



DRUG POLICY Action Group
Re-thinking Drug Policy in Ireland

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KEY ISSUES FOR DRUGS POLICY IN IRISH PRISONS

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Policy Paper 3

KEY ISSUES FOR DRUGS POLICY IN IRISH PRISONS

By
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Drug Policy Action Group

The Drug Policy Action Group aims to promote an approach to drug policy that seeks to change ineffective, unfair and counterproductive laws on drugs, and to advocate for positive health and social service responses to drug use in Ireland. It also seeks to progress effective evidence based treatment models that engage drug users, families, and communities in the reversal of the harms associated with problem drug use. One of the main objectives is to promote the development of high quality information and education on drug use and drug policy. In doing so a series of discussion papers have been compiled. This third paper in the series examines the reality of and policy responses to drug-related problems within Irish prisons.

The Drug Policy Action Group (DPAG) is a member of the International Drug Policy Consortium (IDPC) which is a global network of 24 national and international NGOs that specialise in issues related to illegal drug use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. For more information see www.idpc.info

Introduction - The Current Context

There can be no doubting the magnitude, complexity and difficulty of the problem of drugs in Irish prisons. There is an abundance of research evidence on the extent of the problem. In 2000, a national survey of a representative sample of more than 1,000 prisoners found that 52% of all Irish prisoners had used heroin and over 40% had injected heroin.¹ In 2005, a survey of the psychiatric status of Irish prisoners found that 59% of male sentenced prisoners had a drug dependency problem, and 45% an alcohol dependency problem.² Only 26% of sentenced prisoners had neither a drug nor an alcohol dependency problem. Allwright et al³ in 1999 found that 43% of their sample of 1,188 prisoners from throughout the Irish prison system had experience of injecting drugs, almost exclusively opiate drugs. According to oral fluid assays undertaken for this study, 38.5% of all prisoners tested showed evidence of either hepatitis B, hepatitis C or HIV infection. Among injecting drug-using prisoners specifically the prevalence rates of hepatitis B, hepatitis C and HIV were, respectively, 19%, 81%, and 4%. The National Steering Group on Deaths in Prisons⁴ found that, excluding all prison suicides, in some cases of which drugs may have played a crucial role, there were 11 drug-related deaths in Irish prisons between 1990 and 1997. These 11 deaths were due to accidental overdose or choking on vomit. Indicating the intensification of the problem, in the most recent single year for which there are statistics (i.e. 2006), there were 12 deaths in Irish prisons, the majority of which were drug-related in one way or another.⁵

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The drugs problem clearly poses immensely difficult challenges for many prison services, especially the health, rehabilitation and education services. Equally, it poses extremely difficult challenges for law enforcement and security in Irish prisons. This is not simply a question of dealing with the large number of addicted persons being sent to prison, many of who have severe physical or psychiatric drug-related illnesses, but also of dealing with the on-going circulation of illicit drugs within the prisons. There is irrefutable evidence from surveys and from the results of mandatory testing that many drug users continue to take drugs in prison.⁶ There is even substantial evidence that people begin drug use or graduate to more serious forms of drug use in prison. In fact, one survey of prisoners suggests that as many as 21% of intravenous (IV) drug users first injected drugs while in prison.³ A prisoner culture has developed in Irish prisons, which is not only resistant to drug rehabilitative efforts but itself successfully propagates and perpetuates pro-drug values. Given the extent of the problem of addicted and ill prisoners and the fact that a powerful drugs culture pervades most Irish prisons, it is an enormous challenge to maintain a prison environment that is secure, safe, ordered and law-abiding. Unfortunately, in many ways it is obvious that the Irish Prison Service has long failed and is continuing to fail to meet this challenge.

Writing in 2006,⁷ the Chairman of the Parole Board stated that "The Board views with great dismay the fact that drugs are available in so many places of detention in the country. We have even seen examples of prisoners who went on drugs for the first time whilst in custody. Whilst this difficulty arises in other jurisdictions the information we have gathered reveals that it is far less prevalent than in Irish prisons and what can be done in other jurisdictions can surely be done here."

The European Committee for the Prevention of Torture (CPT) made a fourth periodic visit to Ireland in October 2006 and they reported on this visit in October 2007 in terms that make it clear that the drugs problem in prisons is as serious as ever and very probably worsening.⁸ In their report, the CPT delegation observed that drug misuse was a major challenge in all the prisons visited. They state that "the management and health-care staff in most prisons visited acknowledged both the rising numbers of prisoners with a substance abuse problem and the widespread availability of drugs within prisons. Further, drugs were a significant element in making a number of prisons unsafe for inmates and staff."

The CPT were alarmed at the culture of intimidation and violence in Irish prisons especially, Limerick and Mountjoy Prisons and St. Patrick's Institution, all of which they considered unsafe for prison staff and prisoners. The CPT met numerous prisoners who were the victims of bullying and inter-prisoner violence. For example, they describe meeting one young inmate who had been assaulted and kicked in the head, with a brief loss of consciousness, and another who had had his jaw broken when attacked by two prisoners wielding a sock filled with several large batteries. The CPT connect this violence to the availability of drugs and the lack of purposeful activities and state that "the increased use of and demand for drugs within prisons is fuelling a younger, more aggressive prison population, who have little to do

1 Hannon F. Kelleher C. and Friel S. (2000)

General Healthcare Study of the Irish Prisoner Population Dublin: Stationery Office

2 Kennedy H. Monks S. Curtin K. Wright B. Linehan S. and Duffy D. (2005)

Mental illness in Irish prisoners: psychiatric morbidity in sentenced, remanded and newly committed prisoners. Dublin: National Forensic Mental Health Service

3 Allwright S. Barry J. Bradley F. Long J. and Thornton L. (1999)

Hepatitis B Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk Dublin: Stationery Office

4 National Steering Group on Deaths in Prisons (1999) *Report* Dublin: Stationery Office

5 Annual Report on Prisons 2006 Longford: The Irish Prison Service

6 Lally C. (2008) '40,000 positive drug tests in prisons' *The Irish Times* Feb. 18th; O'Mahony P. (1997) *Mountjoy Prisoners: A Sociological and Criminological Profile* Dublin: Stationery Office

7 *Annual Report of the Parole Board 2005* (2006) Dublin:

Department of Justice, Equality and Law Reform

8 European Committee for the Prevention of Torture *Report on Visit to Ireland 2006* (2007) Dublin: Department of Justice

besides plotting how to get their next fix. Further aggravating factors include the existence of feuding gangs carrying on their vendettas within the prison environment; the lack of an individualised risk and needs assessment for all prisoners; the lack of space and poor material conditions in prisons.” Since 2004 there have been three homicides of prisoners by other prisoners in the Irish system. There has been a drug connection of one kind or another in all three killings⁹.

Official policy

The Irish Prison Service published its latest drugs policy and strategy paper, entitled *Keeping Drugs out of Prison* in May 2006. This policy statement was a rather belated articulation of, then Minister for Justice, Michael McDowell’s commitment to the idea of a totally drugs free prison system. While a drugs free prison system had been the explicit aim of the Irish government since 2002,¹⁰ in September 2004 Mr McDowell¹¹ promised to introduce whatever tough measures were needed to end the supply of drugs in prisons and claimed that in this way the prisons would be made drug free within 18 months. As its title declares, *Keeping Drugs out of Prison* states that the main aim of current strategy is to achieve drug free prisons and makes it clear that the chief means by which this aim is to be achieved is through supply control. In operational terms this mainly involves an escalation of surveillance and searching and a hardening of security controls, especially in areas, such as the visiting rooms, where there is a risk of contraband drugs entering the prison. Mandatory drug testing and punishment for drug using offenders and incentives for those who cooperate with the testing regime are also part of this tougher approach.

In addition to prioritising the elimination of the supply of drugs into prisons, the policy document covers three other areas in which the IPS (Irish Prison Service) has stated objectives. These are: 1] responding to drug abuse through a) identifying and engaging drug misusers, b) providing them with treatment options and c) ensuring there is appropriate through-care; 2] developing standards, monitoring and research on drug issues; and 3] the provision of staff training and development.

Keeping Drugs out of Prison makes three key statements of principle. These are: 1) The presence of drugs in prison will not be tolerated. 2) Prisoners will be encouraged and supported to develop a responsible attitude to drugs, both while in prison and following release, through a range of measures including education and counselling. 3) Prisoners who are addicted to drugs or have other medical problems caused by the misuse of drugs will be offered every reasonable care and assistance.

Current prison policy on drugs and key issues arising will be examined below following the format of the National Drugs Strategy¹² as modified by the mid-term review.¹³ This establishes five pillars under which action will be taken: 1) supply reduction; 2) prevention; 3) treatment; 4) rehabilitation; and 5) research. Before proceeding to this, however, it is useful to reflect on the recent history of the response to the drugs problem by the Irish prison system.

Of course, current policy must always primarily address present circumstances. Policy-makers rightly conclude that past mistakes

cannot be undone and that the urgent task is to deal with current realities and move forward. On the other hand, policy-makers and politicians often stress the urgency of current problems and suggest that they are starting afresh with new thinking and newly minted determination, because this rhetoric can persuade people to overlook the relevance of past policy failure. But current policy is inevitably shaped by past policy and often faced with responding to its legacy of failure. It is clearly necessary to examine recent history in order to understand the present situation and ensure that past mistakes are not repeated. In fact, the analysis of the failure of past policy is especially important in this area because a powerful case can be made that the criminal justice system and the prison system in particular have played a very active, generally pernicious role in the creation and spread of drug-related harms in Ireland. In other words, it is arguable that past policy and its manner of implementation have not only failed to improve matters but have seriously aggravated the situation.

Our response to new drugs policy initiatives, then, should be shaped to a large degree by an awareness of how past policy has impacted on

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the problem and by knowledge of the extent to which past initiatives have actually been implemented. We should be concerned with two separate issues: 1) the overall adequacy of the policies themselves and 2) the adequacy of the implementation of the policies. Unfortunately, when policies are

not adequately delivered, it usually becomes difficult to separate these two issues and to properly evaluate overall policy.

The historical background to the current situation

The Misuse of Drugs Act (1977) began the modern era in Ireland with respect to the handling of illicit drug issues. The Act contained some enlightened elements aimed at including harm reduction and the constructive treatment of drug users within a general prohibitionist framework. This dual approach has been popularly labelled a ‘cops plus docs’ strategy. The 1977 Act called for the establishment of a custodial drugs treatment centre and effective non-custodial treatments for drug-using offenders. However, despite the positive, evidently humane intentions of the legislation, a strongly prohibitionist mindset, which relied heavily, and rather naively, on law enforcement and repressive, punitive responses to drug use, dominated the public and political discourse on drugs in Ireland in the late 1970s and early 1980s. Despite the introduction - mainly in reaction to the threat of HIV - of some harm reduction measures in the mid-80s, the repressive, strictly prohibitionist mindset shaped the actual implementation of criminal justice drugs policy until 1996. In that year, largely in response to the murder of Veronica Guerin by a drugs gang and in response to a well-supported and vociferous community-based anti-drugs protest movement, there was a quantum leap in government investment in treatment and preventative services. However, despite the enormous increase in funding for harm reduction since 1996, repressive rhetoric and an over-emphasis on law enforcement solutions have continued to dominate the political debate and skew policy-making.

The prohibitionist policy focus in the 1980s discouraged and indeed effectively prevented the implementation of the more humane aspects of the Misuse of Drugs Act. A custodial treatment centre was not set up and non-custodial alternatives for drug-using offenders were not properly developed. These omissions had drastic consequences for the Irish prison system and indeed for Irish society. The prohibitionist policy focus also ensured utterly inadequate treatment facilities for prison inmates with drug problems.

Indeed, as was eventually admitted by the then Minister for State at the Department of Enterprise and Employment, Pat Rabbite, in the reports on the issue which he commissioned,¹⁴ the response to drug problems

⁹ Derek Glennon, a drugs gang member, was stabbed to death in June 2007;

Gary Douch, an addict, was beaten and strangled to death in August 2006

whilst under ‘protection’ in a holding cell; Alan Green, an addict, was stabbed to death in January 2004. All killings occurred in Mountjoy Prison.

¹⁰ *Agreed plan for Government between Fianna Fail and the Progressive Democrats 2002* Dublin: Fianna Fail and the Progressive Democrats

¹¹ Speaking at the PACE annual conference ‘After Crime & Punishment – Rehabilitation’ 28th September 2004

¹² *Irish National Drugs Strategy 2001–2008* (2001) Department of Tourism Sport and Recreation Dublin: Stationery Office

¹³ *National Drugs Strategy Mid-term Review* (2005) Department of Community, Rural and Gaeltacht Affairs Dublin: Stationery Office

¹⁴ Rabbite Reports (1996)

generally was woefully inadequate and drug users and young people from deprived areas, who were especially vulnerable to the attractions of drug use, were for many years almost entirely neglected. Minister Rabbite frankly admitted that the tragic consequences of neglect, lack of political will and insufficient funding for treatment and prevention were most obvious in the marginalised, deprived areas of Dublin.¹⁵ The same areas, which suffered most from the heroin epidemic, were those that had always supplied the majority of inmates for the prison system.

Of course, the drugs problem sneaked up insidiously on Irish society and on the Irish prison system in the late 70s and early 80s. Cultural change and economic growth and factors such as the globalisation of communications, trade and travel contributed very significantly to the onset of and continuing upsurge in drug misuse. Certainly, many of the causal factors in the rise of drug misuse were outside the sphere of influence of the Irish prison system or even the Irish government. However, the Irish authorities cannot plausibly excuse their drug policy failures on the grounds of impotence - that no one, facing the powerful heroin epidemic, which swept the U.K., Ireland and other countries in the early 1980s, could have done anything useful to reduce the harms of drugs. As is evidenced by the unfulfilled, constructive potential of the Misuse of Drugs Act 1977, the authorities had useful harm reductive alternatives available to them and were well aware that they had. However, they chose to place a disproportionate faith in the ability of law enforcement to eliminate illicit drug use. This policy preference contributed very significantly to the failure to initiate, implement or properly fund harm reductive, treatment and preventative actions.

The Irish authorities also cannot excuse the neglect of the key role of prisons in the drugs problem on the grounds of ignorance of the seriousness of the phenomenon. The Irish prison system was in possession of survey data on drug users in prison as early as 1981.¹⁶ This survey painted a vivid picture of the seriousness of the problem and provided dire warnings about the potential for the escalation of the problem. Two follow-up surveys in 1986¹⁷ and 1996¹⁸ documented the exponential growth of the drugs problem in prisons and the manner in which an almost unchallenged drugs culture was gaining an ever stronger grip on Dublin prisons.

The prisons as the epicentre of the drugs problem

Despite the fact that the Irish policy emphasis was resolutely on prohibitionist law enforcement - greatly to the detriment of harm reductive initiatives - in reality the system tended to imprison drug users only for their non drug crime, i.e. for their property crimes motivated by the need to raise funds for drugs.¹⁹ This had the unfortunate consequence

First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs and (1997) Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs
Dublin: Stationery Office

15 Minister Rabbite stated in his introduction to the second Report that "for a decade or more, this State failed to tackle effectively the spread in the illicit trafficking and pushing of opiates, the destruction of the lives of individuals, the havoc wrought in communities. It neglected adequately to address also the underlying forces at work in such communities that fed from within the drug phenomenon - their marginalisation within the formal economy; the geographical marginalisation that reinforced economic marginalisation; misguided approaches to public housing policy. Deficiencies in education and social policies also, for example, compounded the other forces at work. Work itself was made scarce in these communities. The result was a spiral of decline"

16 O'Mahony P. and Gilmore T. (1982) *Drug Abusers in the Dublin Committal Prisons: A Survey*
Dublin: Stationery Office; see also Sean Flynn (1986) 'Official neglect met drug problem' *The Irish Times* January 28th

17 O'Mahony P. (1987) *'Drug abusers in Mountjoy prison: Five years on'*
Dublin: Department of Justice 1987 Internal Document now available on the Health Research Board National Documentation Website

18 O'Mahony P. (1997) *Mountjoy Prisoners: A Sociological and Criminological Profile*
Dublin: Stationery Office

19 O'Mahony P. (2004) *'Drugs, Crime and Punishment: An Overview of the Irish Evidence'*
Administration (52,2) 3-35

that it made it easy for the prison authorities to largely ignore prisoners' addiction problems. Many addicted offenders were in prison but were not officially known as addicts to the system. On admission most prisoners were offered a short detoxification course to wean them off opiates, but many refused this, preferring that their addiction status remain unknown. The neglect of the drug problems of an ever-growing number of prisoners and the generally very poor treatment facilities meant that the prison system rapidly became a location where the main preoccupation of many prisoners was obtaining and using drugs and where drug-related harms, such as hepatitis, HIV, suicide and overdosing became highly concentrated.

The Dublin prisons and Mountjoy Prison in particular became the epicentre of destructive drug-taking in Ireland, playing a major role in the spread of pro-drugs attitudes and of seriously damaging forms of drug use. They became the centre of a virulently powerful drugs culture, notable for its embrace of reckless hedonism and mindless risk. In short, the very institution, prison, which was intended to be the main instrument of general and individual deterrence from drug use, became a hothouse environment, nurturing destructive drug use, unhealthy patterns of behaviour and wildly pro-drug attitudes.²⁰ Ever-increasing numbers of prisoners embraced a lifestyle centred on drugs; in effect, adopting a favourable attitude towards drugs and towards the opportunities afforded by the criminal drugs business. They tended to avoid serious consideration of risks and negative consequences. These behaviours, values and attitudes were sometimes initiated and almost invariably strongly reinforced within the prisons. They were destined to inexorably spread out from the prison to the prisoners' home communities. The situation was greatly exacerbated by the fact that the Irish criminal justice system failed to develop the non-custodial sanctions for drug-using offenders promised in the 1977 Act and continues to rely very heavily on short terms of imprisonment as a sanction for minor property offences. The fact that, for most of the period, Mountjoy was the only committal prison in the country also aggravated the situation. This meant that Mountjoy received thousands of new prisoners per annum, most of who spent only a short time in prison. These short periods in custody, however, involved a very intensive and frequently life-changing exposure to the drugs culture. The prisons inevitably became a training ground and recruiting centre for drugs gangs, producing hardened, drug-using young men, who felt no compunction about dealing in substances, which were wreaking havoc on their own families and communities as well as on their own health and life opportunities and who had little fear of the sanction of imprisonment or of public disapproval.

For many prisoners, the prison environment was not secure, safe, ordered or law-abiding.²¹ The prisoners' drug culture operating within the over-crowded, very poor material conditions of prisons like Mountjoy (lacking in-cell sanitation, sufficient showers and work, educational and recreational facilities) along with the essentially indifferent and unsympathetic attitudes of the system, as seen in the system's utter failure to provide appropriate levels of treatment, ensured that prison life was often intimidating, dangerous and nightmarishly chaotic for drug-using and non-drug-using inmates alike. Officially appointed watchdogs such as the Visiting Committees regularly reported on this state of affairs. For example, the Mountjoy Visiting Committee stated in their 1994 report that "the second highest category of complaints to the Committee are from prisoners stating that their wishes to go off or

20 See Yeates P. and Flynn S. (1985) *Smack: The criminal drugs racket in Ireland* Dublin: Gill and MacMillan; O'Mahony P. (1997) *Mountjoy Prisoners: A Sociological and Criminological Profile* Dublin: Stationery Office, (1996) Chapter 2 'Fix and Quick-fix: the Illicit Drugs Crisis' in *Criminal Chaos: Seven Crises in Irish Criminal Justice* Dublin: Roundhall Sweet and Maxwell, and (2008) *The Irish War on Drugs* Manchester: Manchester University Press; Keogh E. (1997) *Illicit Drug Use and Related Criminal Activity in the Dublin Metropolitan Area* Dublin: Garda Headquarters; Dillon, L. (2001) *Drug use among prisoners: An exploratory study* Dublin: The Health Research Board; O'Mahony P. and Barry M. (1992) 'HIV Transmission Risk Behaviour Amongst HIV-infected Prisoners' *British Journal of Addiction* 87, 11 1555-1560; Long J. Allwright S. and Begley C. (2004) 'Prisoners' views of injecting drug use and harm reduction in Irish prisons' *International Journal of Drug Policy* 15 139-149.

21 These are the goals laid down for the prison system in *The Management of Offenders: a Five Year Plan* Department of Justice (1994) Dublin: Stationery Office

remain off drugs are being consistently frustrated both by the pressure of the present drug culture in Mountjoy or by the absence or the near absence of appropriate support services".²²

Prison life heaped numerous indignities, degradations, risks and miseries on inmates. Notable among the events exemplifying this state of affairs was the inhumane treatment of the dozens of prison inmates who were discovered to be HIV positive following compulsory testing in 1986. These inmates first discovered their HIV positive status when prison officers clothed in space-suit like garb rounded them up from their various locations and herded them to an isolation unit at Arbour Hill prison. The Head Teacher at Arbour Hill was to lose his position when he spoke out on the *Late Late Show* about the humiliation and stigmatisation suffered by these inmates and about the appalling insensitivity and lack of compassion of the authorities. The miserable conditions, in which HIV positive prisoners were later held - sometimes until their deaths - in a dungeon-like prison within a prison at Mountjoy, were egregiously inhumane and a blatant indictment of Irish society. Much suffering connected to drugs continues today in a system, which still drastically fails to fulfil its stated mission to make the deprivation of liberty the only punishment inflicted on prisoners.

Indicating the serious, long-term failure of the prison system to address the drugs problem and the continuation of this failure - even long after a more appropriate level of services was being provided in the wider community - the Director of Prison Medical Services stated in his 1999 report²³: "for a considerable number of years previous reports (of the Director) have lamented the failure to adequately address the problems associated with drug abuse among the prison population. The ongoing lack of adequate therapeutic resources allocated to tackling the problem within prisons has become more marked in the context of the large amount of resources being devoted to addressing the problem in the general community, most specifically to those communities which are particularly affected by drug abuse".

Judge Bridget Reilly was appointed to the Irish Drug Treatment Court in 2001 - this Court is a long overdue, positive, but as yet too small-scale, attempt to develop non-custodial responses for drug-using offenders.

Speaking from her depth of experience of the situation, Judge Reilly recently said²⁴: "I have viewed the awful cycle of drug abuse-offending-imprisonment-release-drug abuse-offending-imprisonment, and was struck with a realisation of the hopelessness and ineffectiveness of the situation. The cycle is self-perpetuating and in turn influences a wider pool, a new generation, increasingly in larger numbers and more and more associated with serious violence. It seemed obvious that imprisonment failed to break the cycle or to act as a deterrent to further offending. Ultimately the interests of the public at large are not met. Trust in, and collaboration with, the criminal justice system is undermined."

Two discourses on the prison drugs problem have become common and help explain why the appalling drugs situation in Irish prisons is not the well-recognised public scandal that it ought to be. The first suggests, no doubt correctly, that the drugs problem in prisons is a reflection of the drugs problem in wider society. The second emphasises the public health dimension, suggesting that prisons deserve special attention because prisons are a concentrated reservoir of disease, such as hepatitis, HIV and tuberculosis and, therefore, pose a high degree of risk for the spread of disease to wider society.

The former 'society's problem' argument is often used to deflect attention away from the abject failure of the Irish prison system itself to deal properly with its drugs problem. It may be true that the prisons will always have a drugs problem as long as there is a drugs problem in society, but this is a trite point which ignores the unique and central

role of the prisons in the Irish prohibitionist system and ignores the reality of the enormous independent contribution of the Irish prison system to the spread and escalation of destructive drug use in Irish society.

The second, 'public health' argument appeals to public and political self-interest and prioritises the 'common good.' It is commendable, insofar as it is a convincing and useful argument for sufficient attention and funds to be provided for prison-based drug treatment. However, the prison system should be operating to a higher standard than concern only for the public interest (whether in terms of economics, crime reduction or the minimization of health risks) and should have an equal concern for justice and human rights. This would include a principled, proactive commitment to promoting the health and well-being of prison inmates as ends-in-themselves and, above all, a commitment to avoiding unnecessary and preventable harm to inmates. Appropriate resources should not be conditional on the fact that prisoners represent a risk to the wider community, although the very real risk that does exist certainly underlines the urgency of the task. Moreover, the public health discourse is unsatisfactory because it focuses primarily on physical disease and fails to do justice to the social, psychological and behavioural factors, which are at the core of the drugs problem. The 'public health' discourse deflects attention from the problem by professionalizing and medicalizing it. This compartmentalisation of drug issues dilutes the moral impact of the scandal of the prison drugs problem and obscures its human rights dimension.

The lessons from hindsight

In short, the record of the Irish prison system in regard to the drug problem is extremely poor. There are obviously a number of important lessons to be learned from this dismal history. From the start of the serious prison drugs problem in the early 1980s, there have been major policy failures, both in conception and implementation. There has been a lack of public attention and political commitment, severe under-funding and a dearth of creative solutions. The response of

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the authorities has been characterised by neglect, apathy and defeatism and often by a callous disregard for the suffering of prisoners. Internal reports from the system provide compelling evidence that these failures have persisted despite the warnings

and pleas for improvements from medical staff, Visiting Committees, the Inspector of Prisons, the Chaplaincy and many others. As a result the present situation is possibly worse than it has ever been. According to the CPT, many prisons recently reported experiencing ever more serious drug-related problems and an increasingly violent and intimidating atmosphere linked to drugs.

Ironically, this lamentable record has been punctuated by numerous political and official promises to the effect that the system was at last responding properly to the drugs problem and would soon make significant headway in improving the situation. *Keeping Drugs out of Prison* is only the most recent in a long line of seemingly positive policy statements, which promise effective action. A crucial lesson, then, is to resist being dazzled by the public relations spin generated by the latest new policy statement - the over-optimistic rhetoric about starting afresh and building a new future. The past record of delivery on promises has been so dreadful that it is now merely realistic to not give the benefit of the doubt to the government and the prison authorities. The unfortunate fact is we can confidently anticipate that the system will fail to live up to its promises.

It is important that the media, the political opposition and the public do not give credit for the simple articulation of 'new' plans and promises and simply assume that these plans will be realised or are even realisable. Many prison drugs policy statements, like *Keeping Drugs out of Prison*, have been well-meaning and sensible, at least on the surface. They usually lay down goals to which everyone can subscribe and suggest

²² *Mountjoy Visiting Committee Report for 1994* (1995) Dublin: Department of Justice

²³ Director of Medical Services for the Irish Prisons Service

(1999) *Report* Dublin: Department of Justice

²⁴ Speaking at the Pompidou Group Conference on Alternatives to imprisonment in the treatment of drug-using offenders. Bucharest: 11th and 12th October 2007

initiatives which everyone can support. It is necessary, nonetheless, to evaluate each new set of official promises and continuously monitor their progress. It is important to critically evaluate plans in terms of the real benefits they might deliver and how exactly they will do this. Most importantly, it is necessary to monitor the delivery of new resources, structures, and actions and assess their adequacy and general impact. On the one hand, policy must be workable and effective and, on the other, it must be properly implemented with the fidelity, energy and resources required to fulfil its important goals. This, as the record shows, is a tall order that has been rarely met in the past.

It is clearly vital to learn from the deficiencies of past policy and from the failures to deliver on policy. However, it is just as important to avoid the defeatist, cynical outlook that can derive from reflecting on the sorry history of the Irish criminal justice system's response to the drugs problem. Confident, positive attitudes and strong political momentum are required in order to drive and sustain effective interventions and genuine improvements. The drugs problem in prisons is now, partly because of past failures, extremely complex and difficult, but it is not beyond help. An understanding of past mistakes should not be allowed to engender a sense of hopelessness about the task of confronting the current appalling legacy of those mistakes. On the contrary, the failures of the past can and should inspire a determination to redouble efforts and do whatever is necessary to improve matters.

It is also important to remember that many of the initiatives that have been taken by the Irish prison system over the last 20 years have in fact been at least partially successful. While clearly nowhere near sufficient to overcome or even hold back the prison drug culture, these initiatives have achieved considerable benefits for many individual prisoners. It is important to recognise the dedication and good work of the many people working with drug-using prisoners and the usefulness of projects such as drug free zones, extended methadone-based detoxification and Narcotics Anonymous among others. The positive potential of the Drug Treatment Court is obvious, although this initiative came much too late to make the kind of positive contribution that, by diverting petty, non-violent drug using offenders away from prison to treatment, might have prevented the development of many of the problems in the first place.

Many of the current initiatives of the Irish system are in fact essential to a balanced response to the drugs problem in prison. They have failed to have a system-wide influence not because they were ill-conceived or poorly executed, but because most often they were small, token or pilot projects, which were under-resourced and not large-scale enough to impact on the general situation.

In recent years the standard of medical care has considerably improved and funding has greatly increased for medication, consultants and doctors, nursing staff and psychologists and counsellors (recently a contract has been signed with the Merchant's Quay Ireland for the provision of the equivalent of 24 whole-time drugs counsellors to the prison system). HIV positive prisoners are no longer treated as pariahs and receive, as a matter of routine, the expensive medication which keeps the virus in check. There has been considerable effort to implement the policy of the Steering Group on Prison Based Drug Treatment Services²⁵ that "the Prisons Service must replicate in prison to the maximum extent feasible the level of medical and other supports available in the community". These well-intentioned efforts have been recognised by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), which also, however, cites Ireland as an example of the persistent barriers to achieving the desired outcomes in this area. In their Annual Report for 2004²⁶ they state: "Many prisoners have restricted access to health services. Health professionals working in prisons have little contact with the regular health system; in addition,

they are unable to access further training, which aggravates the isolation of prison health services. These problems are difficult to overcome, as seen in Ireland, where, despite efforts by prison authorities and healthcare staff to improve access to treatment and healthcare services for drug users, there is little evidence of improvement".

The EMCDDA's negative assessment appears to attribute some of the difficulties to institutional and bureaucratic barriers and to the perhaps inevitable lack of coherence between prison and community services. As Wexler et al²⁷ have argued "most prison-based treatment programmes operate under so many bureaucratic and political constraints that they are programmed to fail from their inception." A major difficulty is that prison authorities, however benign and progressive in outlook, cannot evade their primary law enforcement role. Their primary focus must be on the secure custody of convicts and, furthermore, as agents of the state, they are obliged not to ignore the legal reality that drug use is criminal.

However, the drugs problem, is not simply about health and legal issues. It also has important psychological and social determinants and effects, which need to be taken into account by prisons drugs policy. Even the material conditions of prison life play a significant role. So, for example, prisoners, who must live in the squalid, overcrowded and unsanitary conditions of a prison like Mountjoy, will not find their day to day lives greatly improved by the provision of a state of the art medical facility. In fact, the motivation, thinking, background and lifestyle of prisoners are key to the whole issue of drugs in prison. Many prisoners' lives revolve around not just using drugs, but talking and thinking about them, and smuggling and trading in them. Many prisoners are not motivated to change or at least not yet ready to cooperate with treatment programmes.

Indeed, the specific realities of prison life mean that, for many prisoners, drugs are never more attractive than in prison. The stress, idleness, boredom and ubiquitous petty coercion of prison life make the pleasure, release and oblivion provided by the opiate fix or other powerful drugs especially attractive.²⁸ The acts of smuggling, trading, and drug-using in defiance of the rules of the prison can be particularly exciting and gratifying and can afford the prisoner a rare opportunity to secure the appreciation of fellow inmates. The general lack of autonomy experienced by the prisoner sharpens the sense of personal control obtained from controlling one's own internal psychological environment through the use of drugs. The psychosocial context of the prison, therefore, promotes both drug use and the drugs culture in ways which extend well beyond the simple pharmacological effects of drugs or the issues of individual physiological and psychological dependence.

Furthermore, under the best of circumstances in open society, treatment for drug addictions is beset with problems. Drug treatments invariably experience high failure and attrition rates. Very few treatment modalities can credibly claim much better than a 30% success rate.²⁹ The progress of an addict towards abstinence is very often slow and characterised by a series of setbacks. The recovery process often takes the form of a cycle of abstinence and relapse before permanent or long-term abstinence is eventually achieved.³⁰ This means that, as the Drug Abuse Council in the U.S. have pointed out,³¹ "the overall efficacy of treatment cannot be judged on the basis of a brief episode of treatment or by the immediate achievement of abstinence".

Another severe constraint that should be addressed by prison drugs

...the specific realities of prison life mean that, for many prisoners, drugs are never more attractive than in prison.

25 Report of the Steering Group on Prison Based Drug Treatment Services (2000) Dublin: Department of Justice

26 European Monitoring Centre for Drugs and Drug Addiction (2004) Annual Report Lisbon: EMCDDA

27 Wexler H. Lipton D. and Johnson B. (1988) *A Criminal Justice System Strategy for Treating Cocaine-heroin Abusing Offenders in Custody* Washington: U.S. Department of Justice

28 Dillon, L. (2001). *Drug use among prisoners: An exploratory study*. Dublin: The Health Research Board.

29 Parker H. (2007) 'The new drugs interventions industry: What outcomes can drugs/criminal justice treatment programmes realistically deliver?' *Probation Journal: Journal of Community and Criminal Justice* 51(4): 379-386

30 Marlatt G. Baer J. Donovan D. Kivlahan D. (1988) "Addictive Behaviours: Etiology and Treatment" *Annual Review of Psychology* 39 223-252

31 The Drug Abuse Council *The Facts about Drug Abuse* (1980) New York: The Free Press

policy is that in the prison situation there are all sorts of drug users, including 1) young people in the first flush of excitement about drugs, perhaps just beginning to experiment with opiates or IV use in the prison and more impressed and driven by peer pressure and the socio-cultural meaning of drugs than by the drug intoxication itself; 2) long established addicts who are HIV-positive or have other serious illnesses and have no intention of giving up drug use; 3) long-term users who have avoided serious illness and are now careful not to share syringes; 4) injecting users outside prison, who choose - for convenience or to enhance their sense of personal control - not to inject while in prison but instead smoke heroin or cannabis; 5) totally rash and uninhibited IV poly-drug-users who will use any drug in any way regardless of the consequences to themselves or others; and 6) users who feel desolate and destroyed by the drug experience and their prison life and who are close to suicide. Prisoner drug users will also have had varied experience of treatment programmes inside and outside prison and will vary greatly in their attitudes towards treatment. On top of all this, the penal status of drug-using prisoners varies widely. They may be unconvicted and 'presumed innocent' remand prisoners, or debtors, or people in contempt of court or convicts serving sentences, which might range from a few days to life. Young offenders, women prisoners and the increasing number of immigrant offenders from very different cultures present their own special challenges.

Appreciation of the limits of what might be achieved and of the obvious difficulties facing the prison authorities should not translate into disillusionment...

Prison-based programmes and the overall drugs strategy of the prison system must take account of all these differences and constraints. So too must the critics of prison drugs policy. Plainly, everyone must accept that drug treatment cannot always be relied upon to be effective in the short-term, that the current prison environment is in many ways not conducive to drug treatment, that prisoners often lack motivation for treatment and that prison life itself often promotes drug use. It is essential, therefore to set expectations at a realistic level. On the other hand, it is important to avoid self-defeating pessimism and reject the fatalistic view that the prison drugs problem is intractable and inevitable.

Appreciation of the limits of what might be achieved and of the obvious difficulties facing the prison authorities should not translate into disillusionment or into ignoring the past failures that have contributed to the present problems. There is no cause for defeatism based on the failure of past policies which were inappropriate or inadequately implemented. The urgent task now is to construct a system of treatment and rehabilitation built on a solid foundation of realism, pragmatism and purposefulness and inspired by a vision shaped by respect for human rights and justice.

A major lesson to be learned from past mistakes is that it is right and worthwhile to go to extraordinary lengths in terms of effort, investment and innovative thinking in order to provide an exemplary response to the drugs problem in prisons, even if this involves reshaping the general prison environment itself. The past tells us that extraordinary efforts are needed in order to decisively improve the current situation and avoid future disasters. The past also tells us that such efforts are warranted and potentially very worthwhile. Surely the lesson from history is that the prison system, rather than being neglected and left as the most inadequate component in a generally inadequate response to the drugs problem, should in fact be provided with the best possible facilities for tackling the drugs problem.

In order to achieve this goal, it will be necessary to confront and hopefully transform the Irish public's generally hostile and punitive attitudes towards the imprisoned. It will also be necessary to overcome the public's indifference to the conditions in which prisoners are held. The Irish public and their politicians tend to have sadly low aspirations for the Irish prison system and are widely presumed to resent the spending of public funds on improving prison conditions and on recreational, rehabilitative and other treatment facilities for prisoners. Many people appear to have a vested interest in ensuring that prisons

do not become and are not perceived as 'holiday camps.' The public and politicians frequently view prisoners as rightly punished outcasts, who have placed themselves in jeopardy by harming others and who are only getting their 'just deserts.' If prison conditions are appalling and prison life is challenging and dangerous, then this is the responsibility of the prisoners themselves. Convicted prisoners are seen as the least eligible for assistance and the least deserving of sympathy. However, this is a very complacent, self-righteous and short-sighted view that ignores the state's responsibility for how it punishes wrongdoers in the name of the people and ignores the many unjustifiable, collateral wrongs that the state commits against prisoners in the name of legitimate punishment. Official neglect and public indifference have contributed to the development of dangerous, degrading, and inhumane conditions of imprisonment, which should be a source of profound shame for the Irish nation. Moreover, these conditions of imprisonment have proven ineffective at achieving the key, penal goals of deterrence, reform and rehabilitation and the failure to provide the best possible or even an adequate response to the drugs problem in prisons has contributed significantly to the escalation of drug use and drug-related harms throughout Irish society. Principle and public self-interest, therefore, converge in support of the provision of the best possible prison facilities both for rehabilitation generally and for the social, psychological and physical treatment of drugs-related problems, specifically.

Key Issues: Supply Control

As *Keeping Drugs out of Prison* makes clear, current policy is primarily focused on creating drug-free prisons. On the surface this appears to be an eminently sensible approach. Possession of illicit drugs is after all an offence within and outside of prison. And a prison system that was securely free of illicit drugs and drug-taking would be an obvious blessing and would eliminate many drug-related harms and problems. On 28th September 2004,³² the then Minister for Justice, Michael McDowell announced that ridding the prisons of drugs was the main priority of his drugs policy for prisons and that he was confident that this could be achieved within 18 months. This target has not been met and, although for obvious reasons there are no accurate figures for the amount of drugs circulating in prisons, it is clear that a great deal of illicit drug use still occurs in Irish prisons and that the drugs culture still predominates there. For example, the Mountjoy Visiting Committee in its report for 2006³³ rather pointedly stated that despite commitments by outgoing Justice Minister Michael McDowell to tackle the drug problem in Irish prisons, illegal substances were still getting in and were widely available to prisoners.

The most important and damning evidence on the failure of the drug free prisons policy comes from the results of mandatory drug testing in the prisons. In February 2008, the Irish Times published the data it had received in response to a request under the freedom of Information Act.³⁴ These data covered the years 2005, 2006 and the first 9 months of 2007. Approximately 40% of all tests over this period were positive for illicit drugs and a little more than 25% were positive for illicit opiates. The rate of positive test results had not fallen over the 3 years despite the introduction of many of the more rigorous restrictions and supply control measures, which it had been assumed would totally eliminate illicit drugs from the prison system. Remarkably, the positive test result rate for Mountjoy prison was 75% and in the first 9 months of 2007 57% of tests in Mountjoy proved positive for illicit opiates. Conor Lally of the Irish Times, unsurprisingly, concluded that 'measures aimed at reducing drug consumption in Irish jails are having little impact.' Indeed, these results place the whole policy emphasis of *Keeping Drugs out of Prison* in serious doubt.

32 Speaking at the PACE annual conference

'After Crime & Punishment - Rehabilitation' 28th September 2004

33 *Mountjoy Visiting Committee Annual Report for 2006* (2007) Dublin: Department of Justice

34 Lally C. (2008) 'Prison drugs figures show extent of challenge ahead' *The Irish Times* February 18th.

A number of key issues arise concerning the drugs free policy:

- 1) Is a drugs free prison system in fact achievable?
- 2) What are the costs to the general regime in prisons of the various strictures and disciplinary measures required by a drugs free policy?
- 3) Does prioritising the drugs free policy deflect attention and resources from or is it in conflict with other useful strategies?
- 4) How can a drugs free policy be squared with an ever-increasing reliance in prisons on drug substitution treatments such as methadone maintenance?

Despite the original optimistic claims of Minister McDowell, the IPS and the current Minister of Justice, Mr Brian Lenihan, now maintain that the failures of the drug free policy are due to the as yet incomplete implementation of rigorous control methods. They contend that the supply control measures need more time to prove their effectiveness. However, the results from mandatory testing are so devastating as to suggest that a drugs free Irish prisons system may in fact be unachievable, at least by way of a policy founded primarily on supply control measures.

The present drugs free policy, whatever its feasibility, depends on repressive measures. This has unavoidable, negative consequences for the relationship between prisoners and prison officers and for the already highly circumscribed freedoms of all prisoners, not just those who use drugs. The policy requires tight controls over everyone entering the prison and everyone in contact with prisoners. This involves measures like drug-detecting sniffer dogs, glass screens between visitors and prisoners, x-ray machines, random searches of places and intimate searches of persons, and mandatory drug-testing. However, the ingenuity and daring of prisoners appear endless when it comes to finding ways to secure a supply of drugs. In a prison system dedicated to the drug free ideal, the failure of supply control measures to eliminate the supply of drugs to prisoners inevitably creates its own pressures for increasingly repressive measures. This leads to a vicious cycle of ever more oppressive measures with diminishing returns in the elimination of drugs but increasingly negative effects on the climate in the prisons.

It is relatively easy and obviously warranted to eliminate methods of supply that have made a mockery of the security of Irish prisons, such as the throwing of footballs and tennis balls full of drugs over the prison walls into recreation yards. However, there are very unfortunate consequences of ever tighter general controls that successfully shut off the routes by which prisoners access drugs, including an increase in tension between staff and inmates, a greater need for and therefore a greater possibility of corruption of staff and a marked increase in the intimidation of fellow inmates. The following are excerpts from the 2006 report of the Mountjoy Visiting Committee: "The trustees and non drug users are now under huge pressure to bring in drugs.....They are intimidated/threatened personally or by phone. Their families are also threatened. ...Prisoners who are allowed out on temporary release also come under huge pressure to smuggle drugs back into the prison." The Mountjoy Visiting Committee conclude that "the only way to protect the innocent is to introduce screened visits as part of an overall drug policy. Limiting this to known users or mules will only serve to increase the pressure on the innocent inmates." These comments illustrate how the constraints and intrusions necessitated by a drugs free policy inevitably tend to proliferate and impact on the quality of life and human rights of all prisoners and on the climate in the whole prison system. It is arguable that this policy approach will inevitably fail to create drugs free prisons, but in the course of trying will certainly create tougher, nastier and more volatile and dangerous prisons.

Mandatory drug testing is regarded as an essential component of the drugs free policy.³⁵ However, this approach has serious drawbacks and

in Scottish prisons has been withdrawn after 10 years of use because it was considered to be a waste of funds with little useful effect on drug use in prison - except possibly to encourage graduation to the more dangerous opiates from cannabis, which is more readily detected both because of its bulk and its longer presence in the bloodstream after use.³⁶

There is no doubt that the current drugs free policy has failed to deliver on Minister McDowell's promises for it. Indeed, given the negative consequences of the policy, it is questionable whether the policy has achieved significant net gains. Moreover, it is obvious that the policy deflects attention and resources from other, possibly more fruitful approaches and, indeed, that it is in conflict with specific harm reduction measures, which are strongly advocated on public health grounds.³⁷ For example, in a written answer to a parliamentary question (8th December, 2004) the then Minister for Justice, Michael McDowell stated his opposition to needle exchange programmes in the Irish prison system. He stated "needle exchange schemes would subvert and run contrary to increasing staff vigilance in searching for drugs and preventing them from being smuggled into prisons. I remain committed to pursuing government policy to end the use of heroin in Irish prisons. It would be a contradiction of this stated government aim for the Irish Prison Service to tolerate continuing intravenous drug use involving a needle exchange programme. Ending of all heroin use must mean just that."

Finally, there is a glaring contradiction in a system that claims to have a drugs free policy but increasingly relies on methadone maintenance. Methadone maintenance is a medicalised system for legally supplying opiates on a continuing basis. At one level this approach implies a tolerance of continued drug use. This creates an ambiguous and conflicted situation, where one cellmate could be legitimately receiving opiates from the prison authorities while the other is prevented by every means possible from obtaining similar illicit drugs and is open to punishment for actually obtaining them. Ironically, this approach normalises drug use because it encourages prisoners to opt into the prison system's legally condoned provision of an otherwise illicit drug (methadone).

It is relatively easy and obviously warranted to eliminate methods of supply that have made a mockery of the security of Irish prisons.

Key Issues: Prevention

Prison is not the most suitable environment for preventative programmes, such as educational projects aimed at persuading people to avoid drug use. Indeed, this area is not well developed within the prison system and does not appear to be a strong focus of policy. There are few effective initiatives in place despite the promise in *Keeping Drugs out of Prison* that a "key to development in this area will be the wide scale provision of informational and educational drug misuse programmes".

It could be said that the Irish Prison Service believes that keeping drugs out of prisons is the best form of prevention. However, this is another example of a situation where the perfect, but probably unattainable

prisoner, if so requested by a person acting on the authority of the Governor, shall, for the purpose of detecting the presence or use of intoxicating liquor or any controlled drug or any medicinal product other than a controlled drug or medicinal product for which a prescription has been issued by a prison doctor, psychiatrist or registered dentist, provide all or any of the following samples, namely, (i) urine, (ii) saliva, (iii) oral buccal transudate, (iv) hair.

(b) Without prejudice to any enactment, a refusal by a prisoner to provide a sample under paragraph (a) of this Rule shall be regarded as a breach of discipline under these Rules.

36 Dean J. (2005) 'The future of mandatory drug testing in Scottish prisons: A review of policy' *International Journal of Prisoner Health* 1, 2-4 163-170

37 Long J. Allwright S and Begley C (2004) conclude (in 'Prisoners' views of injecting drug use and harm reduction in Irish prisons' *International Journal of Drug Policy* 15 139-149) that injectors take health risks during detention that they would not take outside prison and Lines, R., Jurgens, R., Betteridge, G. & Stoever, H. (2005), suggest (in 'Taking action to reduce injecting drug-related harms in prisons: The evidence of effectiveness of prison needle exchange in six countries' *International Journal of Prisoner Health*, 1(1): 49-64) that "Based on the evidence and experience, it can be concluded unequivocally that prison needle-exchange programmes effectively address the health-related harms associated with needle sharing in prisons and do not undermine institutional safety or security."

35 *The Prison Rules (2007)* state at sections (5) (a) and (b): (a) In the interest of good order, safety, health and security and in accordance with directions set down by the Minister, a

solution, is the enemy of a merely good, but more realisable goal. Of course, if there were no drugs in prison, inmates would not be in a position to, for example, initiate drug use. In truth, the prospect of altogether banishing drugs is quite remote and so there continues to be a real possibility that inmates will begin serious drug use or start intravenous use in prison. Preventative programmes based on honest information, education and persuasion are therefore still very much required. Unfortunately, they tend to be discouraged or under-resourced in a system which believes that ever stronger repression offers the best solution to the drugs problem. Why should a system, which expects drugs to be totally unavailable to inmates within the next few months, be concerned to persuade inmates not to start using drugs?

Prevention is not just a matter of preventing the initiation of drug use or intravenous use in prison. Education and non-coercive forms of persuasion have an important role in motivating established users to confront and possibly gain more personal control over their own drug problems. Preventative programmes focused on harm reduction rather than drug use itself are also important in the struggle against blood-borne viruses, other health dangers and overdoses by prisoners who take drugs on leaving prison after a period in which their tolerance was reduced. A system, which puts all its eggs in the one basket of preventing access to drugs, will not be strongly motivated to run educational programmes based on harm reduction. For example, a drugs free prisons policy, which does not permit needle exchange projects, will obviously tend to undermine its own general credibility in offering harm reductive educational programmes.

Key Issues: Treatment and Rehabilitation

Keeping Drugs out of Prison describes the plan for treatment and rehabilitation in prisons as follows: "A prison based drug team with dedicated staff will be created in each prison, which will build on current arrangements in many institutions. All institutions, where appropriate, will provide the following core treatment options: Assessment and Through-care Planning Information; education and awareness programmes etc; opiate replacement therapies (where clinically indicated); detoxification, maintenance and reduction programmes; symptomatic treatment options; support services, to include mental health Supported Voluntary Drug Testing Units; and motivational intervention. Extended treatment options will be provided in specific sites based on assessed risk or needs of the prison population there. These will include: Evidence informed programmes regarding drug misuse and offending behaviour/Cognitive Behavioural Treatment programmes/12 Step programmes/and appropriate peer support programmes." In addition, on the issue of continuity of care, the policy document states: "The IPS will ensure, insofar as is practicable, continuity in the provision of treatment, care and services to the individuals with drug problems. Through-care processes will be co-ordinated through a multidisciplinary team, reflecting the range of services involved with drug misusing prisoners. The IPS must form strategic and tactical partnerships, and increase its interaction with community-based agencies, in order to integrate and co-ordinate the delivery of services to prisoners."

This is an evidently impressive catalogue of initiatives in the treatment area, which at least name-checks most of the different drug treatment modalities. Some of the approaches mentioned fall into the category of rehabilitation, i.e. psychotherapeutic, counselling and motivational interviewing techniques. However, the main focus is on specific forms of drugs treatment and the role and centrality of rehabilitation is not properly elaborated. The list of planned approaches consists mainly of initiatives that already have a presence within the system, if at an inadequate level. There are, however, some progressive elements in

Keeping Drugs out of Prison. Most obviously, there are the plans to develop coherence in the drug treatment programme, to establish multidisciplinary teams of professionals in each prison, and to develop through-care, that is follow-up services for drug using offenders on their release back into the community.

However, there are a number of key issues concerning the new policy for treatment and rehabilitation that need to be addressed:

- 1) Based on past record, the first response must be to query the capacity of the Irish Prison Service to deliver and adequately implement the constructive elements in this plan.
- 2) The lack of any plan for a purpose-built custodial drug treatment centre and the much-needed post-release facilities for through-care.
- 3) The lack of analysis of and response to the special features of the prison milieu which impact on treatment and rehabilitation.
- 4) The lack of a detailed plan for handling the divergent treatment and rehabilitation needs of the huge diversity of differently situated prisoners, including remand, long-term and short-term prisoners, and women, young and immigrant prisoners.
- 5) The barriers created by the drugs free prison policy to a pro-treatment ethos, particularly by way of restrictions on harm reduction approaches such as needle exchange.
- 6) The appropriateness of the ever-increasing expansion of the methadone maintenance programme in the prison system.
- 7) The apparent dismissal of the therapeutic community approach within the prisons despite the accumulating research evidence for its special relevance and effectiveness.
- 8) The medicalisation of the drugs problem at the expense of more holistic approaches that do justice to the social and psychological components of the problem.
- 9) The general lack of emphasis on rehabilitation and the failure to recognise that drugs rehabilitation is inextricably connected to the rehabilitation of imprisoned offenders in the broadest sense of the term.
- 10) The failure to develop an integrated plan which looks at the whole context of the criminal justice system response to drugs, including sentencing policy, alternative sanctions to custody and parole policy.

...a failure to acknowledge the profound need for a radical improvement in the level of treatments and facilities provided.

The fate of past prison drugs policy and earlier failures to deliver on the promises of policy provide ample justification for scepticism about the claims of *Keeping Drugs out of Prison*. Its strong emphasis on achieving a totally drugs free system is probably not only unfeasible but also counterproductive, insofar as it undermines harm reductive approaches and creates tension

and a more violent and threatening atmosphere in the prisons. Admittedly, in recent years, there has been a real improvement in the amount of funding provided for drugs treatment in prison and significant increases in the numbers of relevant professional staff. Current evidence suggests, however, that these investments have had only limited beneficial effects and are being concentrated in specifically medical areas.

The formulaic, rather cursory approach of *Keeping Drugs out of Prison* to treatment issues, the familiarity of the catalogue of treatment initiatives, and the absence of innovative ideas all suggest a failure to acknowledge the profound need for a radical improvement in the level of treatments and facilities provided. These weaknesses tend to dent faith in the policy and in its potential to deliver real improvements. The general lack of detail and the lack of attention paid to the special difficulties of treatment in the prison environment also undermine confidence that this plan, unlike its predecessors, will have a major impact. The prison population is particularly heterogeneous in respect of both drug experience and legal status and very different plans and facilities are required to deal with differently-situated prisoners. The absence of any detailed planning in this area is disappointing and telling.

The proliferation of treatment modalities endorsed by *Keeping Drugs out of Prison* suggests a lack of a coherent model of treatment. While recognising that there may well be a place in the system for different, even opposed treatment types, for example the 12 step abstinence-based and the methadone maintenance approaches, there is surely a need for an overall understanding of the role and interrelationship of the different treatment modalities and for a scheme for the appropriate allocation of inmates to treatment type. An evaluation³⁸ of the relatively straightforward, extended methadone detoxification treatment offered in Mountjoy (to groups of 9 prisoners at a time) points out that the clients of the programme are likely to find it confusing because it involves three distinct therapeutic approaches undertaken by three different agencies. A considered, comprehensive, theory-based overview of treatment is lacking in *Keeping Drugs out of Prison*, as is any discussion of the part played by the institution and the prisoner culture in the perpetuation of drug problems.

The emphasis on a drugs free prison also ensures that insufficient thought and emphasis are given to the role of harm reduction approaches in the overall treatment plan. Indeed, the veto on needle exchange and other harm reductive initiatives and the use of mandatory testing and threats of punishment for drug use alongside the ever-expanding prison methadone maintenance programme may send confusing and counterproductive messages to inmates. The essential requirement of drug treatment is to help individuals to gain personal control over drug use and persuade them to behave more responsibly. Treatment of various kinds can support drug users in this endeavour but the enterprise can easily be undermined by coercive and punitive approaches and especially by the failure to encourage responsible behaviour by way of harm reduction programmes.

Although this is not clearly articulated in *Keeping Drugs out of Prison*, methadone maintenance has in recent years become the most important drugs treatment in the Irish prison system. The Annual Report on Prisons for 2006 tells us that at the end of that year there were 492 prisoners on methadone maintenance, spread across 8 prisons, but mainly in Cloverhill Remand Prison (175), Mountjoy (157), Wheatfield (82) and the Dochas Centre Women's Prison (32). This compares (excluding the Open Prisons that 'aspire to drug free status') with a far smaller number of drug free prison places, which are mainly in the Training Unit (96) and St Patrick's Institution for Young Offenders (76). Cloverhill Prison, which now has a policy of starting inmates on methadone maintenance as opposed to simply continuing a treatment already established in the community, has in fact become one of the largest centres for methadone maintenance in the country.

A major part of the rationale for methadone maintenance is the stabilization of an opiate habit and of the chaotic, criminal lifestyle frequently associated with opiate use. This approach has had some success in the community, where it is also the state's main response to the opiate drugs problem with currently almost 10,000 people on maintenance. The programme has undoubtedly had a positive impact by lowering the amount of drug-related property crime. It has also had some other social benefits and harm reductive health benefits, mainly by decreasing the number of people sharing injecting equipment or having unprotected sex. Methadone maintenance has also helped some people gain significant control over their drug habit or even abandon it. However, there has been justified criticism of the failure of the methadone maintenance programme to focus on rehabilitation and the goal of eventual abstinence. Only a small minority of clients have used the programme as a stepping stone to complete abstinence and many people on the programme continue to be poly-drug users, availing of street heroin and other drugs and sometimes behaving in a risky manner, for example by sharing needles.³⁹ The addition of

rehabilitation as a fifth pillar of strategy at the mid-term review was largely a response to this criticism.

The rationale for methadone maintenance is not so clearcut in the prison situation.⁴⁰ Given that the primary principle of Irish prison drugs policy is to create a drugs free prison system, it is difficult to see how the system can justify maintaining large numbers of prisoners in their opiate habit. The proven success of the community methadone maintenance programme in reducing drug-related crime is largely irrelevant in the prison context, where there are few opportunities for such crime. The discipline of prison life, its rigid structure, and the difficulty of sourcing drugs in prison by comparison with the outside world, all provide the prisoner with opportunities to stabilise their drug habit and lifestyle without requiring the system to provide a continuous supply of opiates. The uncritical application of the principle of equivalence of treatment with the community, which apparently underpins the prison methadone maintenance programme, is clearly naïve because it does not recognise the unique features of the prison context. The argument can be made that, while 'equivalence of care' might justify keeping short-term prisoners on a methadone maintenance regime already begun in the community, in the case of relatively long-term prisoners, the use of methadone maintenance can best be justified as a first stage in a process aimed ultimately at abstinence. *Keeping Drugs out of Prison* does not address this issue and does not plan for the necessary supports and services for such an approach. In the context of 500 or more prisoners on methadone maintenance the provision of 24 drugs counsellors is obviously inadequate to the task of reorienting the maintenance programme towards more constructively rehabilitative goals. The policy document does not discuss the option of greatly expanding the abstinence-based, extended methadone detoxification treatment, which is currently offered in Mountjoy on only a very small scale.

The rationale for methadone maintenance is not so clearcut in the prison situation.

However, advocates of methadone maintenance in prisons, such as Stoever, endorse it chiefly for its harm reductive benefits, fully accepting that "the expectations that large-scale distribution of substitute drugs would stabilize drug users and lead to the elimination of drug subcultures and drug scenes have not been realised in practice." In other words, the main purpose of methadone maintenance in prisons is to reduce unsafe practices such as needle sharing. Unfortunately, the results of mandatory testing over the last few years indicate that the greatly expanded methadone maintenance programme is having a very limited impact on the use of illicit opiates and by inference on the sharing of injecting equipment. In Mountjoy Prison in the first 9 months of 2007, 57% of all tests were positive for illicit opiates. Most of these tests were undertaken with known drug users including those on the methadone maintenance programme. The figures provided do not give a breakdown showing the test results for those on the methadone maintenance programme, but given the general 57% positive rate for opiates it is likely that many were positive. The current policy does not allow needle exchange and so needles and syringes are prohibited and therefore very scarce and likely to be shared. In this context, the demonstrated level of continued use of heroin by prisoners on methadone maintenance strongly implies that the programme is failing to prevent the hazardous behaviour of sharing injecting equipment.

If the crime reductive aim of methadone maintenance has little relevance and the harm reductive aim has little apparent success in the Irish prisons programme, perhaps the official support for and commitment to methadone maintenance can best be explained by its stabilising effect on the prison environment rather than on individual

38 Pugh J. and Comiskey C. (2006) 'Drug treatment programmes in prison: longitudinal outcome evaluation, policy development and planning interventions' *Irish Journal of Psychological Medicine* 23(2): 63-67; see also Crowley D. (1999) 'The Drug Detox Unit at Mountjoy Prison – A Review' *The Journal of Health Gain* 3 (3) 17-19

39 Cox G., Comiskey C., Kelly P., and Cronly J. (2006)

ROSIE Findings 1: Summary of 1-Year outcomes Dublin: National Advisory Committee on Drugs

40 On the other hand, Stoever H. ('Drug substitution treatment and needle exchange programs in German and European prisons', *Journal of Drug Issues*, Spring, 2002) in his analysis of the use of methadone maintenance in European prisons argues that "the practice of methadone use in prison is consistent with those that exist in the outside community... Even when maintenance behind bars is seen as a mere improvement of "misery management," i.e., as a harm reduction tool rather than as a solution to drug use, it remains both useful and necessary on practical grounds alone. In principle, methadone maintenance is a form of treatment that is particularly well suited to the correctional system."

prisoners. Carlin's study,⁴¹ based on the perceptions of both prisoners and prison officers in Mountjoy, finds that both groups tend to see the maintenance programme as useful and beneficial to prisoners but as primarily a method to "control prisoners and maintain order and discipline within the prison." Supplying opiates to prisoners provides the authorities with useful leverage in the struggle for a more docile and compliant prison population.

Alternately, methadone maintenance can be seen as an integral part of the drug free prisons policy - a kind of quid pro quo whereby rigorous repression of drugs in the prisons is justified by the provision of methadone to those that need it. Methadone maintenance is useful because it both lessens the motivation for illicit drug use and undermines excuses for such use. The paradox is that supplying opiates, if under very controlled conditions, has become a major component of the overall strategy for eliminating illicit drugs, particularly opiates, from the prisons.

Arguably, the official provision of opiates without an accompanying focus on eventual abstinence has a normalising influence, rendering drug dependence unremarkable and more socially acceptable. The results of mandatory testing certainly indicate that a considerable number of prisoners on methadone maintenance may treat it as no more than a convenient source of drugs. The maintenance programme by definition tolerates and condones drug use, albeit under specific, restrictive conditions. As a policy based on a qualified tolerance of opiate use, methadone maintenance appears to run counter to both the drugs free prisons ideology and the official claim that harm reduction initiatives such as needle exchange are vetoed precisely in order not to appear to condone drug use.

According to Stoever, methadone maintenance as practiced in prisons is a relatively low aspiration approach, useful mainly for its harm reductive effects. While its harm reductive benefits appear to be limited in Irish prisons, methadone maintenance remains attractive to the authorities for its contribution to the drugs free prisons strategy and because it helps win the compliance of some addicted prisoners. Methadone maintenance may also be supported because of widespread scepticism about what can be achieved with other approaches to drugs rehabilitation in prisons. However, recent special journal issues of the *Probation Journal* and *The Prison Journal*⁴² have examined the evaluation research on drug treatment in prisons and concluded that there is now a relatively strong evidence base supporting the efficacy and usefulness of a variety of treatment modalities in prisons, including cognitive behavioural programmes and therapeutic community approaches. Recently, Wexler and Fletcher⁴³ (2007), referring to the broader criminal justice system, argued that "a large body of research shows the effectiveness of drug abuse treatment in reducing drug use and criminal behavior for individuals with drug problems who are involved with the criminal justice system." Of course, these optimistic appraisals of the utility of drug treatment in the criminal justice system must be understood within the parameters of what is known about the limits of drug treatment effectiveness in the wider community.

There are evidently many dilemmas and contradictions associated with the methadone maintenance programme in prisons and these have not been sufficiently addressed in *Keeping Drugs out of Prison*. It is clear, however, that this programme is part of a trend in Irish prison

drugs policy to medicalise the drugs issue. Medicine has an essential role to play in the response to the drugs problem - in the treatment and management of addiction itself and in the response to associated illnesses and communicable diseases. However, the temptation to compartmentalise the drugs problem as a medical problem or even as mainly a public health problem should be resisted. Medicalisation is attractive to the prison authorities because it neatly packages the drugs problem, individualises it as basically a problem intrinsic to isolated patients, and shifts the main burden of responsibility to the health services. Human rights groups and others also frequently focus on medical responses because they are relatively straightforward, concrete and sometimes vital and because the medical duty of care has a special ethical status, which receives almost universal recognition and respect. On the one hand, the medical profession is seen to have a principled and benevolent interest in serving patients whatever their legal or social status and, on the other, the public instinctively recognises prisoners' rights to medical treatment. It is, therefore, far easier to obtain funding for medical responses. One outcome of this is that it becomes

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convenient for the prison authorities to assume that their responsibilities are fulfilled so long as sufficient medical services are in place. This appears to describe what in fact has occurred in Irish prisons, since most of the greatly increased funding for the prisons drug problem has been channelled into the recent medicalisation of the problem by way of the methadone maintenance programme. Arguably, this process has diverted attention and funds from more ambitious and potentially more constructive rehabilitative approaches.

In this context, many doubts remain about the appropriateness of the methadone maintenance programme and the tendency to prioritise medical and individual-level responses over psychosocial and institutional-level responses. Although methadone maintenance has some harm reductive benefits, may increase a drug addict's openness to rehabilitation and, perhaps more relevantly, is a useful tool for maintaining the institutional goal of control, it does little to address the prisoners' drug culture, the aspects of the prison environment that promote this culture, or even (without proper supports for the aim of eventual abstinence) individual prisoners' drug dependence and related problems.

In order to put rehabilitation at the centre of policy, far more emphasis has to be placed on psychosocial, environmental, educational and occupational approaches and on the root causes of prisoners' problems with both drugs and crime. In other words, drugs rehabilitation cannot be detached from more broadly conceived methods of rehabilitation for prisoners. Such rehabilitation would have a focus on remediating the deficits of individual prisoners (in areas like literacy, employability, emotional maturity etc.) and enhancing their potential for personal growth. Drugs rehabilitation must pay due attention to the fact that the majority of both Irish opiate/poly-drug users and convicted criminals come from a similar background of marked socioeconomic deprivation and educational disadvantage. They are likely to have had few opportunities in life and will frequently have emotional and behavioural difficulties, which may stem from their upbringing in dysfunctional or disrupted families in marginalised neighbourhoods. These background conditions evidently generate a susceptibility to both criminal offending and opiate drug use. The challenge for the system is to create regimes that help people that have failed in society but have also been failed by society, to recover from their disadvantages and realise their potential to live productive, law-abiding lives.

Effective action is dependent on the adoption of the ambitious goal of creating a prison system, which provides a genuine platform for rehabilitation and which minimises the features of prison life and of the prison environment, such as boredom, idleness, purposelessness, petty coercion and unsanitary and inadequate living conditions, which not only act as major barriers to effective drug rehabilitation but

41 Carlin T. (2005) 'An exploration of prisoners' and prison staff's perceptions of the methadone maintenance programme in Mountjoy Male Prison, Dublin, Republic of Ireland' *Drugs: education, prevention and policy* Vol. 12, No. 5, 405-416

42 *Probation Journal* (2004) Vol 51(4) and *The Prison Journal* (2006) Vol. 86; see also Friedmann, P, Taxman, F, Henderson, C (2007) 'Evidence-based treatment practices for drug-involved adults in the criminal justice system' *Journal of Substance Abuse Treatment* 32 267-277 and Taxman, F, Matthew L. Perdoni, M., Harrison, D (2007) 'Drug treatment services for adult offenders: The state of the state' *Journal of Substance Abuse Treatment* 32 239-254

43 Wexler H. and Fletcher B. (2007) 'Overview: National Criminal Justice Drug Abuse Treatment Studies' *The Prison Journal* 87; 9

also actively promote the drugs culture. It is essential to target the criminal drugs culture itself, its values, and the specific benefits that the addict prisoners derive from it. This is best done by winning the hearts and minds of the prisoners through education and persuasion, by developing their personal potential and by providing them with the chance for an alternative, more positive path through life.

There is always likely to be some need for unambitious prisons, which do little other than provide secure warehousing for dangerous, intransigent and incorrigible offenders. However, it is crucial that most of the prison system should not be designed to this low standard. It is also critically important that an holistic strategy is developed, embracing the whole criminal justice system, particularly sentencing practice. Many more drug-using offenders could and should be diverted to community-based and treatment-based sanctions, thereby easing the pressure on the prison system. Indeed, Ireland's over-reliance on short-term imprisonment for petty, non-violent offending⁴⁴ needs to be radically reversed, if there is to be any real chance of creating a more rehabilitative, purposeful and humane prison system. A recent report⁴⁵ by Sean Lowry, a former Head of the Probation and Welfare Service, has detailed the extent to which Ireland lags behind other jurisdictions in the use of non-custodial sanctions. This report also describes a variety of effective non-custodial sanctions that have proven to be of considerable value in other countries.

The Irish Drug Court has an obviously important role to play in diverting drug using offenders from prison. It has already proved its value⁴⁶ and should be greatly expanded. Portugal, with a similar heroin problem to Ireland's, has introduced a somewhat more radical nation-wide system of non-judicial tribunals (called Commissions for the Dissuasion of Drug Use), which are oriented towards health, treatment and local community issues and deal with petty offenders with drug problems.⁴⁷ The Portuguese approach recommends itself and may be worth trying here both because it has had considerable success and because it has an important restorative justice element, which can help rebuild solidarity and mutual respect in neighbourhoods under pressure from illegal drugs.

Provision for the early release of suitable prisoners into drug treatment-based reintegration programmes should also be greatly strengthened. Unfortunately, the 1999 Criminal Justice Act, in order, evidently, to signal the government's desire to appear tough on serious drug criminals, prohibits the granting of parole to offenders convicted of possession of illicit drugs worth €13,000 or more. Many of these offenders are drug users who would not be involved in the drugs trade but for their addiction. It appears counter to common sense to not use the incentive of early release to a treatment programme as a way of motivating such prisoners to tackle their drug problem. However, on March 3rd 2008, the Minister for Justice, Brian Lenihan, announced a sensible, new scheme for incentivising long-term prisoners, including drug users and sex offenders, to engage with rehabilitative services within the prisons. This allows male prisoners to benefit from the 33% remission of sentence, which is automatic for female prisoners, rather than the normal 25%, if there is proof of positive engagement by the prisoner with prison rehabilitative services. The decision to grant extra remission is entirely at the discretion of the Minister and would reduce a 12 year sentence to 8 rather than 9 years.

Modern technology and design make possible far more effective prisons that focus on creating a genuine learning environment. For example, Cottam et al⁴⁸ propose new architectural approaches that

The need for a custodial drugs treatment centre is as pressing as ever...

make possible a prison regime based on the promotion of learning. Their vision suggests that "the prison building maintains security whilst freeing up financial and staff resources. Spaces are specifically designed to support a programme of rehabilitation. Organisation of the prison day and the role of the prison officer can thus be re-orientated to provide an intensive programme of learning. In this context, learning includes but goes much beyond the acquisition of basic skills – it becomes the principle for personal and institutional transformation." Cottam et al acknowledge that if prisoners are to change in a positive direction so too must the institution of prison.

New prison building in Ireland should be at the vanguard of such constructive developments, particularly with respect to the provision of drug treatment facilities. The need for a custodial drugs treatment centre is as pressing as ever and it is obvious that a purpose-built facility separate from the conventional prisons would maximise the potential for effective treatments and for reversing the current synergy between prison life and the drugs culture. There are many non-violent offenders who would cooperate with a properly designed and resourced, low security establishment, if it had a genuine focus on rehabilitation and learning. Such a building would also be required for the operation of a therapeutic community. The therapeutic community, which has been operated with success at Grendon Prison in Britain and is considered by some experts to be the best drugs treatment option for prison systems,⁴⁹ uses peer pressure and a positive psychosocial environment to build up and sustain the sense of personal responsibility of the individual and their determination to stay drug free. Unfortunately, *Keeping Drugs out of Prison* makes no mention of therapeutic communities, although five years earlier the Steering Group on Prison Based Drug Treatment Services had said that it was something that deserved in-depth consideration.

Through-care has long been a weakness in the system.⁵⁰ Ó Loingsigh's study⁵¹ has pointed to major problems with co-ordination of services, timing of release etc., which lead on to homelessness and to a rapid return to drug use and crime. Some of these problems are apparently simple and easily remedied. For example, Ó Loingsigh writes: "Ex-prisoners faced a range of problems upon release. Many of their problems were related to a lack of information about services often compounded by being released late in the evening when such services were closed. Ex-prisoners were at risk of becoming homeless in such situations and many of them turned back to crime within hours of being released in search for money to pay a B&B. Others still sought out money to pay for drugs as there was a delay in getting back onto their methadone programme once released." However, the response needs to go beyond an improved coordination of services and a more rational bureaucracy. The successful reintegration of offenders and the provision of positive supports for prisoners, who have made progress in respect of their drug dependence whilst in prison, are such crucial goals that investment in high quality, non-custodial treatment centres for ex-prisoners with a focus on preparation for employment is undoubtedly warranted.

A study by Byrne⁵² of 332 opiate-related deaths recorded by the City and County Coroner's Office between 1998 and 2001 also indicated a serious gap in the through-care and preventative educational provisions for drug-using offenders. Byrne found that 26 (or 8%) of all deaths

44 O'Mahony P. (2002) 'A Critical Analysis of the Irish Prison System' *Crime and Justice International* 18, 67 5-17

45 Lowry S. (2007) *Report on non-custodial sanctions in other jurisdictions* Internal report to the office of the Minister for Justice, Equality and Law Reform.

46 Farrell, M. and Farrell Grant Sparks Consulting (2002) *Final Evaluation of the Pilot Drug Court*, Dublin: Irish Courts Service.

47 Allen L., Trace M., And Klein A. (2004)

'Decriminalisation Of Drugs In Portugal: A Current Overview' The Beckley Foundation

48 Cottam H., Henley B., Horne M. and Comely G. (2002) *Learning Works: The 21st Century Prison* London: The Do Tank

49 Inciardi states: (in Inciardi J. and Harrison L. (Eds) (2000)

Harm Reduction: national and international perspectives London: Sage) "the therapeutic community is unquestionably the most appropriate form of drug abuse treatment in correctional settings because of the many phenomena in the prison environment that make rehabilitation difficult"

50 Pellissier, B, Jones, N, Cadigan, T (2007) (in 'Drug treatment aftercare in the criminal justice system: A systematic review' *Journal of Substance Abuse Treatment* 32 311– 320) warn that "Although drug treatment literature consistently cites the importance of aftercare, general research on aftercare is limited and the evidence for the effectiveness of aftercare in reducing drug use is not strong"

51 Gearóid Ó Loingsigh (2004) *Getting Out, Staying Out: The experiences of prisoners upon release* Dublin: Community Technical Aid

52 Byrne R. 2001

Opiate-related deaths investigated by the Dublin City and County Coroners 1998 to 2000 Dublin: Addiction Research Centre, TCD

occurred amongst people who had just been released from prison. It is likely that many of these deaths were related to 'hot shot' overdoses. These are overdoses caused by people taking an amount of a drug, which would not previously have been dangerous for them, but which is now lethal because they have lost physiological tolerance for the drug over the period of relative deprivation in prison. It would appear to be plain common sense that all prisoners about to be released should receive clear information and warnings about such hazards.

Key Issues: Research

Over the last decade there have been some improvements in research on the prison drugs problem. The Department of Justice and the Irish Prison Service have commissioned or facilitated a number of valuable surveys of prisoner health, several evaluations of prison drug treatment programmes and even some useful ethnographic studies, which provide insights into prisoners' and prison officers' perspectives on the drugs problem. *Keeping Drugs out of Prison* also promises a more rigorous, evidence-based approach to the assessment and evaluation of the implementation of its own proposals. While the greater use of and openness to research are welcome, many important aspects of the drugs problem in prisons remain under-researched and the extent and seriousness of the problem still remain largely hidden from public scrutiny.

Keeping Drugs out of Prison assigns responsibilities and sets timelines for the achievement of specific targets. Most of these targets concern physical and procedural changes required by the tougher measures designed to eliminate the supply of illicit drugs to prisoners. An example is the target to "install facilities for screened visits by the end of 2006." Some other targets are easily achievable administrative or bureaucratic tasks, which have only a vague or uncertain relationship with real improvement in the prisons drug problem. For the most part the targets do not focus on the issues that really matter, such as the creation of a more humane, constructive and less violent prison environment and the rehabilitation of prisoners. This is partly due to the predominant policy emphasis on supply control and its promise of a totally drugs free prison system. The one seemingly ambitious target is to "ensure full access for all prisoners requiring drug treatment to the range of healthcare and treatment options by the end of 2007." This is, however, a rather unspecific and ambiguous aim – it is not obvious what the phrase "the range of healthcare and treatment options" refers to. It is not at all clear what conditions would have to be fulfilled for this target to be met and whether the underlying problems would in fact be significantly improved, if the target were met.

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Moreover, many of the target dates laid down in *Keeping Drugs out of Prison* are now past, yet the Irish Prison Service has not published any documentation on whether or not the targets were met. In short, this adoption of the language and techniques of business management may offer some organizational efficiencies, but is unlikely to make a major impact on the drugs problem.

The key issues for research and monitoring are:

- 1) The timely, routine provision on a reasonably detailed level of data on the drugs problem and the responses to it, in order to inform the public, provide an adequate basis for analysis and facilitate the process of transparency and accountability.
- 2) Accessing, analyzing and utilizing the research findings from the international literature on treatment, harm reduction, educational and preventative approaches.
- 3) The external, independent, scientific evaluation of all drugs programmes and the rapid, uncensored publication of the results.
- 4) An adequate research focus on the key social, psychological and environmental outcomes such as the prison climate, the actual quality of life of prisoners, and recovery from addiction and other rehabilitative outcomes, more broadly defined.

Research has an important role in establishing the objective facts and in testing the effectiveness of interventions. Research also has an important role in educating the public about conditions in prison, i.e. about what the State is doing to offenders in the name and on behalf of the public. Prison authorities naturally favour a high level of secrecy, some small portion of which is justified on security grounds. The fact that *The Irish Times* was required to make a request under the FOI Act in order to obtain the results of prison mandatory drug testing is testimony to the prison authorities' reluctance to open its activities to scrutiny and evaluation. The secrecy surrounding prisons is not entirely a matter of official evasion of accountability and transparency, however, because the general public themselves are frequently uninterested in prisons – provided that they continue to incapacitate, control and penalise offenders. The public collude in the secrecy surrounding the prison system through their indifference to how imprisoned offenders are treated. Government and legislators should be aware of this regrettable complacency and challenge it by insisting on the conduct of research and the collection of routine data on the operation of the prison system and on the timely publication of the same. A more humane and constructive prison system, which truly respects human rights, would be a major advantage for everyone and a full understanding of how the system currently falls short is an essential first step in this direction.

Summary points

- 1) The policy statement *Keeping Drugs out of Prison* (2006) provides the blueprint for current Irish prisons drugs policy. While it appears to support a wide variety of positive initiatives, it is premised on and prioritises a probably unrealistic aspiration for totally drug free prisons. This policy relies on a series of security measures designed to eliminate the supply of drugs in prisons. The policy has unintended negative effects for the prisons drugs problem; for example, it tends to undermine harm reduction strategies and increase the prevalence of drug-related intimidation and violence.
- 2) Balancing the main focus on eliminating the supply of drugs, there is a growing reliance on methadone maintenance in the Irish prison system. The methadone substitution programme is aimed at harm reduction and the maintenance of order and control in the prisons. Nearly 1 in 6 prisoners is now on methadone maintenance.
- 3) Despite this dual, but somewhat self-contradictory, approach, the results of mandatory drug-testing and various credible reports on the prisons suggest that the current policy has failed to impact significantly on the use of illicit drugs in prison, has failed in the rehabilitation of addict prisoners, and has not prevented further deterioration of the climate in prisons.
- 4) The current enormous prisons drugs problem is the legacy in part of unrealistic expectations of law enforcement and imprisonment as the main response to drug use and is also due to the failure to implement the treatment oriented aspects of the 1977 Misuse of Drugs Act and to properly resource drug treatment in the prisons.
- 5) Neglect of the drugs problem in prisons has led to a situation where the system consistently fails in its core aim to establish a secure, safe, ordered and law-abiding prison environment. Moreover, the drugs culture, which has been allowed to flourish in the prisons, has contributed very significantly to the spread and escalation of destructive drug use and drug-related crime in broader Irish society.
- 6) In recent years there has been a significant improvement in the medical services for drug using prisoners, but the sociological, psychological and environmental factors which frequently promote drug problems in the prison population are still neglected.
- 7) There is still an urgent need for properly designed and resourced custodial drugs treatment centres, where useful, abstinence-oriented programmes, such as therapeutic communities and cognitive behavioural therapies, could be provided for suitable prisoners.
- 8) The abysmal facilities and material conditions in many prisons actively contribute to the drugs problem. Drugs rehabilitation can only succeed in a humane and well-managed environment of the kind in which rehabilitation in general can succeed. Rehabilitation should be tailored to the individual needs and potential for personal growth of prisoners, who very frequently come from a background of multiple disadvantage and who have often failed disastrously in the normal education system. A rehabilitative approach entails a strong focus on education, training and the purposeful occupation of prisoners. This means that all new prisons should be built at least to the standard of the Dochas Centre Women's Prison, exploiting modern technology and exemplifying positive advances in architectural design.
- 9) In order to achieve a more rational, effective and rehabilitative prison system it is essential to adjust current sentencing policy and reduce the number of minor, non-violent, drug-using offenders sent to prison for short terms. The use of the Drugs Court, mandatory drugs treatment outside the prison system and non-custodial sanctions should be greatly expanded.
- 10) A more coherent drugs policy for prisons would put less emphasis on supply control and far more emphasis on the reduction of the many different types of harm caused to prisoners by the current drugs culture in prisons. A more coherent policy would place far more stress on abstinence-based treatments than on methadone substitution. A more coherent policy would recognise that improving prison conditions and providing an environment conducive to the general rehabilitation of offenders are absolutely essential to tackling the prison drugs problem.

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