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Is Imprisonment Dealing with Addiction?

The Prison Service Perspective

Michael Spurr, Director of Operations of HM Prison Service.

Context

A few months ago, I visited Brixton prison. I ventured on to A-wing and on the 4s landing was soon surrounded by a group of prisoners keen to know who I was and what I was doing. Then along the landing came Joey, 'Hey! leave him alone,' he told the others — 'he's alright, we go back a long way'. That did my credibility a lot of good, I can tell you, and provided a great opportunity for me to really find out what was going on in Brixton. Indeed we did go back a long way — 15 years in fact, and over that period I'd met Joey in a number of different prisons doing a number of different sentences. As with all relationships we had had our ups and downs but had a respect for one another and here was Joey again, back in Brixton looking older than his years and presenting a rather sad shadow of his former self.

Joey is not a shining success for the Prison Service but his problems over the years had changed — and it struck me that in many ways he personified the changes

which Prison Service staff have had to face in dealing with a very different prison population today compared to that which was in custody ten or 15 years ago. Joey himself is a very different person presenting different problems and with different needs to the young man I once knew. And he's not alone, because the biggest difference in the population today is the reason we are all here. It is the sheer scale of addiction dependency and associated mental illness which has changed the nature of imprisonment and to which we have had to respond. The statistics are frightening and although they may be familiar to many, I believe it is important to put the challenges facing the Prison Service in dealing with addiction (both in terms of drug dependency and alcohol dependency) in context before moving on to consider the response to the significant problems which have emerged.

Data now indicates very high levels of drug mis-use amongst new receptions into prison. Around 40-50 per cent of men and 60 per cent of women received into prisons have a chronic substance misuse problem that requires clinical treatment. In some local prisons up to 80 per cent of prisoners received into custody are testing positive for opiates on reception. For example in 2002/3 a study at HMP Bristol identified substance abuse in 1,529 prisoners (65 per cent of all new receptions). Of this group 73 per cent (1,128) had a urine test positive for opiates implying use within the preceding 72 hours; and 52 per cent (809) were positive for crack or cocaine. The outcomes from Bristol are supported by data collected from CARAT drug services in prisons since April 2002. This data indicates that the drugs most commonly used before custody by those assessed by CARAT workers were heroin (71 per cent had used in the 30 days before custody), crack (53 per cent), cannabis (40 per cent) and alcohol (27 per cent). Around half of those assessed considered heroin to be their main problem drug and over one third said they had injected in the 30 days before custody. Current data indicates that there has been a considerable increase of chronic drug dependency over recent years. A study by the Office of National Statistics in 1997 found that 24 per cent of men on remand and 41 per cent of women on remand were dependent on opiates. In the last five years the figure for men has doubled and that for women increased by a third. Poly drug use is the norm for the prison population often combined with alcohol dependency, particularly amongst women.

So the scale of drug and alcohol dependency amongst offenders coming into prison has increased dramatically and front line staff in establishments are having to cope with a much more difficult dependent and vulnerable population than ever before. What's more (and this for me is particularly significant), two thirds of drug dependent offenders entering custody have had no previous contact with drug treatment services in the community. That is a staggering statistic and presents a massive challenge to all of us working with offenders in custody. Effective delivery of drugs interventions is critically important because until addiction is broken offenders are incapable of engaging with wider rehabilitation programmes.

Response

But there has been a response and a significant one. The population has changed over recent years but so too have prisons and much has been done to deal with the multiplicity of problems which prisoners now present. Again, I make no apology for putting the current position in context. Up until the mid 1990s prisons did little to address either drug dependency or alcohol dependency. Apart from very basic absence based detoxification, little was offered to prisoners apart from one to one work with Probation

or Psychology staff and the ever-dependable NA or AA groups. Since then, we have done a great deal to improve drug services, although I have to confirm that much more limited progress has been made with regard to tackling alcohol dependency.

There has been a dual focus on both reducing supply of drugs in prisons (through security measures and testing programmes) and reducing demand for drugs in prisons (through flexible interventions targeted at low, moderate and severe drug misusers). Concentrating on the treatment side, which aims to break addiction, there has been considerable progress and we should not underestimate what has been achieved.

Q In the mid 1990s there were no drug workers in prisons. There are now over 600 dedicated drug workers providing counselling, assessment, referral, advice and throughcare (CARATs). Over 53,000 initial assessments were completed last year.

Q Detoxification provision has significantly increased and around 50,000 prisoners are now entering a clinical detoxification programme each year (covering both alcohol and drug dependency) with around five per cent of cases being supported through controlled maintenance prescribing.

Q Since 1996/7 intensive drug rehabilitation programmes across the estate have increased from

nine to 60. Currently comprising 43 cognitive behavioural therapy programmes; thirteen 12-step programmes; and four therapeutic community programmes. Current provision provides around 5,000 prisoners with the opportunity to enter drug treatment programmes and this is set to increase to 6,500 by March 2005 and 9,000 by March 2006. Q Total additional expenditure on drug treatment since 1999 is around £120 million.

This represents a significant increase in resources devoted to treatment of addiction in prison and when combined with the action taken to reduce supply, the investment has provided positive outcomes.

Outcomes

The most telling indicator of progress is on the level and type of drug use in prison. As we have seen, the level of chronic drug dependency amongst those received into prison has risen significantly over the last five years. Despite this, however, the rate of drug use inside prisons has fallen dramatically with the overall rate halving since the introduction of the Mandatory Drug Testing

Programme from 24.4 per cent in 1996/7 to 12.5 per cent last year. Moreover, not only has there been a reduction in the overall rate of drug use in prison but there has been a significant switch away from Class A drug use with the level of opiate use reducing by 40 per cent since 1996/7 from a rate of 5.5 per cent to 3.3 per cent last year. Similarly, whilst over one third of offenders entering custody admitted injecting heroin in the 30 days prior to reception, the level of drug injecting in prisons is extremely low.

It will no doubt be argued by some that these figures don't tell the whole story — that they are unreliable, and that the real incidence of drug use in prisons is much greater. There is no hard evidence to support this but even if the figures did under-represent use to some degree, statistically the trend is clear and a 50 per cent reduction in drug use in custody demonstrates real evidence of progress.

There is also emerging evidence on the effectiveness of drug treatment in prison. Research shows that reductions in reconvictions of around 11 per cent over two years compared with expected levels can be achieved with good throughcare arrangements in place.

Of course that does not mean that everything is rosy — the real world isn't like that and we still face massive challenges every day in each of our prisons. So I want to turn now and say something about our priorities for the future and how we are looking to tackle the challenges ahead.

Challenges and Priorities

First of all in terms of supply reduction, we face considerable pressure. Efforts are hampered by the continuing growth in the prison population, the level of throughput, and the rise in organised criminal activity responding to the increased profitability of supplying drugs in prison. We are actively working with Police Service colleagues in developing a joint intelligence based approach to tackle the supply of drugs in prisons which will complement the supply reduction strategies already employed across establishments. This is a key piece of work but we know that this will not be enough to break addiction.

So on the treatment side we have three main priority areas around detoxification treatment and throughcare and I would like to say something about each of these in turn. First, we aim to improve the quality and effectiveness of clinical substance misuse services including better care planning and more extensive use of maintenance therapies where these are justified and appropriate. Although there has been considerable improvement in detoxification provision across the estate throughput of prisoners and resource limitations mean that the quality of service provision can still be significantly improved. Working with the Department of Health and increasingly through Primary Care Trusts at a local level, we are committed to introducing better quality services and clinical treatment better tailored to individual need.

There is a clear link between drug dependency, detoxification, mental illness and self-harm. In custody we know that 62 per cent of those committing suicide early in custody have a recent history of drug misuse problems.

There are also potential links with the high rate of deaths on release from custody. A recent study demonstrated that individuals released from prison were 40 times more likely to die than the general population. Between 1996 and 2000, 354 people committed suicide within a year of release from prison (88 cases per year) with 23 per cent of deaths occurring in the month after release. These figures support the need for a more targeted and individually based approach including maintenance provision where appropriate to allow continuation of community

interventions on release. This is a key area of work and we are working closely with Department of Health colleagues to obtain the additional resources necessary to support a significant increase in the quality of delivery.

Secondly, we need to increase access, capacity and effectiveness of drug treatment programmes in response to the rising number of prisoners with serious drug problems received into custody. As I have already mentioned, we are committed to increasing the number of drug programme entrants from the current level of 5,000 to 9,000 by March 2006 and to reduce attrition rates in drug treatment programmes to deliver 5,850 programme completions by March 2006. This will be achieved primarily by a significant expansion of the prison adapted substance reduction programme (P-ASRO) and the Short Duration Programme (currently being piloted in Bedford, Exeter and Nottingham — soon to be introduced in New Hall, Wormwood Scrubs, Brixton, Blakenhurst and Glen Parva). This is a significant expansion in a relatively short period and will be co-ordinated by a National Drug Programme Delivery Unit

which is being established specifically to ensure that programmes are rolled out smoothly on the basis of need and that quality of delivery is maintained.

The expansion of drug programmes will ensure that prisoners across all regions will have access to treatment in custody. We are also working to reduce the treatment gap, in particular improving targeted provision for women (where Low Newton is currently piloting an adapted P-ASRO programme tailored for female drug users), for young offenders and those on remand. Work is about to start on a Crack Intervention package (some CARAT staff are already trained) and we have commissioned the University of Central Lancashire to examine access (and barriers) for Black and Minority Ethnic prisoners with regard to drug treatment programmes.

This work will significantly enhance treatment options for drug users but there remains a gap in terms of treatment for misuse of alcohol. Central funding pro-

vision has been linked to the Government's priority to tackle illegal substance misuse. Specific treatment programmes for alcohol dependency have not, therefore, been developed, although CARAT services do tackle alcohol dependency where part of poly drug use.

We are developing an Alcohol Strategy to provide (support to Governors in delivering local interventions but this is an area where additional targeted funding I could be used productively.

Finally the third, and possibly most important priority, is the need to improve throughcare links with

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much better co-ordination between treatment services within prisons and those in the community.

This is a key area for development. As I have already outlined only one third of offenders accessing drug treatment in prison have made use of community provision. We also know from research that reoffending will only be addressed fully where effective throughcare exists. That is why the Criminal Justice Intervention Programme which aims to co-ordinate interventions in community and in custody is so important. The CJIP was road-tested in the Manchester Drug Action Team area in the Autumn of 2003. The programme has now been rolled out to 25 DATs across the country with a second tranche of 22 DATs coming on-stream shortly. To date, 92 prisons have reported positive engagement with the project. In February and March, 1,314 prisoners have been engaged in prison-based interventions which will act as a platform for release, helping to reduce reoffending post-release with timely aftercare services directly available for these individuals. This work is encouraging and will increasingly become the norm as we develop end-to-end offender management under the new National Offender Management Service.

Conclusion

So where does this all leave us, is imprisonment really dealing with addiction? Faced with an increasingly difficult drug-dependent population the answer is 'Yes' — to a degree. The majority of people coming into prison are able to stop or significantly reduce drug use. They do have access to treatment support and services, which the majority have failed to use in the community and despite the difficulties prison for many provides a relatively stable environment in dysfunctional lives where they can 'clean up*'.
He was pleased to be clean and proud of being a graduate who helped fellow drug users.

That's how it's been for Joey — the prisoner I met in Brixton. When I first knew him 15 years ago, he was clean, doing a sentence for robbery. But he gradually got into drugs outside and came back doing more time and drug dependent. As we developed drug services through the 90s, Joey eventually made use of them. He completed a RAPt course and came off drugs. He was pleased to be clean and proud of being a graduate who helped fellow drug users. Throughcare was in place for him when he went out but it didn't last. He couldn't sustain it outside — the temptations and the problems

were too great and so he went back to drugs and came back inside. I guess the scenario is not unfamiliar to many people here and it reminds me of a story:

There was a man walking along the side of a riverbank. As he did so, he heard the cries of a child in the river drowning. The man dived in, swam to the child, rescued him and pulled him out safe on to the riverside. But no sooner had he finished then he saw another child in the river. Again, he jumped in, swam, saved the child and pulled her out. But low and behold, once again, there was another child in the river drowning. And this went on and on until the man eventually looked up the river and saw someone else on a hill, throwing children in.

Sometimes working in prisons feels a bit like that man diving into the river. We may pull people out, clean them up but the numbers keep on increasing, we lose some, others return and we can never break the cycle. Imprisonment alone cannot deal with addiction amongst offenders. There needs to be a holistic approach which combines treatment for offenders in custody with improved effectiveness and

take-up of community-based services for offenders both before and after custody. The Criminal Justice Intervention Programme has had an encouraging start and is likely to provide a significant boost to community-based aftercare services. But much more is needed including further alternatives to prison custody for individuals convicted

of drug related offences which will encourage take-up of community provision. The creation of the National Offender Management Service provides an opportunity to focus on the individual needs of offenders. In the Prison Service we are committed to working in partnership with colleagues across the Criminal Justice Sector, in the Department of Health and with voluntary partners to improve the provision available to the chronically dependent in our care. It is a key objective and it matters because people like Joey matter and because addiction creates misery for individuals and their families and for the community as a whole. We have done much to deal with addiction but there remains much to do.

The Drugs Economy and the Prisoner Society

Dr Ben Crewe, Senior Research Associate at the Institute of Criminology at the University of Cambridge.

Introduction

The relationship between prison sociology and policy and practice has been a complex and changing one. During prison sociology's early years, from the 1940s to the 1960s, in the USA particularly, sociological knowledge was vital to the thinking of prison managers, and even politicians, about the design and governance of penal regimes (Simon 2000). In an era of rehabilitative optimism, studies of the everyday culture and social life of the prison were seen as critical tools for understanding how prisons could most positively intervene in the lives of their inhabitants. Accordingly, the founders of the discipline, such as Donald Clemmer and Gresham Sykes, were given privileged access to prisons (Simon 2000)¹. Given this intimate relationship with 'the administrators', it is striking that these early and seminal studies were not narrow, administrative or directly policy-oriented, but broad, thick, descriptive accounts of the ordinary life of the prison community. Clemmer and Sykes recognised that, to understand issues such as how order was maintained within prison, and how the more debilitating characteristics of imprisonment might best be mitigated, one needed to understand features such as the inmate value system, the informal hierarchy amongst prisoners and the relationships between prisoners and officers.

Nowadays, such studies are much less common. In the US, research on prison culture has virtually disappeared, such that we have very little knowledge about the internal dynamics of everyday life in prison at the very time when incarceration is becoming a normal pathway for many sections of the population (Simon 2000). Whilst the issue of crime is 'hyper-visible' in US culture and politics, punishment itself has become almost totally invisible (Wacquant 2002).

In the UK, within the prison estate, it is psychological rather than sociological knowledge that is the dominant scientific discourse. Outside it, the community of academic prison researchers is relatively small, but research such as Sparks et al's (1996) work on order and legitimacy, and Alison Liebling's studies of prison

officer work (2001), suicides and self-harm (1992; ongoing), and the moral performance of prisons (2004) have made significant practical and conceptual contributions to the running of prisons. However, there is general agreement in the academic community that our knowledge of the daily tissue of prison life is dated and underdeveloped.

Not least, there is little analysis of the role of drugs within the prison community. For anyone who lives and works in the penal estate, the centrality of drugs to its inner life is more than apparent. Yet, in the academic literature, where drug use has been discussed in relation to imprisonment, the focus has tended to be on public health implications and policy initiatives (for example, Keene 1997; MacDonald, 1997; Swann and James 1998; Edgar and O'Donnell 1998; Gore et al 1999) rather than on the effects of drugs on prison culture and social relations.

The insights offered in this paper on drugs and the prison social system have developed from a broad study of prison life, which aims to revisit the concerns of the classic prison sociologies, and their method of sustained fieldwork in a single establishment. Following a two-month pilot study in spring 2002, research was conducted over ten consecutive months in HMP Wellingborough, a category C training prison for men. Full access was granted, and the prison was visited around three or four days per week, including evenings and weekends. After a three-month period of observation and informal conversation in all major areas of the prison, 70 prisoners were interviewed in significant depth about their life histories and prison life. From the very early stages of the research, drugs — particularly heroin, the main substance referred to here — were highlighted as the key motor of social dynamics. This paper outlines some of the main findings in this area, and proposes a number of ways in which an appreciation of the role and implications of drugs in the adult male prisoner community might have implications for policy and practice².

Heroin and prison culture

With remarkable consistency, experienced prisoners claim that it is heroin that is chiefly responsible for

1. Some US states employed sociologists as well as psychologists and social workers in their prisons (Wacquant 2002).
2. The role of drugs in young offender institutions and women's prisons may be very different.

the erosion of a former culture of solidarity and cohesion amongst prisoners. The following quote captures general sentiments:

Smack — that's what's changed things a lot in prisons. People would never steal from people or grass each other up. Now that's just commonplace: grassing and co-operating with staff. (. . .) It's lowered general morals in the prison system. Proper heroin addicts have got no morals, y'know, they'd steal from their mum, they can't be trusted with anything. (. . .) So there's a kind of general mistrust around the place. (...) The violence levels have gone right up because of drugs. It was unusual for someone to get slashed up. There was fights (. . .) but now people are getting slashed up and set fire to just over nothing, five or ten pounds (debt). There's a lot more debt now in prison than ever before. And big debts as well. (. . .) People sell their clothes now in prison, which you never saw, for drugs, and all their belongings. People work for other people in prison for drugs now. They'll spend their life cleaning someone else's cell out for drugs, or whatever else they have to do. General moral standards have gone downhill, because of heroin. (...) it's hardened people's feelings towards their fellow prisoners. If someone's ill or poor or in a mess — a few years ago people would've gone to them and said 'here you are mate, here's some tobacco', or a phonecard, 'get yourself sorted out'. Now they say 'oh, he's a smackhead, forget him'. (So) people's good nature to other prisoners has got less and less. (. . .) Heroin culture has destroyed the humanity that was to other prisoners, that's gone now. That's why I think there's more slashings and whatever, because people don't look at each other as humans anymore, especially if they're smackheads — that's all they are: they get that label and they're finished.

Between them, then, heroin users and dealers violate almost every element of the prisoner code of

conduct. The heroin economy, and the debt that it generates, is linked to bullying and exploitation, grassing, and stealing from cells. Heroin users are seen as manipulative and phoney, undermining general levels of trust and breaching norms about behaving without front or pretence. They are considered volatile, unpredictable and confrontational, in ways that add to the stress of everyday life. Their behaviour brings the attention of officers onto other people's activities. And their dependency, desperation, and physical degeneration are considered insulting to the collective dignity of the inmate community.

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Heroin use and stigma

It is for all these reasons that heroin users in prison are stigmatised — albeit less than in previous years, when being a heroin user or dealer could result in being violently ostracised from a wing (Duke 2003)³. Users recognise this stigma, often acknowledging in private the shame that they feel about having to sell their clothes, work for other prisoners, and steal or beg from others in order to feed their consumption. 'It makes you into a worse thug than you already were', one prisoner commented, remorsefully (fieldwork notes, 2002).

However, while 'smackheads' are certainly at the bottom of the prisoner pecking order (within the mainstream community), drug use itself is tolerated (or perhaps accepted as inevitable) provided that it does not interfere with the lives of other prisoners, or come to suggest vulnerability, immorality or lack of control. Such distinctions are partly based on views brought into prison from outside communities, where heroin dependence is associated with weakness and 'dirtiness', and where there is great distaste for the kinds of acts perpetrated by addicts.

Many prisoners will be candid about their drug consumption, but will downplay its extent and try to distance themselves from the identity attached to hardcore users: 'I smoke heroin, but I'm not a smackhead' is a common refrain. Prisoners differentiate between those drug users whose use dominates their lives, and those for whom it is an occasional and controlled pursuit. Indeed, whilst being unable to control your drug use is a mark of being unable to handle incarceration, some credibility can be gained from

3. 'In the old days if you knew somebody who had smack, you'd go and have a chat with them, quietly, on the side. [And say] "Make sure nobody else gets it. You will take it. Nobody else will. You alone will take it. You won't knock any of that stuff out. If you go knocking it out, we'll knock you out".'

being able to afford heroin and knowing where to find it⁴

Heroin dealing and power

It is through drug dealing, though, that significant status and power can be amassed. Prisoners repeatedly described the influence and comfort that being a drug supplier can afford:

Drugs run every prison. (...) When you've got heroin, you're up there. You're one of the men. If you've got a constant flow of heroin, your prison life can be very comfortable.

God, y'know, heroin in prison is the most powerful thing. It's the most powerful thing in prison, you can get anything done. You can get somebody stabbed, you can get somebody slashed, whatever you want with heroin.

Power? Power's drugs. Drugs is power.

Clearly, those prisoners directly dependent on drugs are most susceptible to the power that drugs bestow upon dealers. However, non-users are also affected by the ability of drug dealers to accumulate other tradable commodities such as tobacco, and pay others to settle scores. They can also be drawn into the violent politics of the drugs economy if their friends find themselves in debt.

In an environment in which personal possessions often represent status, as well as currency, prisoners whose involvement in the drugs trade allows them to build up belongings are held in high regard. One interviewee said:

I was just admiring the way they done it, (...) They got the whole wing under control (and) they had everything (...) chocolate bars, boxes of brand new trainers and tracksuits all hangin' up.

Another aspect of the respect assigned to drug dealers relates to the 'nerve', ambition and contacts

that they are assumed to have in order to be able to secure their supplies. As one prisoner reported, dealers get 'respect for getting the gear in the first place (...) They must be big people if they can get drugs into jail'. However, it is important to identify the true nature of the 'respect' that drug dealing brings. Largely, prisoners recognise that it is borne out of fear rather than genuine admiration. They also note that it is often only a temporary form of power, which resides in the drugs themselves, rather than in any aspect of character, and which therefore dissipates somewhat when the drug supply itself runs out. The term 'powder power'

The term 'powder power' encapsulates what is, in fact then, a form of proxy or 'dummy respect'.

encapsulates what is, in fact then, a form of proxy or 'dummy respect'. It signifies both the false friendship that drug users give dealers in order to get hold of heroin, and the disrespect that dealers can show to users in the knowledge of the power they hold over them.

Many prisoners therefore take exception to drug dealing not only because it leads to forms of exploitation, and undermines notions of equality, but also because it allows otherwise 'ordinary' prisoners to climb the social hierarchy and boost their social image. Such complaints often have racial overtones, as well as connotations about masculine prowess. Thus, there is some disdain about the rising social power of Asian prisoners, who have traditionally been a relatively weak grouping, but whose involvement in the drugs economy is transforming their collective status: 'They're not powerful people — they're like matchsticks!', exclaimed one prisoner, 'but they have power, through the drugs they bring in'.

However, it would be wrong to suggest that prisoners can simply ascend the pecking order through the provision of drugs. A prisoner who without heroin is weak is unlikely to be able to hang onto his stock. In this respect, it is necessary either to already have some degree of physical or social clout, some other source of status, or to make smart alliances with powerful prisoners, in order to be able to operate as a dealer. Drugs alone are unlikely to enable a very weak member of the inmate community to become very powerful.

The opposite trajectory is more likely, as a result of drug use. Another reason why heroin is begrudged, particularly by experienced prisoners, is that it has corroded traditional sources of status and distinction

As one prisoner commented: It is [stigmatised], yeah. But it's also, it's also a status symbol to them. Somebody that can be seen to be running about, and eventually get the prize, ie. a bag of smack [...] they'll come out and walk about the wing, scratching their nose, 'yeah, I'm a gangster man, I can afford smack, and I know where to get it'.

among prisoners (such as age, physical strength, staunchness and offence):

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You can still be an armed robber, but if you\ a smackhead as well then the two don't go, do they? (... JYou'll get comments like, 'he used to be top brethren, but he's a smackhead now.' (...) You've got a weakness. And if people know you've got a weakness, it can be exploited. (People) can buy your loyalty because of your weakness. (...) You're not staunch no more, because people can buy you.

There is no hierarchy no more. Whoever brings in the most drugs is the hierarchy now.

If you can get drugs in, you're somebody, in prison. (...) You can be the biggest rapist on earth. But as long as you're bringing smack in, it doesn't matter what you've done.

Someone may be physically strong, they may be strong willed, they may be a bit of a bully, but because they're on the brown, people will frown upon them.

Heroin means you can have a 23 year old selling to a grown man, who's licking their arse.

Heroin's presence on a wing also shifts the terms on which prisoners associate with each other. Drug users are not really loyal to each other, nor do they trust each other, but they are 'loyal to each other's company' (Lamer and Tefferteller 1964: 14): they will associate with each other pragmatically in order to acquire and consume heroin. Former affiliations are often, therefore, abandoned. As one prisoner summarised, then, this has altered the conditions of social interaction:

You can have a senior heavy armed robber type who'll be hangin' around with a house burglar, simply because they both take smack, whereas in the old days you wouldn't get that: people were drawn to each, other because of what they were in for.

Overall, then, heroin's impact on prisoner power and social relations is complex. In some respects, it

distorts and supplants traditional relationships. In other ways, it amplifies existing inequalities and expands the conventional hierarchy, making some vulnerable prisoners all the more indebted, ostracised and stigmatised, and increasing the power available to certain prisoners whose position in the prisoner world allows them to command the drugs trade.

Motivations for drug use and drug dealing

Accumulating goods, services and status while in prison are some of the main motivations for dealing. Prison drug dealers are often dealers outside too, and many claim that continuing is a means of offsetting the material deprivations of incarceration, and living a life that corresponds, at least a little, to their lifestyle outside. Suppliers also take pride in 'beating the system', as one former dealer highlighted:

I got my victories by selling drugs. (...) They paid me £77 a week. If I wasn't working they paid me £3 a week. I lived well above that. I could have what I wanted. (...) When a screw came in my pad and saw it overflowing with food and tobacco and just everything, that was good enough for me.

The appeal of heroin consumption is generally discussed in terms of sanctuary, diversion and relief: 'it brings the walls down', 'it's like being wrapped up in cotton wool', 'every single weight on your shoulders just seems to disappear'. However, it is important to note the different patterns of drug use inside and outside prison. Not least, many prisoners report that they use heroin *only* when in prison. Furthermore, they appear to manage their consumption quite consciously — reducing it in the months before release to ensure that they do not risk adding days to their sentences, or leave with a taste for heroin.

In contrast, many prisoners whose offences are addiction-related use prison as an opportunity to get clean. For them, the experience of imprisonment is of a different nature from other prisoners. Firstly, they are more likely to talk of having 'real friends' in prison than other prisoners, who generally regard prison 'associates' as much less trustworthy and sincere than their 'proper friends' outside, and consider it reckless to put faith in people met in the artificial context of

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incarceration. In contrast, ex-addicts see their prison identities as 'real' and reliable and their outside selves as inauthentic, and project this view onto others:

I'll be able to trust (other prisoners) in a jail scenario, but otherwise, I don't know, they could get out of jail and change totally. I know that I would. I change when I get out. It's not as if I come in prison and put a mask on. I come in prison and I revert to me. This is the real me. Outside, I'm totally false (...) It's a chemical lifestyle I lead outside. My whole character changes.

Secondly, because of their experiences as addicts outside prison, some prisoners find confinement a relatively less painful phenomenon than freedom. Often, they describe imprisonment as an 'opportunity', or a 'relief from the chaos, misery and immorality of their lives outside. The kinds of degradations documented by prison sociologists in the past, for example, the deprivation of power and control, are considered less arduous than those that accompany addiction on the streets, as this interviewee describes:

(Outside) I don't have control of my life, heroin has a control over my life. I hand the reins to heroin (...). It's in prison that I can find I'm able to control my life more. . .and I'm happy, I'm happier. (...) How can a prison have power over you when you're in no rush to go beyond the boundaries of the gates. Cos I'm not. If I was to go out there, I would end up in a bigger state (of addiction) than I've ever been in.

For this cohort, then, prison provides a respite from drugs (rather than vice versa): a chance to improve their physical and psychological health, and the state of their personal relationships.

Interventions and further research

The practical and policy implications of these findings are by no means self-evident, and academic

sociologists are not always the best people to assess them. A number of suggestions and notes of caution can nonetheless be offered.

First, as is clear to most practitioners, interventions need to be institutional as well as individual, and they need to be well-planned and balanced. If prisoners use drugs to relieve stress and boredom, and to escape temporarily from reality, then decent, constructive regimes are likely in themselves to reduce demand. At the same time, however, open regimes may increase supply by allowing drugs to more easily enter and circulate, ^"likewise, if prison wages are higher, this

If prisoners use drugs to relieve stress and boredom, and to escape temporarily from reality, then decent, constructive regimes are likely in themselves to reduce demand. At the same time, however, open regimes may increase supply by allowing drugs to more easily enter and circulate.

may increase demand for drugs by making more currency available for prisoners tempted to consume. However, there may be less motivation for suppliers if there is less need to substitute canteen food for poor quality meals, and if there are alternative, legitimate ways of establishing status within the prison community.

Establishments do have some scope to shift the terms on which status is assigned. Certainly, prisoners suggest that the kudos attached to violence is greater in some prisons than others, and those changes in modes of control and in officer culture have reduced it across the prison system as a whole. Decreasing the status of drug dealing might be more complex. If prison staff raise the stakes or revel too openly in their successes in combating drugs, this might make dealers, who tend to hold relatively anti-authority attitudes, all the more determined. Officers might also be careful not to appear to legitimise or enhance the status of drug dealers by acknowledging their power — even if

only through the banter that can be part of the game between security staff and suspected dealers.

Similarly, since powerful prisoners are often involved in drug networks, there are dangers in mobilising them in order to control wings. That is, giving privileged wing-jobs and perks to influential prisoners, in return for them 'keeping the wing quiet', may be very imprudent. Even if a wing run along these lines appears calm, it may actually be the case that drugs are rife, but that a loose (and illegitimate) order is being maintained through collusion between officers and drug dealers who are keen to protect their markets by preventing overt and excessive disorder.

There are also dangers to be aware of in taking advantage of the lack of trust and loyalty that heroin engenders, and that exists between heroin users in prison. Prison sociologists have long noted that some level of solidarity is beneficial not just for prisoners, in terms of helping them to alleviate the pains of imprisonment, but also for prison administrators, who might otherwise face a much more unruly, discontented and self-interested prisoner population (Sykes 1958). It may be tempting for prison administrators to promote a culture of informing in order to eradicate heroin, and therefore promote greater harmony and safety within the prisoner community. However, this may itself undermine levels of trust and solidarity between prisoners, in ways that create an equally damaging and isolating environment. Moreover, prisoners may be very reluctant to grass on drug dealers, not only because this may be highly dangerous for them, but also because it can be self-incriminating, especially in a prison where admissions of drug use are dealt with in highly punitive ways.

However, in the same way that the official language about bullying has built upon, and been absorbed into, prisoner discourse, it is not implausible that a campaign against prison drug dealing could harness the antipathy felt by many prisoners about the presence of drugs within the system.

Given the stigma attached to drug use, compared to the more ambivalent status of dealing, it may be easier to tackle drug demand than supply. This requires a degree of understanding about the attractions and contexts of drug-taking. Prison staff need to recognise the ambivalence about heroin consumption felt not only by heroin-users, but also by users themselves, who are often full of shame about selling their clothes or getting family members to fund their habits. They may be unlikely to express this to officers, or want to discuss with them the intensity with which they may desire heroin when it is available. Again, this will be the case all the more if Prisoners feel that drug use is dealt with only punitively or dismissively, rather than with some level of sympathy and support. It is also worth staff being aware that, although heroin users in prison may appear to be collectively powerful, as individuals they are often isolated, with few proper friendships. Labels that simply deride

Staff should also be conscious that there exist different patterns of demand and behaviour amongst prisoners in relation to heroin. If drugs are consumed in prison as a way of easing the pains of confinement, then there are certain times during a sentence when this temptation is likely to be greatest: at its beginning, and in its middle-phases, when the prisoner is most isolated from the outside world, and most psychologically dependent on support within the prison. For recovering prisoners, support and resettlement are critical. Activity may be seized upon with relish; and peers — often in similar positions — are not sources of mutual support. It is unhelpful if officers believe (as prisoners sometimes — and often wrongly — think that they do) that 'druggies are druggies' or 'junkies never change', when these may actually be the prisoners most receptive to rehabilitation. Equally, it may be unwise to encourage prisoners to present themselves only as helpless victims if this risks undermining their sense of agency and self-esteem.⁵

Drug strategies should not be left only to drug specialists,

Conclusion

These are, then, highly complex interventions. Many would require further, more focused research. What should be clear is the importance of seeing the prison as a social system of interlocking components, and acknowledging the presence of drugs in each of them. Drug strategies should not be left only to drug specialists, CARAT teams, and Voluntary Testing Units.⁶ They should be part of the culture of an establishment.

Finally, it is worth repeating that tackling drugs in prison is not just a question of dealing with issues around addiction. There are implications for the entire social fabric of the prisoner community, and thus for the general health of the prison. Where a prison is unsafe, lacking in trust and chaotic, there are consequences for the general well-being of prisoners that are also likely to impact upon their attitudes after release, not only towards drugs, but also towards themselves, their families, and society at large.

A full list of references is available from the author.

Promoting helplessness as the key means to gain support or escape sanctions is also dangerous because it encourages prisoners who do not have drug problems to present themselves as if they do (see also Shewan and Davies 2000). A small number of interviewees reported that they had claimed, on entry into prison, to have drug abuse issues, because they believed that providing the prison with 'something to address' made it more likely that they could appear 'corrected', and therefore worthy of parole and other benefits. Drug policies also need to make sense to prisoners and be implemented with consistency and transparency. There is considerable cynicism about 'targeted' drug testing, the sanctions attached to cannabis consumption, and the importance of MDTs as a performance target. This does have implications for the legitimacy of the prison regime.

Is Imprisonment Dealing with Addiction?

Ruth Wyner, Co-ordinator of the Dialogue Trust. She was formerly Director of Overstream House, a day centre for the homeless in Cambridge, and was controversially imprisoned in 1999.

Introduction

My first rather flippant thought was that they are: prisons are making money by accommodating addicts through a prison sentence. Could be quite a good deal, but actually it's not. Prisons are so full of addicts that serious over-crowding is preventing staff from running decent, humane and useful regimes — useful in the sense that prisoners can be given the tools they need to get away from crime and into mainstream life.

It's also making life extraordinarily difficult for prison staff. The stress has led to difficulties in recruiting and retaining staff and to the high levels of staff sickness, which we are told is worse than in any other of our public service institutions. Interesting, isn't it, that almost four years after my release I can be this understanding of the prison officer? I certainly didn't feel that way during my time inside: the screws were the enemy and my fellow prisoners my peer group; that is how it is in prison. I had to unlearn a lot when I came out.

My second thought on today's theme was: should prisons be dealing with addiction? We know that addiction all too often covers up vulnerabilities, traumas, mental ill-health, depression, internal terror and despair. That is why people take drugs, or drink to excess, because they can't manage any other way. Should we be placing these times of unbearable pain and distress into the punishing environment of prison?

I expect some of you are thinking: what naivety, to describe addicts like that, when they are sly, dishonest, completely untrustworthy and don't give a toss about the rest of us. Of course, when they need a fix that is absolutely true. But how on earth did they get into that state? How did they become prey for the big-time dealers? Perhaps we can take a little time to look together at who these addicts are. It is important to know, well, that you have this shell on'. Another man said, when over 100,000 people come into our prisons every year and if what we are told is true, the majority are addicts. Some prisons report that over 80 per cent are. In my experience, that rings true.

The prisoner profile

When I first hit Holloway I was terrified. I think it was a fairly usual event that I was booked in with five drug addicts and a sixth person who had a drink problem. She had stabbed her boyfriend during a drunken argument.

I was, however, lucky to make a pal of one of my cell-mates, a young skinny Class A drug user who looked like an advert for Belsen: her teeth stood out from her wizened face like they do in the starving, and I suppose starving she was. Ironically, she was in prison for stealing food, meat, but to sell rather than to eat. She was an old hand and did her cold turkey in the cell because, she said, the conditions in healthcare were awful and anyway they gave you nothing of note to see you through. 'I'll do my detox on the wing', she asserted. I saw her do it.

After a few days I was moved upstairs to the convicted wing and the tears that had abated returned. I was comforted by someone who was in for armed robbery. Another drug addict. She said not to worry, we all feel like that on arriving in prison. This in itself is interesting. Throughout my sentence I found that the processes I went through were mirrored by my fellow prisoners: the despair, the anguish. It doesn't just happen if you are middle-class. Prison is destroying for most if not all of the people who go through it. It is essential to find ways of coping; to harden up.

For me, everyone on this new prison wing seemed hard and scary. But my armed robber friend ended up spending much of her sentence in healthcare because of ill-health, depression, internal terror and despair. That is why people take drugs, or drink to excess, because they can't manage any other way. Should we be placing these times of unbearable pain and distress into the punishing environment of prison? some ways it did. I wasn't really picked on and I managed to keep my dignity. In other ways it did not. On release I had manufactured my own psychosomatic response: I had developed breast cancer while in prison.

'You put on a shell when you come in here J because you have to', a prisoner said at one of our dialogue groups. 'It's because kindness is seen as weakness. It's easy, but then when you get out you forget that you have this shell on'. Another man said, when challenged about the prison bravado being displayed in the dialogue group: 'It's when the cell door shuts and your head hits the pillow that you feel it'. Then, when the issue of drugs came into the dialogue, a third male prisoner told us: 'Drugs fill the empty hole inside'.

Working as a psychoanalyst, I'd come across that empty hole inside before. Broadly speaking, it's a common component of borderline conditions, personality disorders, insecure and disorganised attachment patterns. Inside that empty hole should be caring, loving and safe figures from childhood and from later life. Suppose the parents had been depriving, neglectful, insecure themselves; suppose

they had tried to love this child but for some reason the 'fit' between parent and child was not good enough; suppose the child had been exposed to the trauma of unthinking neglect or sheer, brutal abuse? The terror of the emptiness is what causes some people, when they have a drink or try out drugs as part of the adolescent rite of passage, to become addicted. The black hole, the vortex within. Sending addicts to prison re-ignites old traumas and adds to the terror, the despair; the fragile self disintegrates further.

I know that much good work is being done in prisons to combat drug abuse, but do we really think that the occasional CARATs session, that giving people the first five of the 12-step programme or whatever it is over a few weeks will cure their addiction? For some it might, some for a while, but I have met plenty of folk in prison for whom these interventions would be laughable if it was not so tragic. A friend of mine who still works in my old profession of homelessness, which of course encompasses a great deal of work with active drug addicts, told me not so long ago that if any of us (us being the comfortable middle-class) had just one of the myriad of disasters that dog her clientele, we would be in therapy for years.

In fact, the trauma of prison can open up those old buried traumas and bring them back to consciousness. One prisoner had forgotten about the physical abuse he had suffered as a boy. During his prison sentence, he started to be plagued by thoughts and dreams about it. The experience all but destroyed him. The effect on his wife and kids was devastating.

Journalist Nick Davies writing recently in *The Guardian* described his experiences thus:

A week in court is a week watching a billion-pound machine hurt people who need help. The police and the prosecutors and the defence lawyers who mingle in the big hall outside the courtrooms agree that most property crime is committed by drug addicts; most violent crime is committed by people who have been drinking; most people who come through these courts are desperate in one way or another. 'Is there any evidence that anything that these courts are doing is having any impact on the amount of crime which is committed out on the streets?' They laugh at that idea.

Laughing at the tragedy of it: if they didn't laugh they'd cry. So here we are, committing those 'hurt people' that Nick Davies writes about to the pains of

imprisonment. For as the eminent Professor of Criminology Nils Christie says, prison is all about pain and punishment, and I found that out for myself during my seven months of incarceration.

Alienated and angry, depressed and despairing; however offenders deal with their problems, being in prison tends to make them worse.

Sending addicts to prison re-ignites old traumas and adds to the terror, the despair; the fragile self disintegrates further.

Being removed from all the familiar elements that make up the person's life, the identity disintegrates, the self fragments, personal defences struggle to maintain themselves and harden up. The aim is to become hard as steel so that the prisoner can laugh in the face of the screws and declare: 'I can do this sentence standing on my head'. Some people reach that point at times. Others fall apart completely,

as the increasing incidents of suicides attempts and self-harm in prison shows us.

Here is another quotation from one of our dialogue groups:

I don't care what anyone says, you are feeling low about yourself when you commit a crime whether you know it or not.

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An insightful remark, from someone who felt safe enough in the group to display a little of his personal vulnerability.

The prison environment

Many prisoners have reported that the prison environment is not a conducive one in which to take stimulant drugs such as amphetamines. Opiates, Pharmaceuticals and cannabis are said to be most appropriate within the prison context. I can understand that. In prison you want to relax and blot out reactions to what is happening, not intensify them. When I was in prison I smelt cannabis, saw heroin and was handed an ecstasy tablet. I chucked it into the bin. No-one wanted to take it and I am not surprised. Prison itself is a bad trip.

Prison drug use brings its own dangers. Prisoners' may switch from cannabis to heroin because it goes through the system quicker and is therefore less likely to be detected in a drug test. Some develop more harmful drug use, taking more risks with unusual and adulterated drugs, with un-sterilised syringes and by sharing injecting equipment, exposing themselves to viruses and infections. ! Getting hold of the drugs is risky too. Prisoners can incur j debts and face threats of violence or bullying. They can be J pressured to get their visitors to bring in drugs. On release ; there is the very real risk of overdose. x

Is prison the right place for a drug addict? And with so many addicts inside, is it a safe place for someone who doesn't use drugs? I am not a heroin addict but at a low point I was seriously tempted to accept the offer of a toot; an offer of the chance of an hour or so release from the pains of imprisonment. I resisted, but I came out having learnt plenty of the tricks of the trade, including multifarious methods of drug importation.

The fact is that our police, courts and prisons are increasingly being called on to solve what are essentially social problems. The level of damage and difficulty among the prisoners, and the huge old Victorian prisons which are full to bursting, reminds me of the Victorian mental asylums that were mostly closed and torn down in the final few decades of the last century as part of the laudable community care programme.

Dr. David Clark, who took part in this process in my home town of Cambridge by modernising Fulbourn Hospital, says in his book *Social Therapy in Psychiatry* (Pelican Books, 1974) that many of the men in prison remind him of those who 'filled the back wards of the old custodial asylums'. People now suggest that there are more mentally ill people held in prisons than in psychiatric institutions. How damning of our welfare systems, that so many vulnerable people are incarcerated in these punishing environments. We need a community care approach to criminal justice with proper, well-funded policies to work on developments in community and restorative punishments.

So the government gives us custody plus, custody minus, DTTOs, revs up prison education departments to concentrate on literacy and numeracy — very good, but at the expense of other classes. It talks the talk on resettlement, but as usual there is too much spin and too few resources. Prisons I know of are having to cut back on their budgets and the probation service reports itself to be in chaos.

And what is the Prison Service up to? At its conference this year its Director General Phil Wheatley said:

Drug dealing in prisons appears to be becoming more organised. We will need to ramp up our anti-drug measures.

Now, of course Phil Wheatley takes his responsibility for security in our prisons seriously, and of course, drug dealing is continuing in prison, it always will.

As a number one prison governor told a national newspaper on my arrest (which incidentally was for allowing drugs to be supplied at a day centre for the homeless) if me and my co-defendant were guilty, said this governor, so was he. He said there was no way anyone could

provide a drug-free environment, even in a boat at sea. After all, that boat has to take on supplies and, unknowingly or not, if drug addicts were aboard drugs would be coming aboard too. Supply and demand. The cornerstone of our civilisation.

My main concern about Phil Wheatley's anxious measures is what they will do to prisoners in terms of creating an environment in prison that is harsher than before. More pain, more damage. A little over one in ten of the mandatory drug tests in prison prove positive. Considering that heroin is the main drug in prison, and that it leaves a person's system after three days, it's obvious to anyone that there are plenty of drugs in prison.

So we create drug-free wings, a good idea welcomed by many prisoners. Even by one man I met, who was in his forties and had spent most of his life in and out of jail: 'Gives me a bit of a rest from the drugs', he said. 'Gives my body a chance to catch up. Trouble is, I only need a few weeks for that and the courts keep sending me away for years instead'.

What can be done?

While prisons can help some people with a drug problem, imprisonment cannot deal with addiction *per se*. Prisons can and do provide the containment needed, by some people whose lives are in chaos. However, our prisons are outdated and the regimes generally do not have a rehabilitative effect. In fact, the effect is de-habilitative. Furthermore, prison health services tend to be underdeveloped — especially when compared with community-based services. There are less of them, they are often poorly funded and under-staffed. Specialist treatment is hard and often impossible to access. In time, we hope that the current mainstreaming of prison healthcare will improve things. Again, resources will dictate what can be done.

Some people say that prisons offer a unique opportunity for help and treatment, and for assessing treatment needs, since the majority of problem drug users are likely to pass through prison at sometime. This is the fact of the matter: our prisons are housing drug addicts in large numbers and, with the containment prison provides, there are opportunities that we need to grasp energetically. Unfortunately, the problem of over-crowding, caused by too many people being sent to prison and frequently for too long, and the problems of under-funding lead to the work being done in half measures, with inevitably disappointing results.

I would now like to look at what happens but also at the potential, at how we could make better use of

what is available; at how our prisons could more effectively deal with addiction. I expect that what I am going to present is known to many of you but my aim is to try to reflect the main issues in a systematic way. I agree with Mike Spurr that there are three clear strands to a drug treatment: detoxification, rehabilitation and after-care. Through these stages, there needs to be a constant focus on resettlement: ensuring that individuals have the tools and resources they need to manage a drug-free life once the programme is complete.

3

Detoxification

My pal at Holloway was at the time, which was a few days prior to the start of the new millennium, rightly concerned about the limits of the prison detox on offer. I heard tales of the disturbing conditions in Holloway's healthcare, and at the former women's prison, Highpoint North in Suffolk, which is where I was subsequently sent. Seriously disturbed women were held alongside the less disturbed, and the sane but withdrawing addicts. When out on exercise at Holloway I saw faces at the windows of those women I got booked in with, taut and wan. They had been confined to their cells in healthcare throughout. At Highpoint the clamour for drugs at healthcare was desperate; so much so that any requests from addicts or otherwise were treated at the hatch with contempt.

It is with great relief that I hear that HMP Styal has begun to use methadone for detox. The downside is that the detox as I understand it lasts just two weeks. I have heard of a London men's prison that provides ongoing methadone scripts. There is a lifesaver for many an addict, but available to all too few. A year or so ago there was an article in the national press by an addict describing how he settled into his methadone script while in prison, only to find that on release he couldn't get hold of any. He committed crimes to feed his habit and was glad to get back to his script in prison.

Nevertheless, progress has been made. Detox is accepted as part of the prison regime, and I'm sure to good effect. One researcher compared 30 prisoners who had taken part in a Drug Reduction Programme in Edinburgh prison with 30 prisoners who had dropped out of or had no contact with it. Those who had attended the drug reduction programme were found to have lower levels of drug use while in prison, but the effect of the programme when prisoners were released was not measured. It was measured in studies in the States and in Australia. This time the study looked at the provision of methadone in prison. Again this option considerably reduced the amount of drugs used in prison,

but again its impact on re-offending and retention in treatment upon release was scarcely noticeable.

Another study was made on the KEEP programme -7 in New York, whereby offenders had methadone maintenance for the duration of their sentence, with a

view to participation in a community-based programme on release. It was found that the majority of the 3,000 prisoners taking part every year made contact with the community-based projects on release. Drop-out rates were high at 40 per cent but researchers commented that the value of this programme lay in its ability to provide a bridge to community-based treatment.

Perhaps this is a way forward for addicts serving short sentences which offer too little time for engagement in rehabilitation while in prison: offer a detox but, importantly, give methadone maintenance for those whose habit is ingrained and, again importantly, ensure they have appropriate community programmes waiting for them on release.

However, it goes against the grain, doesn't it, to give addicts, prisoners, what they want and need. It was good to hear, a little while ago, the Home Secretary authorise clinicians to give heroin in a medically controlled way to those whose heroin habit was otherwise untreatable, but deeply frustrating that this is limited to a minuscule number of people.

We have veered away from the issue of detox, which is just the first stage, though a crucial one, of the process. Essentially, the quality of the service offered needs to be at least the same as the quality of community-based detox. We are moving in that, direction but there is a way to travel yet.

Rehabilitation

There are no quick fixes to delivering effective rehabilitation to addicts. One Drug Action Team co-ordinator was quoted last year in the national press:

The (government's) demand for quick hits and early wins is driven by a central desire analogous to the instant gratification demands made by drug users themselves.

It goes against the grain, doesn't it, to give addicts, prisoners, what they want and need?

Now, that's insightful. This person complained that monitoring had become almost religious in its status, as had centralised control.

laughing all the way to the bank and beyond, as we tie ourselves in knots with good practice guidelines and monitoring. It's like trying to

The criminal gangs that control the market are

fight with one hand tied behind your back, a boxing glove on the other and strict instructions not to punch.

While some determined and courageous drug addicts can successfully take their lives forward with a relatively short programme plus some practical help to sort their lives out, sadly this is not, I believe, the case for the vast majority. What an insult, to give someone two or three months to address a drug problem which may have deep roots in the person's psychology, or that might stem from severe abuse or from fearful neglect. Years of self-medicating through illegal drugs cannot be undone that easily. To expect it, could be seen as exposing the offender to further abuse.

We know there has been good work done by prisons in establishing drug free units (DFUs). Research by Europe's Pompidou Group showed these had a more open and less hostile atmosphere than the ordinary prison wings and that there was less drug use on them. Prison staff know how different a drug-free wing can feel. However, two years after release the research indicated that there were no demonstrable differences in drug use, recidivism and psycho-social functioning between those on the DFUs and those who were not. So this is a useful but short-term measure.

Therapeutic communities (TCs) have been shown to make a difference in prison. By providing a total treatment environment which organises itself around the often intense day-to-day relationships that this generates, TCs can fill the empty hole inside that addicts talk about, the empty hole that they have previously filled with drugs and that is said to be caused by inadequate relationships from the past. Not only are TCs a treatment for substance abuse: they are becoming the treatment of choice for personality disorder, a condition which is endemic in the prison population. A key to success is ensuring that the individual has long enough treatment: no way should we be swayed by what the DAT co-ordinator described as the government's desire for quick hits, for instant gratification. Evaluation in Europe and the States shows that the most effective TCs are those that have a full programme, such as one in Texas, which lasts for 21 months. This programme includes nine months in a prison TC, three months in a transitional treatment centre immediately after release and nine months in out-patient follow-up.

The results of evaluation of this type of programme are similar to those of community-based therapeutic

communities (Hough 1996); the longer people remain in treatment, the better the outcome, and those who continue with treatment do better than those who drop out or who do not receive treatment. An evaluation published in 1997 of the TC approach to drug treatment in Delaware indicates that on its own it achieves little when compared to a multi-stage therapeutic community treatment system. Eighteen-month follow-up data were analysed for those who received treatment in a prison-based TC only, in a work release TC followed by after-care, and in a prison-based TC followed by work release TC and aftercare. These were then compared to a non-treatment group. The authors observed a:

Reductions in re-incarceration of more than 40 per cent at 12 months and more than 50 per cent at 24 months after release were found for the group that completed prison TC plus aftercare.

'Consistent and persuasive pattern of results ... supporting the continuum of TC treatment for the reduction of drug use and recidivism' (Inciardietal. 1997 'An effective model of prison-based drug treatment' Journal of Drug Issues, 27-2).

The extension of the TC to the period when drug-using prisoners were released into the community brought a significant reduction in drug use and re-offending. Especially interesting for us, the group that was only exposed to the prison-based TC did not differ significantly from those who had no treatment. Research done in San Diego (Wexler et al 1999, *The Amity prison TC evaluation re-incarceration outcomes. Criminal Justice and Behaviour*, Vol. 21, No.2, pp 147-167) randomly assigned prisoners to two groups: a prison TC with aftercare group and a no treatment group. Reductions in re-incarceration of more than 40 per cent at 12 months and more than 50 per cent at 24 months after release were found for the group that completed prison TC plus aftercare. There has been similar research in Europe.

We are developing more rehab for substance abusers in prison. My complaint is that we are going for the quick fix and, in the end, we will pay for that. A few CARATs and a bit of 12-step will not, and is not, giving us the results we need; nor will short-term TC treatment. As Grendon showed us in its research, lasting change takes time.

As Dr. David Clark, the psychiatrist who modernised psychiatric services in Cambridge, writing 30 years ago in his book on *Social Therapy in Psychiatry* said:

It may be that some day our society, prodded by the reformers within the system, may begin to

see that social therapy (that is therapeutic communities) offers a way to let some of these men (and women) out of their dreary spiral of life-long imprisonment and reconviction.

Reformers within the system: that means you. But there is also the issue of why we use prison. Why not, in the first instance, offer a community-based programme of rehabilitation? On this issue, Robert Sharpe, programme officer at Drug Policy Alliance in the United States, wrote in 2002:

There is far more at stake than tax dollars. The drug war is not the promoter of family values that some would have us believe. Children of prisoners are at risk of educational failure, joblessness, addiction and delinquency. Not only do the children lose out, but society as a whole does, too. Incarcerating non-violent drug offenders alongside hardened criminals is the equivalent of providing them with a taxpayer-funded education in criminal behaviour.

Turning drug users into unemployable ex-cons is a senseless waste of tax dollars. It's time to declare peace in the failed drug war and begin treating all substance abuse, legal or otherwise, as the public health problem it is.

Aftercare

I am very concerned about returning prisoners after rehab to what prisoners at Grendon call 'the system'. That is, sending people back onto ordinary prison wings after treatment. It doesn't make sense and is likely to undo much of the good work that has been done. Similarly, many ex-prisoners have no choice but to return to the community from which they originally came. This will often be to areas where exposure to others using drugs is likely. The resolve prisoners developed not to use drugs on their release may quickly disappear. As a prisoner in one of our dialogue groups said:

When you come out everyone wants to give you a free hit to sort of welcome you back. This goes on for maybe a week and then it stops and you realise that you've got a habit again. So where does that leave you?

Well, I guess it leaves you back where you were. As the research I have seen consistently shows, aftercare in what some describe as a work-based TC is crucial to success. We have to accept that this kind of aftercare just (cannot be provided by a probation service that describes itself in chaos and is seriously over-subscribed. No quick fixes, these are the facts: a full programme in prison of

nine to 18 months, aftercare for six to 12 months and ongoing resettlement and follow-up as needed. It may cost plenty, but the revolving door in and out of prison, the drain on the NHS and homelessness providers, in the long run costs a lot more. We have the choice: a knee-jerk War on Drugs reaction or, as the Irish picturesquely say, looking at the problem with the long finger. That is, taking the longer view.

Conclusion

Much more could be said. For instance, what about alcoholics — I have centred my thoughts here to drug addicts, and to heroin, that being the main drug of addiction. What about crack cocaine? There is no medical alternative to crack, though there are alternative treatments that have proved successful, like acupuncture, shiatsu massage, herbs, yoga and tai chi (Not available in prison of course). When I was inside I met an elderly lady who had treated her arthritis for years with alternative remedies, she wasn't allowed them in prison and her condition was worsening. Then we have methadone recipients who become alcoholics in the community, swapping two drugs for one (methadone and alcohol for heroin) with the obvious chaotic result. They need heroin maintenance but won't get it, though I am continually surprised at the number of quite influential people I meet who support that. In Switzerland there is a prison where heroin is given out on prescription. Never in Britain though. We can't give 'em what they want.

There is a lot of further thought we need to do if we can open our minds to it. The first thing the Prison Service needs to do is to tell it like it is. How can prisons, with budgets being pared to the bone and numbers of drug-addicted prisoners swelling to unmanageable proportions, be expected to do the impossible? It reminds me of when I was in charge of the charity Wintercomfort. At our open-door day centre we also saw swelling numbers of drug-addicted clients. We struggled on, trying to reassure our funders that we were managing, afraid of losing the money that kept us going. In the end I got imprisoned for allegedly allowing drug dealing on site. We could not work with that level of addiction. It was grandiose of us to expect that we could. In retrospect, I should have told the funders so. Similarly, the Prison Service is being grandiose in pretending it is coping too, that it is dealing with addiction. Of course, like Wintercomfort, the service wants to keep the contract, but I think it has a responsibility to its prisoners, its staff, and to society as a whole to tell it like it is. By not doing so it is perpetuating a lie: that imprisonment as it is today can Really deal with addiction) Cut down the prisoner numbers, provide decent regimes and professionally-run TCs with proper aftercare and resettlement? based on the evidence of the research, then, and only then, it might be able to.