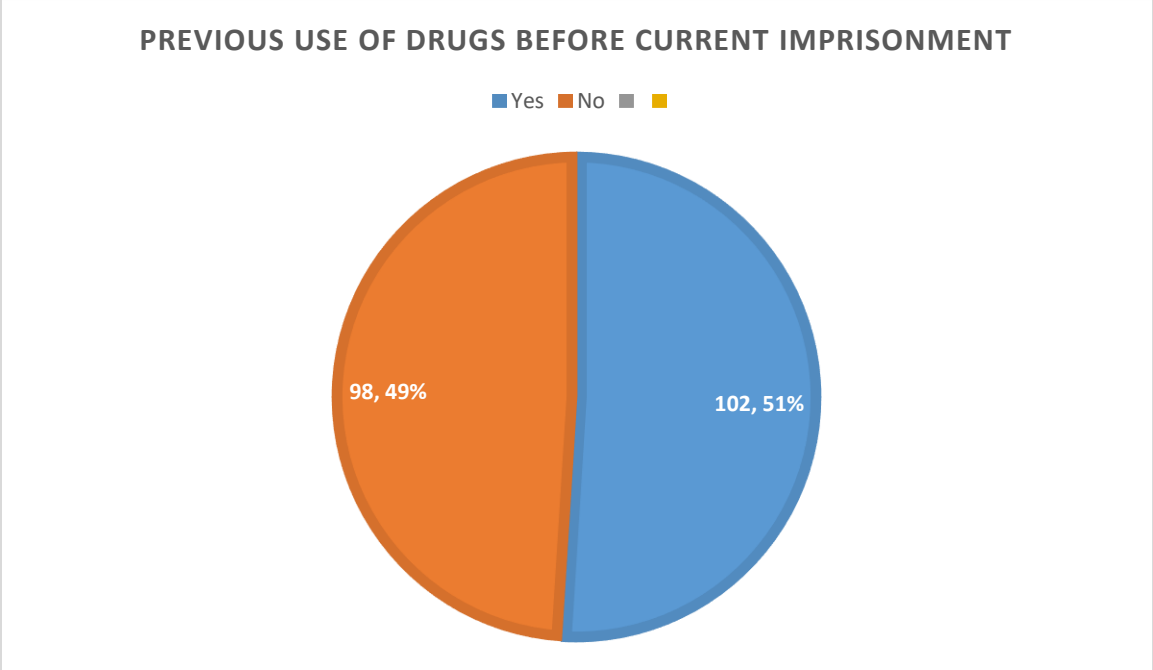


Figure 3.2.2 Previous Drug Use Records prior to Current Incarceration



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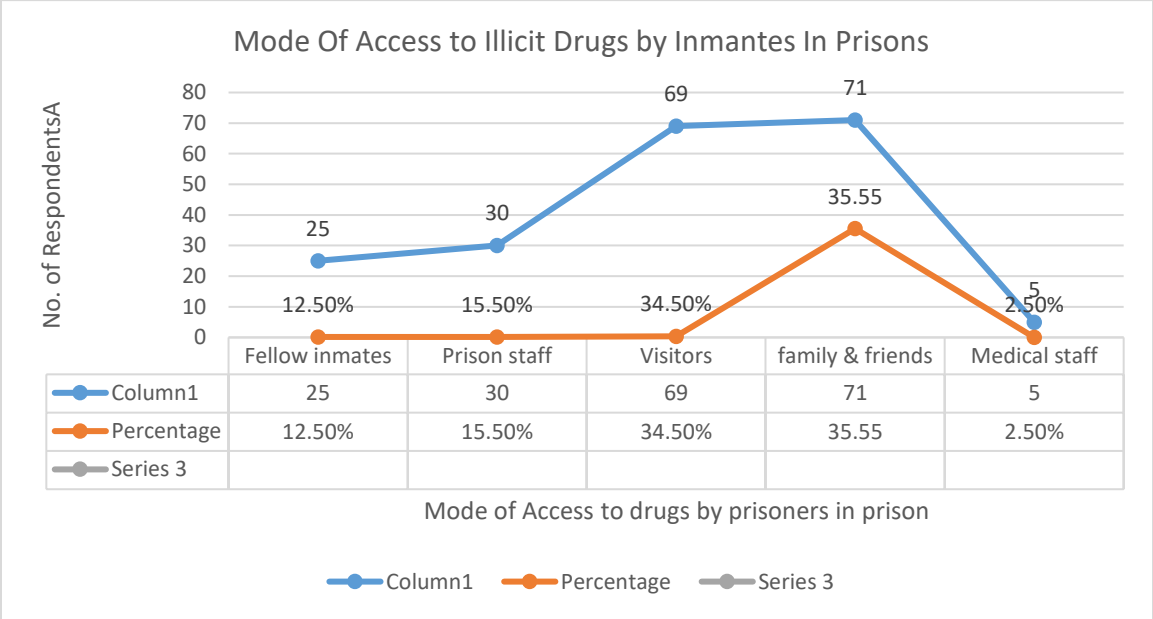
5.3 Drug Availability and Accessibility in Prisons

Prisons are a "secure" establishment and so the presence of drugs can be a difficult issue for the prison authorities to officially acknowledge. However, drugs are widely available in prisons throughout the world and the people will also try to get drugs into prisons (Penford et al. 2005). On the question on how and where prisoners were able to get access to illicit drugs whiles in prisons, the results of the study presented very interesting findings. Out of the 200 interviewees, 25 (12.5%) claimed they received their drugs from fellow inmates, 30 (15%) received their supplies from prison staff, 69 (34.5%) from visitors, 71 (35. %) from family and friends whiles 5 (2.5%) from medical staff who offer medical services to the prisoners (Figure 3.3.1). The revealing part of the study was the involvement of the prison staff and medical staff who were supposed to educate and counsel the prisoners against the use of illicit drugs. Also, it was realized that, the greater majority of prisoners get access to drugs from their visitors, families and friends and these three groups of people are those who are outside of the prison community and only come once in a while to visit the prisoners. The results indicate that aside the inmates and prison staff, the rest of the drug suppliers (72.5%) come from outside and were supposed to be thoroughly searched before entry into the prisons. They being able to pass through the check point shows the porous security arrangement at the point of entry into the prison. Any future measures to check entry of illicit drugs into the prison should critically consider the fortification of the entry points of prisons.

Figure 3.3.1: Mode of Access by Prisoners to Illicit Drugs in Prisons



The results presented by Figure 3.3.2 how illicit drugs enter the prisons. Out of the 200 interviewees, (45%) of respondents claimed the drugs were concealed in food items supplied to them by their collaborators, (35%) said they were concealed under the clothing and beddings whiles (20%) said the drugs were thrown over the perimeter walls of the prisons into the main prison yard. This again exposes the ineffectiveness of the searching at the entry points of the prisons.

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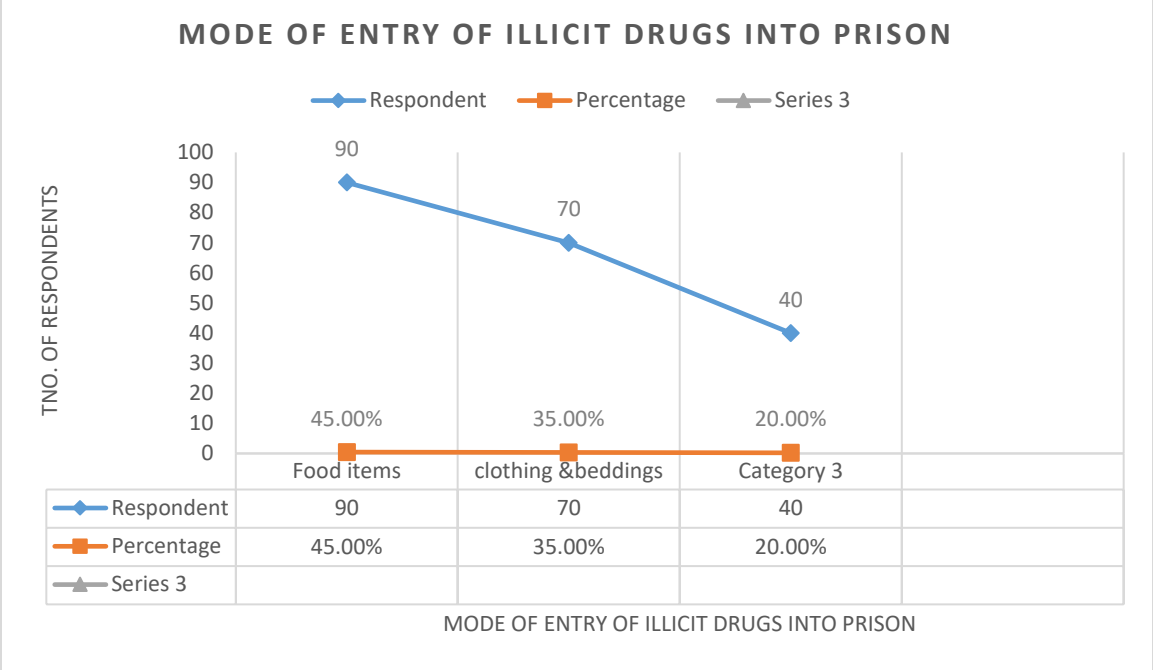
Figure 3.3.2: Mode of Entry of Illicit Drugs into the Prison



5.4 Factors Influencing the Use of Illicit Drugs by Prisoners during Incarceration

Various studies estimate that, the percentage of individuals reporting problematic drug misuse is comparatively higher in prisons than in the community. It is reported that, the percentage of people in prisons who have drug problems ranges from 40-80 percent (Dolan et al. 2008). Also, a recent survey conducted by the United Kingdom government found that, evidence from other countries show that levels of drug use are influenced by factors more complex than legislation and enforcement alone (UK Home Office Report, 2014). The survey results as presented in table 3.4, show a number of influencing factors that motivate prisoners to engage in illicit drug use during incarceration.

The factors have been ranked based on the responses of the interviewees. Seven factors were identified and out of that, 86% of respondents spoke of boredom and lack of constructive activities in the prison as what forced them to take to drugs. A further (83%) said that they engage in drugs to cope with the harsh conditions in prisons whiles (72%) believe taking drugs will help them to overcome stress and depression in prison. Also, (70%) believe that the general pressures in prisons. which are as a result of high overcrowding rates, influence them to use drugs in order to cope with the consequences. It is worth noting that, all the study sites, with the exception of James Camp prison which is underutilized, have an overcrowding rate of over 100%. For example, the Nsawam Male Prison which has an authorized capacity of 851 now houses 3,416 inmates. This is equal to an overcrowding rate of 401%. The Kumasi Central Prison, with an authorized capacity of 416, now houses 1,760 making an overcrowding rate of 430% and the Ankaful Main Camp prison houses 720 inmates instead of the authorized capacity of 480 leading to overcrowding rate of 150%.

Table 3.4: Ranking of Contributory Factors for Illicit Drug Use in Prisons in Ghana

No.	Contributory Factors	Ranking	Number of Respondents	Percentage of Respondents over Total Respondents %
1	Boredom and lack of constructive activities	1st	172	86.0

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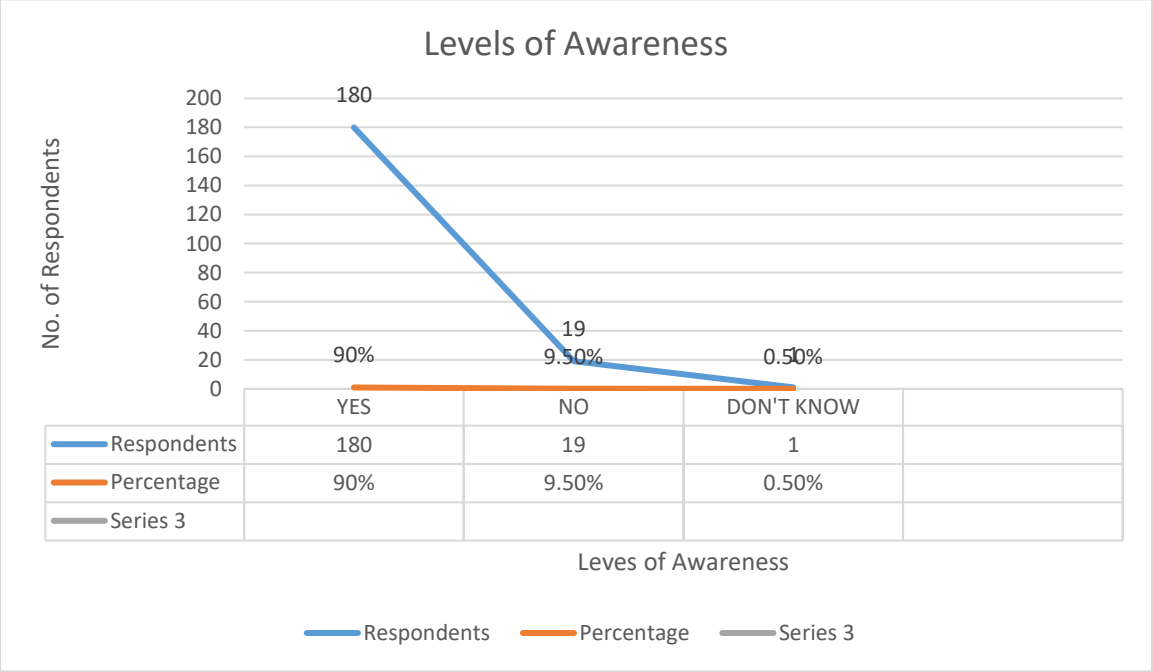
2	To cope with harsh prison conditions	2nd	166	83.0
3	To overcome stress and depression	3rd	144	72.0
4	General pressures resulting from high levels of overcrowding in prison	4th	140	70.0
5	Peer pressure (social relationship)	5th	136	68.0
6	Addicted to drugs before incarceration	6th	130	65.0
7	Lack/low level of drug educational programmes in prisons	7th	106	53.0

The result also indicate that 136 (68%), and 130 (65%) of the interviewees engage in drug use due to peer pressure (social relationship) and addicted to drugs before incarceration respectively. Lastly, 106 (53%) believe that, lack and/or low level of drug education programmes in the presence has contributed to prisoners engaging in illicit drug use. From this results, it will be useful if any drug intervention policy or programmes should be tailored in addressing above issues.

5.5 Awareness of Drug Use and its Consequence in Prisons

The results from the study as presented in figure 3.5 show that, the majority of the interviewees were aware of the presence of illicit drugs in the prisons and its consequences. Out of the 200 respondents, 90% claimed that they were aware of illicit drug use by the prisoners and its consequences. Only (9.5%) said that they were not aware of the presence of illicit drugs in the prisons. One person (0.5%) said he cannot tell of the presence of drugs in the prison or not.

Figure 3.5: Level of Awareness of Illicit Drug Use and its Consequences



5.6. Types and Cost of Illicit Drugs Use in Ghana Prisons

Figure 3.6.1 present the results in relation to the most common types of illicit drugs used by the prisoners and their corresponding cost. Out of the 200 respondents, 82 (41%) said that cannabis,

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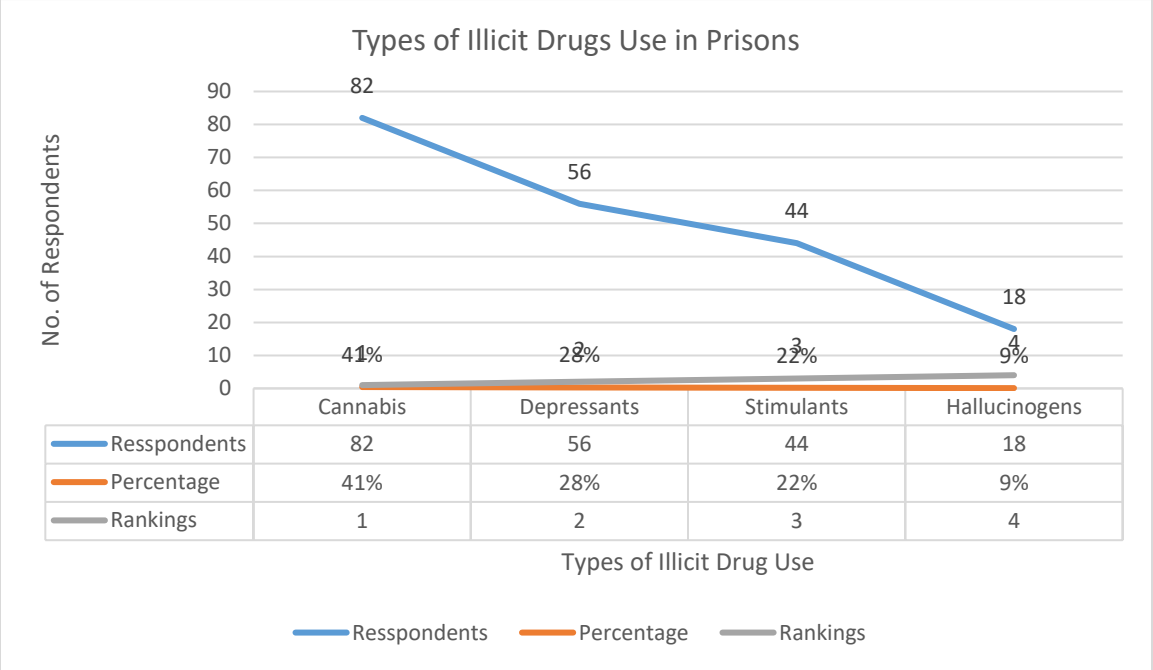
particularly marijuana is the most common drug used by inmates in prisons. They claimed that the cost of one roll of marijuana ranges from GH₵2 to GH₵3 depending on the size. It was reported that, on the average each user spent between GH₵60 to GH₵200 per month depending of number of times of usage. The second common drugs being used are depressants mostly Valium, Librium and alcohol which had 56 respondents (28%).

The cost according to the interviewees is GH₵3 for a stripe of valium and Librium tablets and the average monthly cost is GH₵20 to GH₵50 depending of magnitude of usage. Also 44 respondents (22%) said stimulants such as cocaine, heroin, caffeine and tobacco are being used by the prisoners. They said the cost of the tobacco ranges GH₵0.5-1.5 per stick depending of the brand whiles cocaine and heroin ranges from GH₵010-15 per dose. Average monthly spending on tobacco ranges from GH₵50 -100. For cocaine and heroin, only a few prisoners can afford it and it costs an average of GH₵250 per month for regular users. Hallucinogens (LSD and PCP) were rated the 4th most common drugs in the prisons by 18 (9%) of the respondents. They claimed that the cost depends on the type of drugs and on the average, the monthly cost is estimated between GH₵40-80.

Figure 3.6: Types of Illicit Drugs Use in Prisons



5.7 Knowledge of Drug Treatment Programmes and Policies in Prison

According to the findings of the study as presented by Table 3.7, it seems the majority of the prisoners are not aware of any drug policy in the prisons. Even prison officials claimed they are not sure of any effective or laid down policies in prisons with regard to problematic drug use disorders. The results show that only (15%) of respondents claimed they are aware of any drug policy in prisons. They mentioned religious and counselling activities as the one they know of. Majority of the respondents, that is, (60%) said they are not aware of any such policies in place, (25%) said they cannot tell if there are such policies in place.

Table 3.7: Knowledge of Drug Treatment Programmes and Policy in Prison

Do you know any drug policy in the prison	No. of Respondents	Percentage of Respondents %	Existing Programmes	Effectiveness of programme

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Yes	30	15.0	Religious and Counselling	Not all that effective. Just a routine church service.
No	120	60.0	-	-
I can't tell	50	25.0	-	-

5.8. Existence of Rehabilitation/Treatment/Policy/ Programmes for Illicit Drug Users in Prisons in Ghana

There is no special programme or policy or treatment for prisoners who have become drug dependent (such as heroin and cocaine users). The prison authorities admitted that prisons have limited budget and therefore cannot initiate such programmes on their own. While the prison administrators at the study sites acknowledge that drug dependence in the prisons was a problem, no special programmes or policies have been established to deal effectively with it. The results presented in Table 3.8 show that, apart from the medical screening that is usually done for prisoners who are being admitted, no other subsequent screening is done for prisoners who are suffering from drug use disorders. Even this screening is just a onetime activity during admission period and is only a physical examination. The prison officials claimed lack of prison clinics, medical staff and funding as a constrain factor. The result in table 3.8 also show that, there is the nonexistence of rehabilitation programmes for problematic drug users in prisons and neither are there any drug policies for the prisons. The only policy is the routine searches and destruction of retrieved prohibited drugs and items.

On the issue of health-related provisions in the national drug regulation, Prisons Service Act 1972 (NRCD 46) section 1, provides that, "the Prisons Service shall ensure the safe custody and welfare of prisoners and undertake the reformation and rehabilitation of prisoners whenever practicable". It is not clear what practices there are with regards to convicted problematic drug users or those in pre-trial detention.

Table 3.8: Existence of Rehabilitation/Treatment/Policy/ Programmes for Illicit Drug Users in Prisons in Ghana

No	Programme/ Policy	Level of awareness by Respondents		Reason for response	Effectiveness of programme/ Policy	Challenges of implementation
		Yes	No			
1	Medical screening and treatment	Yes	-	Initial medical screening on first admission	It is just a onetime activity during admission period and is a only physical examination	Lack of prison clinics and medical staff. Funding is a constraint factor.
2	Rehabilitation programme	-	No	There no such activity the prison	The programme is non-existence	Lack of funding to implement such an activity. Also, most prisons lack the needed logistics and resources
3	Psycho-social counselling	Yes		Is been done some central prisons	This activity is not all that effective due to lack of resource persons and space in the prisons	Lack of funding to implement such activity. Also, most prisons lack the needed logistics and resources
4	Religious programmes	Yes		Is a routine activity	Is the most effect reformation activity in the prisons	Lack of space for the large numbers of prisoners in custody

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5	Any drug policy in prisons	-	No	Non existence	Non existence	There is no drug policy in the prisons aside the usual search and destroy activity.
6	Any National Drug Policy been implemented	-	No	Non existence	Non existence	Lack of Funding and other resources

5.9 Consequences of Illicit Drug Use, Measures in Place, its Effectiveness and Challenges

According to the responses from both prisoners and officers, the inflow of illicit drugs into the prisons is of grave concern to the prison authorities and the nation as a whole. It undermines security, health and control of the prison system. Table 3.9 presents some of the key challenges raised by the respondents particularly the prison authorities, some measures that have been put in place, its effectiveness and the problems facing these measures.

Table 3.9: Consequences of Illicit Drug Use, Measures in Place, its Effectiveness and Challenges

No	Identified Challenges/ Consequences	Measures put in place by Prison Authorities	Effectiveness/ Success	Constraint Factors
1	Health challenges such as increasing rate of infectious diseases such as HIV/AIDS, Tuberculosis, and Hepatitis etc. This is a challenge for inmates, staff and the entire community. Also, the increasing number of inmates who report drug use disorders is a great concern.	Occasional screening of all inmates and staff and also health education sessions for both inmates and staff. Also, enrolment of all inmates on National Health Insurance Scheme to reduce health care cost	This programme has been a very useful intervention; however, its effectiveness is constrained by high cost of health care and lack of funding.	Inadequate budgetary allocation to fund such an activity. Also, the lack of clinics and medical staff in the prisons is a major constraint.
2	Large quantities of illicit drug inflow into the prison particularly those that pass through unmanned areas such as throwing over the perimeter walls.	Searches are conducted on all items and persons entering and leaving the prisons. Also, frequent searches are conducted on the inmates unannounced to retrieve all prohibited items including illicit drugs.	Some persons manage to conceal the drugs in some places where it will be difficult for physical detection.	Lack of modern drug fighting logistics such as walk-in scanners and cameras to detect the concealed drugs. Also inadequate staff to patrol and monitor the various posts especially along the prison outer walls.
3	Lack of effective Drug Policy and Rehabilitation programmes for drug users.	A draft proposal on drug policy is almost at the completion stage.	Is at the proposal stage	Long bureaucratic process of passing bills is delaying the efforts been put in place

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4	Increasing violence of drug users and the safety of both inmates and staff in the prisons is a great concern to the prison administrators	Increasing education of inmates on consequences of illicit drug use is yielding some results. Also stiffer sanctions such as forfeiture of remission and solitary confinement in an extreme case is in place.	This measure is yielding the some level of results	Lack of space for educational programmes.
5	Lack of medical facilities and staff/ drugs and rehabilitation experts in the prisons system	The Service is collaborating with the British High Commission in Ghana to refurbish and upgrade the prison clinics in Nsawam male, Ankaful maximum and Kumasi Central prisons into a full grade hospital.	The Nsawam clinic has been refurbished and upgraded to a full hospital status. Work is progressing at the Ankaful maximum. Also 15 Physician Assistants and two medical doctors has recently been recruited and undergoing regimental training.	Low salary levels and poor conditions of service is demotivation factor for professional staff.
6	High levels of overcrowding is a major contributory factor.	New prisons are been constructed at Nsawam. Also expansion and refurbishment works in ongoing at Ankaful complex.	Construction works are at various stages and ongoing	Inadequate funding is key challenge.

5.10. Conclusion

This chapter has analyzed the results of the study and discussed the various findings and observations. The findings and discussions were centered on the demographic factors of the target group and their relationship with the use of illicit drugs. The major discussion points were on why, where and how prisoners get access to drugs in prisons and the influencing factors the push the prisoners into contact with the drugs. The issue of existence or otherwise of drug policies and treatment programmes in prisons for problematic drug users were also discussed intensively.

Finally, the chapter discusses illicit drug use by prisoners and its consequences on the prisoners, staff and the society. The researcher is of the view that, drugs use in prisons and its related consequences should be an issue of considerable concern to all. In addition to high levels of drug disorders, illicit drug use can generate dependence, which overtime can lead to chronic medical conditions. Given that the greater percentage of illicit drug user are in the age range of 18-45 years as indicated by the results, this group of prisoners may pose a danger (in terms of healthcare, reoffending and other social vices that are related to drug use) to the society when they are released from prison. The government, the prison authorities, all stakeholders and the general society should join hands together to support efforts to curb this illicit drug menace in our prisons.

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6.0 CONCLUSION

This chapter gives a summary and conclusion of the study on the illicit drug use among prisoners in Ghana prisons. The chapter also presents some recommendations for policy makers and prison managers and provides knowledge for future research.

4.1 Summary

The study was undertaken on illicit drug use among prisoners in Ghana prisons. Four prison establishments namely; James Camp Prisons in Accra, Medium Security Prisons, Nsawam in the Eastern Region, and Ankaful Main Camp Prison in the Central Region and Kumasi Central Prison in Ashanti Region were used as a case study. Both primary and secondary data were collected from the prisons concerned and a total sample size of 200 prisoners and prison staff were randomly selected for interview. Field observations were also made during the survey period. The primary objective of the study was to examine why, where and how prisoners get access to illicit drugs and its dire consequence to them, prison staff and the Ghanaian society as a whole. The study also sought to know what policies and measures are in place to curb the challenge and how successful the measures have been.

The results of the study revealed that the majority of illicit drug users in prisons (81%) were in the youthful and productive age group (18 to 45 years). Also, greater percentage (65%) of the drug users in prison were from lower income level (unemployed) whiles 67% of the users have little or no educational background. The results further indicated that, 77% of the illicit drug users in prisons have previous prison records and 56% were incarcerated on drug related offences. On the issue of accessibility and availability, it was revealed that 72.5% of the prisoners have access to drugs through visitors, family and friends while 15% received their drug supplies from prison staff.

The mode entry of illicit drugs into the prisons were mainly concealment in food items (45%), clothing and beddings (35%) and throwing over the perimeter wall of the prisons (20%). The results of the study also identified a number of factors that motivated the prisoners to engage in illicit drug use. These include, boredom and lack of constructive activities in the prisons, means to cope with stress, depression and harsh prison conditions. The rest were, peer pressure (social relationship), general pressures resulting from high levels of overcrowding, addiction to drugs before incarceration and lack of drug policy and educational programmes in the prisons. The majority of the respondents (90%) claimed they were aware of the presence of illicit drugs in the prisons and also knew about the consequences of their presence. The study identified that cannabis (marijuana) remain the most common drug used followed by depressants such as Valium, Librium and alcohol. The rest are stimulants (such as cocaine, heroin, caffeine and tobacco) and hallucinogens.

The results also revealed the nonexistence of drug policies and rehabilitation programmes in the prisons. Most prisoners and prison staff are not aware of any drug policy and treatment programmes for problematic drug users in prison. Finally, the study identified some key consequences the drug menace present to the prison authorities. These include, high level of blood-borne diseases (such as HIV/AID, Tuberculosis and Hepatitis), large inflow of illicit drugs into the prison as a result of weak security at the entry points of the prisons, lack of effective drug policies, lack of medical faculties, medical staff and equipment, and high levels of overcrowding which make monitoring and control very difficult.

4.2 Conclusion

The study has revealed why, how and where prisoners in Ghanaian prisons get access to drugs and some of the dire consequences to the prisoners, the staff and the general public. The study has also determined some of the factors that influence drug use in prisons and finally, it is has been established that, even though there is an increase use of illicit drugs in prisons and drugs can really be found in the prisons, there are no effective measures or policies in place to curb this menace. Also, no effort has been made to rehabilitate prisoners with problematic drug disorders.

The researcher is of a strong view that illicit drug use should be a national concern looking at its impact on health and security challenges to the whole Ghanaian society. Therefore, the government of Ghana, the Ghana Prisons Service and all stakeholders should collectively put our resources and efforts together to tackle this national threat. The study will serve as a baseline for any future study since there has never been any survey on illicit drug use in prisons in Ghana, wishes to state that, any future study of

illicit drug use by prisoners should consider the medical aspect especially psychological and mental. Also female prisoners should be included in any future study.

4.3 Recommendations

On the basis of the results of the study, the following recommendations are made: The Ghana Prisons Service and the government of Ghana, should develop cost effective, standardized and sustainable drug use polices. This will serve as a standard operating procedure for the handling and management of illicit drug use in all the prison facilities. Ghana Prison Service should put effective measures in place for identifying, screening and treatment of illicit drug disorders. Regular medical screening should be done for all staff to avoid transmission of infectious diseases to their families, friends and the general society. Also, prisoners who are due for release should be medically examined to prevent the transfer of prison health problems into the community. The prisons authorities should intensify the rehabilitation and reformation functions of the Service in order to equip the prisoners with requisite life skills that could be used upon their discharge from prisons. Also, prisoners should be actively engaged in recreation and other physical activities that will engage their minds.

The government should construct health facilities in all prisons and provide medical personnel and equipment. Provisions should be made to install high efficiency scanners in all entry points of the prisons to detect all concealed items (illicit drugs) that flow into the prisons. Furthermore, Closed Circuit Televisions (CCTV) and monitors should be installed to aid monitoring and control. Efforts should be made to decongest the country's prisons by constructing new and bigger prisons and also come out with legislations on non-custodial sentence, sentencing policy and parole system. There is an urgent need for the government to come out with an effective national drug policy that will take a look at the establishment of drug disorder rehabilitation centers in all the prison facilities. Finally, The Ghana Prisons Service, the Narcotic Control Board, the AIDS Commission and the Ministry of Health should build an effective collaboration to enhance efficiency in curbing the drug use menace in Ghana prisons.

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