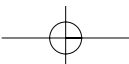
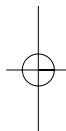
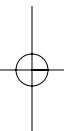
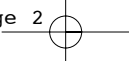


DRUG USE AMONG PRISONERS:
AN EXPLORATORY STUDY



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Lucy Dillon



The Drug Misuse Research Division
The Health Research Board
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FOREWORD

The Drug Misuse Research Division of the Health Research Board has identified the problem of drug use among prisoners as an area much in need of research in Ireland. A research proposal was developed and submitted to The Policy Planning Research Unit of the Department of Justice, Equality and Law Reform to part-fund a study which the Drug Misuse Research Division planned to carry out in collaboration with the Pompidou Group of the Council of Europe. Participation in the Pompidou Group study was officially endorsed by the Council of Europe permanent correspondents in the Department of Health and Children and the Department of Justice, Equality and Law Reform.

The proposal was successful and reports to the Department of Justice, Equality and Law Reform from the project included a *Review of Irish and European Literature* relating to drug use within prisons; an overview of *European Information Networks* in the area; and an outline of a *Research Instrument* developed in the course of the study along with guidelines for its use.

In addition to the work specified in the contract, the Drug Misuse Research Division decided to carry out an exploratory study of drug use amongst a sample of prisoners in Mountjoy Prison, Dublin. Lucy Dillon planned and carried out this study. A qualitative methodology was used, which involved in-depth interviews with prisoners. The results of this study are presented in this report.

The study, although exploratory in nature, provides many useful insights into the culture of drug use within the prison setting and the individual dynamics involved. The report puts forward preliminary implications of the findings for drug policy and service development in the prison setting. In a context where the Irish Prisons Service has identified drug use among prisoners as an issue in need of attention, and where many policy and service developments are under consideration, it is felt that the findings

from the present study can help to inform the direction of emerging and future initiatives.

The report indicates that the prison environment can provide a unique opportunity for some individuals to address their drug problems. However, certain supports have been identified as important, such as the provision of drug-free wings. It is hoped that the Irish Prisons Service and those involved with prisoners will find this report deepens their understanding of the experiences of drug use amongst prisoners and ultimately leads to better informed policy and planning.

Rosalyn Moran
Head of Drug Misuse Research Division
The Health Research Board
Dublin
April 2001

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I would like to express my sincere thanks to a number of people for their help and support with this study.

First and foremost, I would like to express my gratitude to each prisoner who took part in the study. Each person's story was invaluable to the research and I would like to thank participants for their openness in discussing their experiences with me. I hope that the study's participants feel this report has represented their views appropriately.

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April 2001

RESEARCH SUMMARY

Study Objectives

This is an exploratory study of drug use among prisoners and the issues facing prisoners. The aims of the study were to:

- explore the nature of drug use among prisoners;
- explore the impact of incarceration on prisoners' drug use;
- explore users' perceptions of services available to them within the prison setting; and
- examine the experiences of non-drug-users within a prison setting, where there may be a significant number of prisoners with a history of drug use.

Methodology

A qualitative methodology was used to collect the data. In-depth interviews were carried out with twenty-nine prisoners in Mountjoy Prison in Dublin. A network/snowball sampling method was used for sample selection. 'Categories' of prisoners were developed based on general characteristics relating to an individual's drug-using history. Initial contacts were made through probation and welfare officers and respondents selected according to these categories. Respondents located in this way were asked to refer the researcher on to other potential study participants in the prison. Interviews were tape-recorded, with participants' consent, and fully transcribed for analysis.

Study participants were recruited from five areas in the Mountjoy Prison Complex: the main Male Prison (n=12), the Separation Unit (n=3), the Training Unit (n=4), the Medical Unit (n=2) and the Female Prison (n=8).

Sample Profile

Socio-Demographics

Twenty-nine prisoners took part in the study. There were twenty-one men and eight women in the sample. Participants ranged in age from nineteen to forty-three. Respondents reported a low level of educational achievement. Furthermore, their employment histories were generally characterised by long periods of unemployment.

Drug-Using Status

Twenty-four respondents had a history of drug use prior to imprisonment; seventeen were continuing to use illicit drugs in prison and seven were not. Five respondents had no history of drug use prior to imprisonment; one of the five had 'experimented' with drugs during his present incarceration, but had since ceased using drugs.

Drug-Using History

Among those who were engaged in illicit drug use, opiates were the main drug of choice both in the community and while in prison. Cannabis had been the first illicit drug used by most of those with a history of drug use. In the context of early use, cannabis was often used alongside a number of other substances, including lysergic acid (LSD), solvents and then ecstasy and benzodiazepines. Twenty-three of the twenty-four prisoners with a history of drug use prior to imprisonment had used their first illicit drug by the age of twenty.

Criminal History

Twenty-one respondents (72.5%) had served at least two previous prison sentences, with many (n=12) having spent multiple periods of time in prison.

Drugs-Crime Relationship

Thirteen respondents stated that they had been involved in offending behaviour prior to starting their illicit drug use. Nine reported that they had become involved in offending behaviour as a direct result of their illicit drug use. Two respondents reported that their illicit drug use and involvement in criminal activity had begun simultaneously. Irrespective of when their offending behaviour had begun, respondents with a history of drug use prior to imprisonment perceived their on-going criminal activity to be inextricably linked to their illicit drug use.

Main Findings

Prison Life and the Role of Drugs

Drugs Culture

Other than in the designated drug-free wing of the Training Unit, respondents perceived Mountjoy Prison to be characterised by a drugs culture, manifest in the attitudes and behaviour of prisoners. Irrespective of the drug-using history of prisoners, or their current drug-using status, there was an overall consensus that drug use was an issue they faced on a daily basis.

Living Conditions

Respondents reported variations in living conditions between different areas of the prison. They were particularly critical of the living conditions in the main Male Prison, where the majority of inmates were housed. They described conditions as insanitary and overcrowded. In comparison, respondents reported positive reactions to the living conditions in the Training Unit, where inmates had their own cells and the conditions were perceived to be sanitary.

Daily Routine

The daily routine of prison life was perceived to be extremely monotonous, although the monotony was perceived as less acute in the Training Unit. Where respondents with a history of illicit drug use were not engaged in structured activities, the boredom experienced was seen to reinforce the perceived positive aspects of illicit drug use.

Visibility of Drug Use

Respondents reported that they saw significant variation between different areas of the prison in terms of the visibility of the activities involved in illicit drug use, i.e. distribution, administration and being under the influence of drugs. While it was reported that drug use was not seen in one area of the prison (Training Unit), it was reported to be particularly acute in others (main Male Prison, Female Prison). Respondents identified drug use as visible, depending on which area of the prison they were housed in, rather than whether they were engaged in illicit drug use in the prison or even had a history of illicit drug use.

Drugs and the Prison Atmosphere

Respondents reported that the overall atmosphere of the prison was affected by drug use. In an environment where the availability of drugs fluctuated, tensions among those depending on drugs also fluctuated. This resulted in a volatile atmosphere in most areas of the prison. Respondents argued that drugs impacted on all those in the prison setting, including prisoners with a history of drug use, prisoners with no history of drug use, and prison staff.

Impact of Drugs in Prison on Different Categories of Prisoner

Prisoners with a history of drug use argued that the perceived benefits of drug use were reinforced in the prison environment. Drugs were seen to alleviate some of the problems associated with prison, such as boredom and depression. To stay or become drug free in an environment characterised by a drugs culture was not perceived as feasible for those with a history of drug use.

The prisoners with no history of drug use, who were housed outside the Training Unit (n=4), reported that, at least initially, the presence of drugs made the prison environment more threatening for them.

Respondents felt that the presence of drugs in the prison made for a more threatening working environment for prison officers.

Drug Use in the Prison Environment

Current Drug-Using Activities

Seventeen respondents were continuing to use illicit drugs while in prison, six reported cannabis use only and eleven reported heroin use (usually combined with cannabis use). Heroin and cannabis were reported to be the drugs most commonly used within the prison setting.

Six respondents (five males and one female) with a history of drug use prior to imprisonment had ceased their drug use since entering prison. A seventh respondent, who had been on a maintenance programme immediately prior to imprisonment but had been detoxified since entering Mountjoy, had managed to remain off illicit drugs since entering the prison.

A key feature identified in managing to cease drug use while in prison was being removed from a setting characterised by a drugs culture. All the male respondents who had ceased their drug use (n=5) were housed outside the main Male Prison. Female

prisoners were all housed in the one prison wing. Only one woman, who had been using illicit opiates immediately prior to imprisonment, had managed to cease her illicit opiate use since entering prison. This was because she did not have access to drugs and it was likely that she would abstain only temporarily.

Initiation into Drug Use in Prison

Initiation into drug use in the prison setting was rare. Four respondents reported that they had their first-ever experience of heroin while incarcerated. One respondent reported that his first use of any illicit substance had occurred while in prison on his current sentence; at the time of interview he was no longer engaged in illicit drug use.

Motivations to Use Drugs in Prison

Respondents argued that in the prison environment, drug use offered a way of coping with the problems imprisonment presented. Drug use offered prisoners a temporary 'escape' from the prison.

Motivations to Cease Drug Use while in Prison

A number of motivations were cited by respondents for ceasing use while in prison. These included concerns about personal health and family well-being, and attempts to comply with the conditions of a judicial review.

Distribution Process

Respondents reported that, at the time of this study, drugs were not sold for cash in the prison. Respondents reported that drugs were generally distributed in the prison through a reciprocal network system, established between prisoners who had access to drugs from the community. When an inmate received drugs through from the community, he/she would distribute them to others in a particular group. When others in this group received drugs from the community, they would distribute them to the same group members. Groups were generally established between inmates who knew each other from the outside community.

Quantity and Frequency of Use

Once imprisoned, those who continued to engage in illicit drug use greatly reduced the quantity of drugs they used, and the frequency with which they used them, when compared to their drug use in the community.

Routes of Heroin Administration and Associated Risk Behaviour

Respondents reported that injecting was the dominant route of heroin administration in the prison. Four respondents engaged in injecting drug use for the first time while in prison. Two others moved from smoking in the community to injecting in prison, but had previous experience of injecting drug use. Most of those injecting had been engaged in injecting drug use prior to imprisonment.

Respondents argued that injecting was the preferred route of heroin administration within the prison because of the small quantities of drugs available. Respondents felt that where drugs were available, they should be used in what prisoners perceived to be the most efficient way. This meant using the smallest amount to the largest effect for the most people. In this context, respondents reported that smoking heroin was perceived to be wasteful, whereas injecting was seen as an 'efficient' use of heroin.

Respondents argued that injecting drug use in the prison was synonymous with the sharing of injecting equipment. All of those who had injected while in prison had shared injecting equipment. The advantages of using drugs were seen as outweighing the risks involved in equipment sharing.

Respondents felt that the choice drug users in the community have to minimise the risks entailed by their injecting drug use, through accessing appropriate services, was removed from those who decided to inject while in prison. One respondent, who was HIV-positive, reported that he was continuing to share injecting equipment within the prison.

Service Provision

Drug-Related Services

Respondents argued that there was an urgent need to expand the services available to drug users in Mountjoy. This related to both the types of services available, and the number of prisoners who could be accommodated by the services.

Short-term Detoxification (with Methadone)

All those respondents who had been engaged in opiate use up until the point of imprisonment, had accessed the voluntary thirteen-day detoxification programme upon entering prison. This was perceived by respondents to be too short and to involve too low a dose of methadone. Respondents reported experiencing severe withdrawal symptoms, which had not been alleviated by this programme. They argued that this detoxification reflected a general misunderstanding on the part of the prison authorities about the nature of opiate addiction.

Drug Detoxification and Rehabilitation Programme

A seven-week Drug Detoxification and Rehabilitation Programme is run by the Probation and Welfare Service and caters for nine male prisoners at a time. To access the programme prisoners are interviewed by probation and welfare officers and assessed for suitability. Those who had managed to access the programme (n=4) reported that it had helped them cease their illicit drug use. However, two respondents had done the programme on a previous sentence and had since relapsed into drug use. On completion of this programme, participants had been transferred to the designated drug-free Training Unit. Transferral to the Training Unit was seen as a particularly positive feature of the programme.

Methadone Maintenance Programme

The situation at the time of the fieldwork, whereby only those who were HIV-positive, were offered a methadone maintenance programme, was criticised by respondents. It was felt that the methadone maintenance programme should be expanded in the prison. Respondents argued that participation in a methadone maintenance programme would help prisoners to remain off illicit opiates while in prison. Furthermore, it was reported that it would reduce the level of risk activity engaged in by prisoners.

Respondents were particularly critical when those on a maintenance programme in the community were required to detoxify upon imprisonment. However, since October 2000 prisoners who have been on a recognised maintenance programme in the community are no longer required to detoxify upon imprisonment.

Drug-Free Wings

The Training Unit is the only designated drug-free area in the Mountjoy Prison Complex. A drug-free environment is ensured by the requirement for all prisoners to undergo random urinalysis. Removal from an environment characterised by a drugs culture to a drug-free wing was seen by respondents as particularly effective in facilitating those who wanted to remain drug free while in prison. Respondents argued that all prisoners should have the choice of serving their sentence in a drug free wing.

Self-Help Groups

Self-help groups, based on principles of confidentiality and anonymity, were generally perceived to be incompatible with the prison setting, except in the Training Unit.

Needle Exchange and Cleaning Materials

Respondents recognised the complexities involved in introducing a needle exchange programme into the prison. While they argued that the problem of extensive sharing of injecting equipment in the prison needed to be addressed, they also recognised the concerns of staff and prisoners for their safety. However, it was felt that if clean injecting equipment were provided to inmates, this would not necessarily present a greater threat to staff or prisoners than was already present in the prison.

Respondents did not perceive any significant obstacles to the provision of cleaning materials for injecting equipment in the prison. While some cleaning materials were available in an *ad hoc* manner, respondents expressed concerns about their effectiveness in preventing the spread of HIV and hepatitis.

Counselling

Respondents identified the absence of a specialised addiction counsellor as a major gap in service provision.

Drug Awareness Programme

Respondents who had accessed the Drug Awareness Programme run by the Probation and Welfare Service reported that it was effective in delivering relevant information in a non-judgemental and accessible manner.

HIV and Hepatitis-Related Services

Three respondents reported that they were HIV-positive and a further eight had tested positive for at least one strain of hepatitis. A further eight were unsure of their status but had been engaged in high-risk behaviours within the prison setting.

Respondents reported a lack of information on many of aspects of HIV and, in particular, hepatitis. This related to methods of transmission, treatments, vaccines and testing. The prison environment was seen by respondents as a suitable environment in which to receive treatment and/or vaccination.

Alcohol-Related Services

A need for alcohol-related services was identified by the sample. Two respondents, who reported no history of illicit drug use, described themselves as alcoholics. In both cases, they attributed their imprisonment to their alcohol use.

Healthcare Services

Respondents differed in their views on the service provided by the prison's medical officers. They reported that their experiences had varied depending on which doctor they had seen. Some medical officers were seen to be accessible and effective in providing a service to prisoners; others were seen to be both inaccessible and ineffective in meeting the needs of inmates.

Respondents reported experiencing a range of mental health problems. These included periods of anxiety, depression and insomnia, which at times had manifested themselves in suicide attempts and suicidal ideation. Some were also coping with the effects of sexual and physical abuse. Some respondents had accessed both psychiatrists and psychologists within the prison to help them address these problems.

Other Services

In addition to specifically drug-related services, respondents identified education and training programmes as playing a role in reducing the risk of recidivism, both in relation to drug use and criminal activity.

Implications of Main Findings

Drugs Culture

The findings from this study suggest that policies and services related to drug use among prisoners should take account of the drugs culture identified in the prison setting. It would appear that irrespective of their drug-using history, prisoners who do not wish to serve their sentence in a prison environment dominated by a drugs culture, need to be offered the alternative of serving their sentence in a designated drug-free area.

Services for the Prison Setting

Findings from the study highlight the particular nature of the prison environment and suggest that policy makers and service providers need to develop a service programme that recognises the specific nature of this setting. This would appear to support the concept that new services should be developed on the basis of examples of best practice, i.e. services that have proved effective in the care of drug users in prisons elsewhere.

Two-Strand Drug Treatment Service Programme

The findings indicate that services for drug users in the prison environment may best be provided on a two-strand basis. The first strand would be to foster any motivations that prisoners may have to cease their drug use. The reduction in the quantity of drugs being used by participants once imprisoned, suggests that imprisonment may provide an important opportunity to foster an individual's motivations to cease his or her illicit drug use. The second strand would be to address the needs of those who continue to engage in illicit drug use within the prison, minimising the risks to these prisoners' health, and in the longer term, that of the wider community.

Collaborative Approach to Service Development

The findings from this study indicate that prisoners are aware of, and sensitive to, the complexities involved in providing appropriate drug-treatment services in the prison setting. This suggests that a collaborative approach to service development between prison authorities, staff and inmates could be both valuable and feasible.

Peer Networks

Respondents in the study reported that peer networks were well established in the prison setting. These networks could be used for peer education purposes.

Evaluation

On-going evaluations of prison-based drug-treatment services could be carried out to ensure that the services are meeting the needs of the clients and that any emerging needs can be identified and addressed.

Further Research Needs

Decisions on the development of policies and services in the area of drug use among prisoners need to be made on a sound knowledge base, which does not currently exist in Ireland. There is a need for the on-going collection of routine epidemiological data on prisoners, complemented by special studies, which could provide more detailed information on subgroups and issues of particular interest.

GLOSSARY OF TERMS¹

Acid	Lysergic acid, LSD
AIDS	Acquired Immunodeficiency Syndrome
AVP	Anti-Violence Programme
Bag	Small plastic wrap of heroin (about the size of a postage stamp), usually described in monetary terms, e.g. ten bag (£10), twenty bag (£20)
Bang up	To inject drugs
Barrel	Plastic part of syringe which contains substance to be injected
Base	Holding cell for prisoners upon entry to Mountjoy Prison
Buzz	Feeling given by a drug
Chasing	'Chasing the Dragon', smoking heroin by heating the heroin on aluminium foil. The heroin turns to a sticky liquid and can be moved around the foil. The user inhales the fumes given off through a small tube.
Citric	Citric acid used for preparing heroin for intravenous use
Clean Urine	Urine sample free from prohibited substances
Coke	Cocaine
Cooking up	Preparing heroin for injection
Dips	Pickpocketing
Dirty urine	Urine sample with traces of prohibited substances
Draw	Cannabis
E	Ecstasy tablet

¹ This is a glossary of terms used in the course of interviews.

Fixing	Injecting drug use
Gear	Heroin
Gizmo	Syringe
Goof	Effect of drugs, in particular heroin
Green	Methadone mixture (green in colour)
Habit	Addiction, dependence
Hepatitis	Viral hepatitis (in this context B or C)
HIV	Human Immunodeficiency Virus
Joint	Rolled cigarette with drugs in it, generally cannabis
Joy (The)	Mountjoy Prison
Junkie	Habitual drug user
Mainlining	Injecting drug directly into vein
Maintenance	Methadone maintenance programme
Methadone	A synthetic opiate used to treat habitual opiate users. It may be used on a short-term basis, to facilitate detoxification from street opiates. Alternatively, it may be used on a longer-term basis, on a maintenance programme, where users are given a stable dose over a number of months or years.
Needle	Syringe
Needle (On the)	Injecting drugs
OD	Overdose
Pad	Padded cell
Pat's	St Patrick's Institution for Juvenile Offenders
Phy	Physeptone/methadone
Q	A quarter-gram bag of heroin
Quarter	A quarter-gram bag of heroin
Rec	Recreational area within Mountjoy Prison
Score	Acquire drugs
Screw	Prison officer
Sick	Generally means suffering withdrawal symptoms
Sickness (The)	Symptoms experienced in initial stages of withdrawal
Skin-popping	Injecting drug into muscle or under skin

Smack	Heroin
Snort	Taking drug by snorting it up the nose
Spike	Needle on a syringe
Spoon	Spoon used to heat heroin, in preparation for injecting use
SRG	Sentence Review Group
Stoned	Intoxicated with drugs
Strung out	Physically and psychologically addicted to drugs
Ten bag	Small plastic wrap containing £10 worth of heroin
Tooting	'Chasing the Dragon', smoking heroin
Tooter	Tube used for chasing heroin
TR	Temporary Release from prison
Triple therapy	Treatment for those who are HIV positive
Turn on (having a)	Taking drugs, referring to injecting
Using	In relation to heroin use generally taken to mean injecting behaviour, rather than other routes of heroin use
Virus (The)	HIV/AIDS
Works	Equipment required for injecting drug use, e.g. spoon, filter, barrel, needle

Key to Direct Quotations from Respondents

Direct quotations from respondents are set in smaller type than the main text of the report, and are indented on the page.

Where quotations from more than one respondent are used together, a line space is used to separate the different respondents' remarks.

Ellipses (...) are used to indicate breaks within quotations from the same respondent.

Prisons, other than Mountjoy Prison, Mentioned by Respondents

- Castlerea Prison, County Roscommon (closed and semi-open male prison)
- Cloverhill Prison, County Dublin (closed and remand male prison)
- Fort Mitchel Place of Detention (Spike Island), County Cork (closed male prison)

- Portlaoise Prison, County Laois (closed male prison)
- Wheatfield Place of Detention, County Dublin (closed male prison)
- St Patrick's Institution, County Dublin (closed juvenile male prison)

Where respondents refer to other prisons in the course of their remarks, these names have not been deleted, unless they were considered a threat to the respondents' anonymity.

CHAPTER 1

INTRODUCTION

1.1 Illicit² Drug Use among Irish Prisoners

Ireland has a daily prison population of approximately 2,700, located in fifteen prisons (Allwright, Barry, Bradley, Long & Thornton, 1999). It has been found that within the Irish prison population a significant proportion of individuals have a history of illicit drug use (Allwright *et al.*, 1999; Long, Allwright, Barry, Reaper-Reynolds, Thornton & Bradley, 2000). However, there is little known about the nature of this drug use and the impact of incarceration on it.

In estimating the prevalence of dr

injected' was 21%, compared to 58% in the 'high-risk' prisons.⁴ A subsequent study using the same methodology (Long et al., 2000) found that 35% of a sample of committal prisoners (n=607) had a history of opiate use and 29% reported a history of injecting drug use.

Other research carried out in the Irish prison context has been limited to Mountjoy Prison in Dublin, which cannot be considered representative of the overall prison population in relation to drug use. When the current study was carried out, Mountjoy was the main committal prison in the country and received prisoners directly from the courts, either under sentence or on remand. It had an average population of 650 prisoners on any one day, approximately a quarter of the total Irish prison population. Owing to the concentration of problematic drug use in the Dublin area (O'Brien, Moran, Kelleher & Cahill, 2000), and estimates that approximately 66% of indictable crimes in the Dublin metropolitan area were attributable to 'known hard drug users' (Keogh, 1997), Mountjoy was likely to have a higher proportion of drug users in its population than other prisons.

While the data collected through the available research are not directly comparable, owing to variations in methodology, they give a clear picture of drug use among prisoners as an issue facing the Irish prison system (see Table 1.1).

TABLE 1.1
Summary of Irish Research Findings on Prisoners with a History of Illicit Drug Use.

SAMPLE LOCATION	AUTHORS (PUBLICATION DATE)	YEAR OF FIELDWORK	SAMPLE SIZE (N)	EVER USED OPIATES (%)
Mountjoy Male Section	O'Mahony & Gilmore (1983)	1981	22*	73
	O'Mahony (1993)	1986	95	32
	O'Mahony (1997b)	1996	108	66
National Surveys	Allwright <i>et al.</i> (1999)	1999	1,205	52
	Long <i>et al.</i> (2000)	2000	607†	35
	Hannon <i>et al.</i> (2000)	2000	777	32‡
Mountjoy Female Section	Monaghan (unpublished)	1989	34	31
	Carmody & McEvoy (1996)	1994	100	57

* Sample made up solely of prisoners who described themselves as 'drug abusers'.

† Sample made up solely of committal prisoners.

‡ Used opium in last twelve months.

⁴ Mountjoy Prison was designated a 'high-risk' prison for the purpose of Allwright *et al.*'s (1999) study.

1.2 Drug Use within the Environment of Irish Prisons

Irish studies demonstrate that in at least one of Ireland's prisons, namely Mountjoy, the proportion of individuals with a history of drug use has grown over the last decade and a half. However, most of these studies have not considered the extent and nature of drug use by these prisoners while incarcerated. Three studies have looked at the extent to which prisoners use drugs while incarcerated and the risk behaviours in which they engage; two studies were carried out on a national basis (Allwright *et al.*, 1999; Long *et al.*, 2000) and a third in Mountjoy (O'Mahony, 1997b). Rather than questioning respondents solely about their drug-using habits prior to their imprisonment, these three studies explored the extent to which prisoners used drugs while in prison.

1.2.1 Changes in Patterns of Use

Imprisonment has been found to impact on an individual's pattern of drug use. O'Mahony (1997b) found that 42% (n=45) of a sample of 108 prisoners had used heroin while in prison serving their current sentence. This was 63% of those who had ever used heroin. Overall, only eighteen of the sixty people with a history of injecting drug use claimed not to have used heroin during their current sentence. O'Mahony (1997b) highlighted, however, that most of those who had not used heroin in prison on their current sentence had been incarcerated for a short time at the time of interview - eleven for a month or less, and five for a week or less. Consequently, these respondents might not yet have been presented with the opportunity to use drugs. Of those who were convicted and had been imprisoned for a minimum of three months, 56% (n=29) were using heroin in prison. Within the group that reported using heroin while in prison (n=45), twenty-three reported either daily use or use several times a week, sixteen about once a week, and six less than once a week or only very occasionally. Lack of access to drugs appeared to be the main reason for the lower frequency of use. Overall, entering prison did not mean a cessation of drug use.

Six prisoners in O'Mahony's (1997b) sample (n=108) reported that their first-ever experience of heroin had been in prison. One other reported that while he had used heroin prior to imprisonment, it had been while serving a previous sentence that he had become dependent on heroin. There was also some anecdotal evidence in O'Mahony's study (1997b) that as a result of more stringent searching after visits, cannabis had become more difficult to access within the prison. It was suggested that the absence of cannabis meant some prisoners had resorted to heroin use. The findings from O'Mahony's study (1997b) - that some prisoners were initiated into heroin use while in prison and that a shift towards heroin use might have been occurring - highlighted

the need for the issue of drug use among prisoners to be addressed in a comprehensive manner, so that the extent of the problem could be determined and appropriate services developed.

1.2.2 Injecting Drug Use and Risk Behaviours

Studies have found that Irish prisoners engage in injecting drug use while incarcerated and that they tend to share injecting equipment (O'Mahony, 1997b; Allwright *et al.*, 1999; Long *et al.*, 2000). O'Mahony's study (1997b) of inmates in Mountjoy Prison found that 42% (n=45) of a sample of 108 prisoners had used heroin while serving their current prison sentence, and thirty-seven of these had engaged in intravenous drug use. One-sixth of those reporting a history of drug use had tested positive for HIV (n=10), while a quarter had never been tested. In addition, thirty respondents said they had tested positive for at least one form of hepatitis.⁵

O'Mahony described as 'alarming' (O'Mahony, 1997b: 107) the finding that of those who reported having tested positive for HIV (n=10), six were continuing to engage in syringe sharing despite having been notified of their HIV-positive status. An earlier study, based on data gathered between 1987 and 1991, found that 168 known HIV-positive prisoners had spent time in Mountjoy during this period. A study of a sub-sample (n=34) of these HIV-positive individuals, selected on a random basis, revealed that 94% had engaged in drug use in the prison (Murphy, Gaffney, Carey, Dooley & Mulcahy, 1992). While Murphy *et al.* (1992) did not ask respondents about their needle sharing practices while in the prison, the lack of clean injecting equipment and evidence from other studies that sharing injecting paraphernalia is a feature of drug use in the prison (O'Mahony, 1997b), indicated that there was potential for the spread of HIV to uninfected prisoners.

A study carried out by Allwright *et al.* (1999) focused on the risk behaviours engaged in by prisoners in relation to the spread of hepatitis B, hepatitis C and HIV. One-fifth (104/506) of those reporting a history of injecting drug use said they had first begun injecting drugs while in prison. In considering the risk behaviours engaged in by these prisoners, it was found that injecting drug users were more likely to share injecting equipment while in prison than when they were in the community. Allwright *et al.* (1999) found that 58% of injecting drug users said they had shared all injecting equipment (needles, syringes, filters, spoons) while in prison, compared to 37% who reported sharing in the month prior to being incarcerated. This was found to have serious implications for the health status of prisoners. Of those who had shared

⁵ Throughout the current report the term 'hepatitis' is used to mean viral hepatitis. Furthermore in this context it is referring to hepatitis B and C.

equipment inside the prison, 89.1% had tested positive for hepatitis C, compared to 62.2% of those who had not shared in prison. While Long *et al.* (2000) found that a smaller proportion of committal prisoners had a history of drug use, they found similar risk behaviours engaged in by inmates and similarly high rates of infection, particularly hepatitis C.

Mountjoy's Visiting Committee also found evidence that prisoners continue to engage in intravenous drug use while in prison. In their interim report for 1998, the committee emphasised overcrowding and drug use as being the persistent key problems in the prison. As a result of increased searches from 1 January until 6 July 1998, there were 139 seizures of drugs within the prison. Furthermore, there were 137 cases where prisoners were found in possession of a syringe and 61 in possession of other 'prohibited articles', for example the plunger of a syringe (Mountjoy Visiting Committee, 1998).

Despite the potential for the spread of HIV and hepatitis among intravenous drug users in prison, a report evaluating services in this field found that at the time there were no harm reduction strategies in place in the Irish prison system (O'Brien & Stevens, 1997). An award-winning booklet and video, containing information for prisoners on HIV discrimination, infection and prevention, had been produced and were supposedly available to all prisoners. However, focus group interviews with prisoners and former prisoners found that HIV-positive individuals in the focus groups had seen neither of these materials (O'Brien *et al.*, 1997).

1.3 Irish Prison-Based Treatment Provision

In 1994 the Department of Justice clearly stated that equivalence of care and continuity of care of prisoners were among the objectives of the prison medical services in Ireland:

To provide primary health care (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to citizens in the general community; this involves as a minimum an adequate reception, medical assessment and examination, through-care while in prison and making appropriate arrangements for the continuation of health care following release. (Department of Justice, 1994: 51)

This stance was reiterated in a 1999 document concerned with developing drug treatment provision in the prison setting (Department of Justice, Equality and Law Reform, 1999).

The care of drug users in the community falls under the remit of the Department of Health and Children, whereas in the prison setting, it is the responsibility of the Department of Justice, Equality and Law Reform. This situation creates inherent problems for the continuity of care of drug users. A draft action plan drawn up in 1999 (Department of Justice, Equality and Law Reform) sought to reflect a medical policy agreed between the Department of Justice, Equality and Law Reform, the Department of Health and Children and the Eastern Health Board.⁶ It proposed the development of a range of treatment services within the prison setting, including methadone maintenance programmes, detoxification programmes and addiction counselling. In addition, it was proposed that drug-free wings be introduced. There was also a recommendation that by 1 July 1999 prisoners be provided with access to bleach for sterilising injecting equipment, in an attempt to prevent the spread of communicable disease - at the time of writing this has yet to be implemented.

At the end of 1999 a Steering Group on Prison Based Drug Treatment Services was established under the chairmanship of the Director General of the Irish Prisons Service. The group consists of senior prison staff, representatives of the Department of Justice, Equality and Law Reform, the Prisons Psychology Service, the Probation and Welfare Service, the Prisons Education Service, the Director of Prison Medical Services and several nominees from the Eastern Regional Health Authority. In a report by the group, a further commitment to the provision of drug treatment services based on the principle of equivalence of care was given (Irish Prisons Service, 2000). Furthermore, the report proposed a 'new treatment ethos' (Irish Prisons Service, 2000: 3) for a number of prisons in which prisoners with a history of drug use were concentrated. In October 2000 the government approved the implementation of recommendations contained in this report (Irish Prisons Service, 2001). On foot of this report, methadone maintenance service provision was expanded within the prison setting. From October 2000 all new committals to Mountjoy, and prisoners transferring from Cloverhill Prison who are on approved methadone maintenance treatment programmes, were to continue to receive methadone maintenance while in Mountjoy (Irish Prisons Service, 2001).

While recent developments suggest a more innovative approach on the part of the Irish prison system to drug treatment, the principle of equivalence does not currently prevail in the Irish prison system in its care of drug users. The services available to drug users in Mountjoy at the time this study was carried out,⁷ are profiled in detail in Chapter 6 of this report.

6 Now the Eastern Regional Health Authority.

7 Fieldwork for this study was carried out between mid-August and December 1999.

1.4 The Current Study

Little is known about the experiences of Irish prisoners in relation to drug use. To date, research in this area has focused on quantitative data, which demonstrate that a significant percentage of prisoners have a history of drug use, and a proportion of these continue to use drugs while in prison. It was felt that a qualitative approach would help inform the quantitative data available, by offering an in-depth examination of the issues facing prisoners in relation to drug use. The current study is an exploratory study of drug use among prisoners and the related issues faced by prisoners.

The overall objectives of the study were to:

- explore the nature of drug use among prisoners;
- explore the impact of incarceration on prisoners' drug use;
- explore users' perceptions of services available to them within the prison setting;
and
- examine the experiences of non-drug-users within a prison setting, where there may be a significant number of prisoners with a history of drug use.

The report is divided into seven chapters, each addressing the findings in relation to both those prisoners with a history of drug use and those with no history of drug use.

- Chapter 1 gives an overview of research to date on drug use among Irish prisoners.
- Chapter 2 describes the methodology used in gathering and analysing the data.
- Chapter 3 presents a brief profile of the sample, including an overview of both the drug-using and criminal histories of respondents.
- Chapter 4 examines respondents' experiences of prison life. This includes an examination of the general living conditions in the prison and the overall atmosphere. In addition, the extent to which drugs feature in the day-to-day life of the prison and the perceived impact on the experiences of those in the prison environment are explored.
- Chapter 5 addresses two main areas: the impact of prison on respondents' drug use, and the nature of drug use in the prison. The risk behaviours of those continuing to inject in prison are also discussed.
- Chapter 6 deals with the services available to inmates. It explores both services available to drug users in the prison at the time fieldwork was carried out, and respondents' perceptions of the provision of services based on the principle of equivalence of care.
- Chapter 7 discusses the main findings, with reference to other European research, and presents the implications of these findings.

CHAPTER 2

RESEARCH METHODS

2.1 Study Rationale

While it is recognised that a significant proportion of Irish prisoners have a history of drug use, little is known about the impact of incarceration on this use and the nature of use within the prison environment. In addition, knowledge of how prisoners who have no history of illicit drug use cope in a prison setting where drug use may be occurring is extremely limited. This study aims to explore these questions from the perspective of a sample of prisoners (n=29) in one Irish prison.

2.2 Study Limitations

This is an exploratory study and does not purport to be a comprehensive examination of drug use among Irish prisoners. In Ireland it has been found that there are wide variations nationally in the profile of those presenting for drug treatment (O'Brien *et al.*, 2000). These variations relate to both the types of drugs used and the numbers presenting for treatment in different areas. Such variations may be reflected in the experiences of inmates situated in different prisons around the country. The current study is confined to twenty-nine prisoners from just one of the country's prisons - Mountjoy Prison, Dublin. Drug use in other Irish prisons may be very different, both in terms of its nature and the extent to which it occurs. Therefore, the sample is representative neither of the whole prison population, nor of those prisoners who have a history of drug use.

2.3 Study Location

At the time the current study was carried out, Mountjoy Prison was the main committal prison in Ireland, receiving prisoners committed directly from the courts, either under sentence or on remand. It had an average daily population of 650 prisoners, approximately a quarter of the total Irish prison population.

Sixty-six per cent of Mountjoy's population had been found to have a history of opiate use, and 86% cannabis use (O'Mahony, 1997b). Based on these findings, the prison was identified as an appropriate study location for exploring drug use among prisoners.

Mountjoy Prison Complex is made up of six sections: the main Male Prison, the Separation Unit, the Medical Unit, the Female Prison, the Training Unit and St Patrick's Institution for juvenile offenders.⁸ A physical description of each area in which respondents were housed is given in Chapter 4.

2.4 Sample Location

Study participants were recruited from five areas of the Mountjoy Prison Complex:

- Wings A, B, C and D of the main Male Prison (n=12)
- Separation Unit (n=3)
- Training Unit (n=4)
- Medical Unit (n=2)
- Female Prison (n=8)

2.5 Ethical Issues

Sensitive social research has been defined as 'research which potentially poses a substantial threat to those who are or have been involved in it' (Lee, 1993: 3). In designing the current research study, it was felt that exploring drug use among prisoners should be considered a sensitive area of research.

Both illicit drug use and the possession of injecting equipment are prohibited within Irish prisons. The prison authorities invoke a number of measures to prevent prisoners from accessing drugs and the relevant paraphernalia. These include:

⁸ The current study did not include inmates from St Patrick's Institution for juvenile offenders.

- monitoring all visits (both by prison officers in the visiting hall and by a closed-circuit television system);
- prohibiting physical contact between visitors and prisoners during visits;
- internal and external body searches of prisoners suspected of smuggling drugs or paraphernalia into the prison; and
- carrying out searches of cells where it is suspected that drugs or paraphernalia are being kept.

Where a prisoner is found in possession of either illicit drugs or injecting equipment, these are confiscated and the prisoner is subject to a disciplinary procedure in which he or she is brought before the prison's governor. Penalties may include loss of recreational time, loss of privileges and possible loss of remand time.

Initial contact with probation and welfare staff indicated that, in general, prison staff were aware of those prisoners who had a history of illicit drug use prior to imprisonment. This was predominantly due to the high proportion of prisoners who had requested and received a methadone detoxification upon imprisonment, to help alleviate the withdrawal symptoms associated with heroin. Thus, it was felt that a participant's identification as having a history of drug use would not necessarily present respondents with the risk of sanction or stigmatisation. This assumption was confirmed in the course of interviews: prisoners reported that prison staff were generally aware of which prisoners had a drug-using history.

The research sample included those who had no history of drug use, those who had a history of use but were abstaining, and those who were continuing to use drugs in prison. It was not disclosed to prison staff to which category an individual respondent belonged. Furthermore, prison staff (other than the probation and welfare officers involved in initial recruitment) were not always aware of the purpose of the researcher's contact with an individual prisoner. In general, fieldwork was carried out during the hours when prisoners received visits from a range of people, including legal representatives, other professional visitors and family members. Carrying out interviews with both users and non-users, emphasising this to staff, and using discretion in discussing with prison staff the purpose of the researcher's contact with respondents, were all used in an attempt to offset any negative repercussions for study participants.

There were also concerns about the impact that a study around a prohibited activity (drug use in the prison) might have on prisoners' longer-term relationships with the prison authorities. However, it has been well documented that drug use is an on-going activity in Mountjoy Prison (O'Mahony, 1997b; Allwright *et al.*, 1999; Long *et al.*, 2000), and it was not felt that exploring this issue *per se* would have any detrimental

impact on prisoners. Nevertheless, certain issues that arose in the course of the research, which it was felt might have a negative impact on the welfare of prisoners if disclosed, are not addressed in the report. For example, the methods used to smuggle drugs, injecting paraphernalia and other prohibited items into and around the prison are not discussed.

Lee stresses that 'privacy, confidentiality and a non-condemnatory attitude are important because they provide a framework of trust' (Lee, 1993: 98). Assurances of confidentiality were of extreme importance in this research and ensuring confidentiality was a key feature of the research process. Respondents were assured of the confidential status of data collected, and no record of names or any other identifying features were collected as part of the research. Researchers have found that prisoners tend to disclose information about their substance misuse when interviewed by those perceived not to be part of the prison system (Mason, Birmingham & Grubin, 1997). The researcher ensured that her independence from the prison system was made clear to each respondent.

Participation was entirely voluntary and the research was carried out on the basis of informed consent. This requires clear communication, including language which is non-technical and clearly understood by the participants (Sieber, 1992). Potential participants met with the researcher, who described in non-technical terms the purpose of the study, the reasons for requesting an interview and the estimated length of time needed, and gave assurances of confidentiality. Individuals were then asked if they wished to continue to participate; they were assured that a refusal would not be disclosed to anyone. When an individual agreed to continue to participate, a form explaining the nature of the research and the terms on which individuals would participate was read out by the researcher, signed by her and given to participants (see Appendix 2).

2.6 Sample Selection

This study used network/snowball sampling. Snowball sampling involves using a small group of informants, who are asked to put the researcher in touch with other eligible individuals until a 'chain' of informants has been selected (Burgess, cited in May, 1997:119). Dealing with the issue of sampling hidden populations, Lee described snowball sampling as 'ubiquitous in the study of deviant populations because it often represents the only way of gathering a sample' (Lee, 1993: 66).

A random selection of initial contacts was not feasible and therefore sample 'categories' were used in an attempt to offset bias. Categories of prisoners were developed and

initial contacts were selected according to general characteristics in relation to drug use. The sample categories included:

- No history of drug use
- History of drug use
- Drug user at time of entering prison, not continuing to use
- Drug user at time of entering prison and continuing to use while in prison
- No history of drug use prior to entering prison but started using while in prison

Probation and welfare officers in the various areas of the prison played a crucial role in making the initial contacts with potential participants in the various categories. Participants located through probation and welfare officers were asked to refer the researcher on to other potential participants. While it had initially been thought that drug use might be a 'hidden' activity within the prison, and that the involvement of those working in the prison in identifying potential participants would be problematic, this was not the case. Inmates reported that they were open with staff and other prisoners about whether they had a history of drug use. Furthermore, the recruitment of those with no history of drug use, those with a history of use but abstaining within the prison, and those continuing to use within the prison, meant prison staff were not made aware of an individual participant's current drug-using status. The data gathered through interviews with respondents identified by probation and welfare officers did not differ in any detectable way from the data gathered in interviews with respondents who had been identified by other inmates.

Once confidentiality was assured, and the researcher's independence from the prison system emphasised, respondents were very open in discussing their experiences. A number of 'chains' of respondents were used, to minimise the bias that may occur through the use of a networking sample. When a 'chain' of respondents was exhausted, a new one was started. Overall, approximately 60% of the participants (n=17) were located through referral from other prisoners, the remainder (n=12) were identified by probation and welfare officers. The initial link between the male and female prisons was made through a respondent in one section identifying a sibling as a potential participant. Female prisoners were oversampled relative to the male-female ratios in Mountjoy Prison. In the current study the ratio of females to males is 1:2.6, whereas in the areas of the prison complex sampled it was approximately 1:10.

2.7 Refusals

Two individuals refused to participate in the study. They 'declined' to meet with the researcher. One of them had been approached by a fellow inmate to participate, the other by a probation and welfare officer.

2.8 Data Collection

Fieldwork was carried out over a six-week period from mid-August to the end of September 1999. An additional two interviews were carried out during December 1999.

Choosing a Qualitative Methodology

Qualitative one-to-one in-depth interviewing is a key means of carrying out research in sensitive areas. It is a way of collecting data that are capable of centralising the respondent's own experiences, being responsive to the respondent and remaining flexible and reflexive. For these reasons this methodology was used in this current study.

All interviews were carried out by one researcher, which ensured consistency and a grounded approach to data collection. The approach was grounded in that it allowed the researcher to identify and explore emerging themes in the course of individual and subsequent interviews.

Centralising the Respondents in the Research Process

Positioning respondents in a central position in the interview process was attempted in a number of ways. An open-ended, flexible interview guide was used, which could adapt to each respondent's own experiences (see Appendix 3). The interview guide was based on some general themes identified through a thorough review of the relevant literature. However, it remained flexible throughout the interview process and the researcher encouraged respondents to focus on issues of particular concern to them, while also ensuring that each area related to the research objectives (see section 1.4) was addressed by each respondent. The need for a flexible approach to the interview and the time constraints⁹ meant that the issues on the interview schedule were not always all covered in depth with each respondent.

The Interview Setting

Interviews were carried out with only the researcher and respondent present. In the main Male Prison, interviews were carried out in 'professional visit boxes'. These are visiting rooms where one wall is transparent and a prison officer remains outside for the duration of the visit. These rooms are used for professional visits from individuals such as legal representatives or social workers. In the Medical Unit, Separation Unit and Training Unit interviews were carried out in rooms usually used by probation and welfare officers. In the Female Prison interviews were carried out in a vacant cell on the main wing.

⁹ Interviews could only be carried out during the hours when prisoners were unlocked. The researcher was required to be escorted from the main prison entrance to the interview location, and prisoners were required to be escorted from the area of the prison in which they were housed to the interview location. This generally restricted the interview length to approximately one hour.

Methodological Limitations

Methodological limitations were identified in the course of data collection. They were generally attributable to the research setting and the exploratory nature of the study. Respondents were contacted on a one-off basis and no record of their names was kept. This presented limitations on two levels. First, it was not possible to proof the data through feedback with respondents. Second, given the time limit of approximately one hour for each interview, respondents were restricted in the depth to which they could discuss issues not on the interview schedule. The researcher tried to ensure a balance was maintained, facilitating the emergence of new themes and issues through the interview process while ensuring that the areas on the interview schedule were covered. It is recommended that both these limitations be noted for the design of future research in this area.

2.9 Data Handling and Analysis

Interviews were tape-recorded with the consent of respondents, and each interview transcribed for analysis. It was agreed with respondents that these tapes would be destroyed on completion of the study. This will be done one month after publication of this report.

Owing to the exploratory nature of the study, the researcher was not concerned with testing pre-existing hypotheses. Rather, the emphasis was on gaining knowledge of respondents' experience of, and perspectives on, drug use in prison. This meant that it was important to allow understanding to emerge from the data (Bernard, 2000). Unlike experimental or survey research, data analysis commenced during the data collection phase of the study. Issues arising from the data were explored in subsequent interviews. This is a well-documented, qualitative research technique and has the advantage of increasing the internal validity of the study (Huberman & Miles, 1998).

A coding scheme was devised for the interview transcripts. This scheme initially consisted of four broad themes,¹⁰ corresponding loosely with the main objectives of the study, and was later extended to include new 'categories' and themes, which emerged under each broad theme. These were identified inductively, that is, through a process of reading and re-reading interview transcripts, which allowed understanding to emerge from close study of the data (Bernard, 2000). The codes were attached to the relevant chunks of text manually. Emerging themes and patterns were carefully recorded and later verified or dismissed, by comparing 'chunks' of data and seeking consistency across coded categories.

10 Background data; Prison life and the role of drugs; Impact of imprisonment on drug use and the nature of drug use within the prison; Services.

While consistency was sought across coded categories, divergence was also noted. Through the process of data analysis, consensus was found among respondents about themes relating to the prison environment, but variations were also noted. Where respondents diverged, for example in relation to their drug use and how they managed this in prison, the corresponding number of respondents in each divergent category was noted.

Verbatim quotes from respondents¹¹ are used throughout this report as exemplars of the themes and patterns that emerged through the analysis process.¹² The use of quotes ensures that respondents' accounts are fairly and appropriately represented.

11 Respondents' codes, used in the course of analysis, have been removed from quotes to further ensure that respondents' anonymity is maintained.

12 The Glossary of Terms at the beginning of this report explains terms and expressions used by the respondents. It also includes notes on how the quotations have been edited.

CHAPTER 3

SAMPLE PROFILE

3.1 Introduction

Interviews were carried out with twenty-nine inmates of Mountjoy Prison. Basic socio-demographic data, together with an overview of the drug-using careers and criminal histories of respondents, were collected and are presented in this chapter. Little research has been carried out in the Irish context on the links between illicit drug use and criminal activity. While in-depth research in this area is needed, to inform policy development, it is beyond the scope of the current research.

3.2 Socio-Demographic Characteristics

Gender

Of the twenty-nine individuals who took part in the study, twenty-one were men and eight were women.

Drug-Using Status

The sample included individuals who were continuing to use illicit drugs within the prison setting (n=17), those with a history of illicit drug use who were not currently using in the prison (n=7), and a small number who had no history of illicit drug use prior to imprisonment (n=5). One of the five respondents with no history of illicit drug

use prior to imprisonment had 'experimented' with ecstasy and cannabis during his current prison sentence (see Table 3.1). He had not seen this use as problematic and was not engaged in use at the time of interview (see section 5.2.2).

TABLE 3.1
Drug-Using Status of Respondents at Time of Interview, by Gender.
Numbers and Percentages (N=29).

DRUG-USING STATUS	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
Currently Using	13	62.0	4	50.0	17	58.5
History of Use but not Currently Using	6	28.5	2	25.0	8	27.5
No History of Use	2	9.5	2	25.0	4	14.0
Total	21	100.0	8	100.0	29	100.0

Custodial Status

Both those in custody on remand (n=7) and those convicted (n=22) were interviewed. Three female and four male respondents were on remand. The length of sentences being served by respondents ranged from life to a couple of months.

Age

Respondents ranged in age from nineteen years to forty-three years. The female sample came from a younger age group, with only one female respondent being over twenty-five years (see Table 3.2).

TABLE 3.2
Age Profile of Respondents at Time of Interview, by Gender.
Numbers and Percentages (N=29).

AGE GROUP	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
Under 20	0	0	1	12.5	1	3.5
20 - 25	9	43.0	6	75.0	15	51.5
26 - 30	6	28.5	0	0	6	20.5
31 - 35	2	9.5	0	0	2	7.0
36 - 40	2	9.5	1	12.5	3	10.5
Over 40	2	9.5	0	0	2	7.0
Total	21	100.0	8	100.0	29	100.0

Parental Status

Fifteen of the respondents (51.5%) reported that they were parents, ten (34.5%) that they were not, and data were missing for four (13.5%). Of the eight female participants, two (25%) were parents. Of the twenty-one male participants, thirteen (62%) were parents, four (19%) were not, and data were missing on four (19%).

Education

The overall profile of this sample indicated a group characterised by early school leaving (see Table 3.3) and a low level of educational achievement (see Table 3.4). A small number of those with a history of drug use reported that leaving school at an early age had been directly related to their drug-using activities (n=2). Twenty-two (76%) of the twenty-nine respondents had left school without any formal qualifications. Three respondents (11%) left mainstream schooling at an early age, but had continued to have some education while resident in one of a number of institutions for juvenile offenders. However, none of these three respondents reported achieving any formal qualifications while in these institutions. Only two (29%) of the seven respondents who reported receiving any formal qualification while in school, had a history of drug use prior to imprisonment. Both of these had received their Junior Certificate.¹³ All those prisoners with no history of illicit drug use prior to imprisonment (n=5) had received at least a Junior Certificate qualification before leaving school. Two other respondents reported having received their Junior Certificate through the prison system, and one of these had proceeded to do the Leaving Certificate.¹⁴ Both these respondents had left school before the age of fifteen. Another prisoner, who had left school after receiving his Junior Certificate, had completed both his Leaving Certificate and an Open University course since entering prison.

TABLE 3.3
Age at which Respondents Left School, by Gender. Numbers and Percentages (N=29).

AGE GROUP	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
Under 15	11	52.5	4	50.0	15	51.5
15 +	9	43.0	3	37.5	12	41.5
Missing Data	1	4.5	1	12.5	2	7.0
Total	21	100.0	8	100.0	29	100.0

¹³ The Junior Certificate examination is taken by students at approximately 15 years of age.

¹⁴ The Leaving Certificate examination is taken by students at approximately 17/18 years of age.

TABLE 3.4
Current Highest Educational Qualifications of Respondents, by Gender.
Numbers and Percentages (N=29).

CURRENT EDUCATIONAL QUALIFICATIONS	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
None	14	66.5	5	62.5	19	65.5
Junior/Group Certificate	4	19.0	1	12.5	5	17.0
Leaving Certificate	1	5.0	1	12.5	2	7.0
Third-Level	2	9.5	0	0	2	7.0
Missing Data	0	0	1	12.5	1	3.5
Total	21	100.0	8	100.0	29	100.0

Employment

The employment history of the sample was characterised by long periods of unemployment, in particular among those respondents who had been daily opiate users. Combining employment with the lifestyle entailed by daily opiate use was not generally seen to be feasible. Where respondents had work experience, it was overwhelmingly in either unskilled or semi-skilled manual labour. Twenty-five (86%) respondents reported being unemployed immediately prior to imprisonment. Only four respondents (15%) reported being employed immediately prior to imprisonment, and just one of these had a history of drug use. This respondent had been stabilised on a methadone maintenance programme at the time, and the remaining three who had been employed and had no history of drug use, had been working either in unskilled manual, skilled or semi-skilled non-manual positions.

3.3 Drug-Using Career¹⁵

Among the respondents with a drug-using history prior to this current period of imprisonment (n=24), the stage at which they had begun using drugs and the type of drugs they had used varied. The youngest age of first use, for any illicit drug, was eight and the eldest was thirty-two (see Table 3.5). Cannabis was the first illicit drug used by most, but this was often used alongside a number of other substances, including lysergic acid (LSD) and solvents, and after a while alongside ecstasy and benzodiazepines. All twenty-four respondents had been engaged in opiate use.

¹⁵ This includes those respondents with a history of drug use prior to this period of imprisonment. It does not include the one respondent who had 'experimented' with cannabis and ecstasy during this period of imprisonment. He was no longer using and had not seen his use as problematic (see section 5.2.2).

TABLE 3.5
Age of First Use of Any Drug by Respondents with a History of Drug Use prior to Imprisonment,* by Gender. Numbers and Percentages (n=24).

AGE OF FIRST USE OF ANY DRUG	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
Under 10	1	5.5	1	17.0	2	8.5
10 - 14	7	39.0	2	33.0	9	37.5
15 - 19	9	50.0	3	50.0	12	50.0
20 - 24	0	0	0	0	0	0
25 - 29	0	0	0	0	0	0
30 +	1	5.5	0	0	1	4.0
Total	18	100.0	6	100.0	24	100.0

*Excluding alcohol and tobacco.

The decisions around starting drug use and the processes involved in a drug-using career are complex and beyond the scope of this study. However, a limited exploration of respondents' drug-using careers was carried out in the course of the interviews. The following is a brief overview of some of the issues raised, including the perceived benefits of drug use, developing a habit, initiation into injecting drug use and the daily routine of an opiate user. While respondents varied in their particular pathway to drug use, they tended to describe a general pattern of escalating substance use, culminating in daily opiate use.

Benefits of Drug Use

Particularly in its initial stages, respondents saw drug use as meeting a number of needs. Drugs were perceived to have positive physical and psychological effects. Respondents reported experiencing pleasurable physical effects from drugs when they started using them. Different drugs offered different effects and, through the use of a variety of drugs, respondents had selected those that offered them what they perceived to be the 'best buzz'. For example, the woman speaking below described the positive feelings she got from cannabis, ecstasy and heroin. She had initially smoked cannabis and taken ecstasy, and began smoking heroin to 'come down' from ecstasy. Users in this research sample argued that the effect of smoking heroin is complementary to the effects of ecstasy.

Hash used to make me feel giddy and laughing all the time. It used to make me feel good, you know. ... It [heroin] made me feel wonderful, you know. It [heroin] evened it [the effects of ecstasy] out, it brought my head down and still buzzing out of me head but brought me right down, and then there was this lovely feeling that I got out of it when I smoked it first.

Drugs were also perceived to offer users positive psychological effects. They were seen as helping to cope with problems. They numbed people psychologically and offered them an 'escape' from reality for a period of time. Both of the following respondents had begun their drug use before the age of ten and had initially used solvents. For both of them the numbing effect of the solvents was seen to be beneficial.

When I found Tippex like I was in a little world of me own and I thought like I have to, like really it just brought me away, I didn't want to know, I didn't care. It numbed me, that's what it did.

I started to use drugs when I was nine, I was sexually abused when I was a kid and, em, like I always struggled with that so I just used drugs to escape, you know, started abusing solvents in school and that, you know what I mean.

Opiate Use

Of all the drugs used by the respondents with a history of drug use prior to imprisonment, opiates, and in particular heroin, were reported to be the main drugs of choice. Heroin had stronger physical effects than other drugs these respondents had used and was seen to offer the most pleasure. The terms used by respondents to describe their first use of heroin highlight this.

I took it [heroin] one night, and it was just the first buzz you get off it is a lot like, it just turns you. It was like an out-of-body experience, you know.

Respondents varied in the route they took to opiate use. For example, a common pathway among respondents in this sample was to move from ecstasy to heroin. Twelve respondents reported that they had begun their heroin use through their involvement in the 'rave' scene and their ecstasy use. While heroin was initially smoked to facilitate an easier 'come down' from ecstasy, after a period of time it was used on its own.

It's a different buzz, it's a different scene altogether you know, like heroin would be. Like it's very hard to explain, you know the E's you're up all the time and that but the heroin is really relaxed, blocks out everything, you know, and you're just mostly just goofing, you know. That was the buzz that I was getting out of it so I liked that more than the E, so I just stayed with the heroin, you know.

Becoming Dependent

While initial heroin use was described solely in beneficial terms, respondents described how the effects had changed over time. After using heroin on a regular basis for a period

of time, respondents reported that they lost 'control' of their use of heroin. They were no longer using it just for its physical and psychological benefits, but rather to avoid physical withdrawal.

It only takes a few weeks to get into your system, you know it's gone into your system when you wake up, right in your bones, you'd swear that you did a few rounds with Mike Tyson, your bones. Like your body is just real weak, with things like coming out of your eyes, you're sneezing, that's how you know you're under the control of it [heroin] and as soon as you have a few lines, three or four lines, you're perfect, you're just back to normal again.

Route of Administration

The manner in which respondents administered their drugs changed over time. Twenty-three of the twenty-four respondents with a history of opiate use prior to their period of current imprisonment had initially smoked heroin; only one respondent had injected heroin the first time she used it. However, twenty-one of the twenty-three respondents who started by smoking heroin, progressed to injecting. Respondents argued that they had initially developed a heroin habit while smoking, and had moved to injecting for a variety of reasons. The most common reason given was that by injecting heroin a user required a smaller quantity of heroin than would be needed to get the same effect by smoking (Gossop, 2000). Therefore, it made economic sense to switch the route of administration.

That's why we started injecting it, because we couldn't keep this money coming in and you need to smoke more heroin to get a buzz out of it, and then when you start taking it intravenously, like when you start injecting it, you don't need as much.

In addition, injecting was seen as offering users a better and more intense 'buzz' than smoking. This meant that once users had injected, they tended to become habitual injectors.

It [injecting heroin] was like, just a better buzz, like I was getting nothing from smoking, like it just sorted me out and made me feel better [stopped withdrawal]. So I started banging. Then I was getting a better buzz and that, so I ended up starting using [injecting].

The current sample also reported what has been termed the socially transmitted nature of injecting drug use (Hughes, 1999). Individuals were taught how to inject themselves

by other users, who were already experienced in injecting. An experienced injector would administer the heroin until the individual learned the skills involved.

I was with a couple of mates in me flat and showed me the works and like I've never shared anything you know, had the brand new works and grand, and eh, like I says, put it on the spoon, she cooked up one and she put it into me real slow. Like she's dead now, she was destroyed. ... She had an overdose. She taught me how to get meself, like how to get a vein.

Daily Routine as an Opiate User

Once engaged in daily opiate use, respondents described a busy daily routine. The lifestyle involved a pattern of finding the means with which to buy drugs, buying the drugs and using them. The following respondent described a typical day when engaged in habitual opiate use.

Waking up in the morning, having to make sure I had me gear there, getting washed and dressed and heading out, selling a bit of gear, meeting someone, going up to their flat, have another smoke or turn on, whatever they'd be doing. Then back out, that was it, all day.

3.4 Criminal History

The criminal histories of this sample were diverse. Respondents varied significantly in both the number of times they had been imprisoned and the types of crimes they had committed. Twenty-one respondents (72.5%) had served at least two previous sentences, with twelve reporting that they had been 'in and out of' penal institutions since they were teenagers; two respondents (7%) had only served one previous sentence; and for six respondents (20.5%), this was their first time in prison. Of the four respondents with no history of illicit drug use, only one had been in prison before. The criminal activity in which respondents reported that they had been involved included shoplifting, burglary, fraud, 'syringe attacks', mugging, murder, drug dealing and drug smuggling.

3.5 Drugs-Crime Relationship

The relationship between drug use and criminal activity has attracted much attention in both public debate and the literature. In the Irish context, it has been argued that

there is a strong link between growth in opiate use and a rise in crime (O'Mahony, 1993; McCullagh, 1996). An in-depth examination of this relationship is beyond the scope of the current study. This section presents a brief overview of the experiences of those respondents with a history of drug use prior to imprisonment (n=24). It highlights the complexities involved in understanding the relationship between drug use and criminal activity. It should be noted that in this current study, 'criminal activity' means crime other than that implicit in being a drug user, i.e. the purchase and possession of illicit drugs. The use of illicit drugs, other than opium, is not illegal in Ireland.

Broadly speaking, those respondents with a history of drug use fell into one of two groups:

- those who had been involved in crime prior to their drug use; and
- those who had not been involved in crime prior to their drug use, and attributed their involvement in crime directly to their drug use.

Within the sample there was a distinct alignment between differences in the drug-crime relationship and gender (see Table 3.6). Women were more likely to have become involved in crime after commencing illicit drug use, while men were more likely to have been involved in some level of criminal activity prior to becoming involved in

TABLE 3.6
Drugs-Crime Relationship among Respondents, by Gender. Numbers and Percentages (N=29).

DRUGS-CRIME RELATIONSHIP	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
Involved in Criminal Behaviour prior to Illicit Drug Use	13	62.0	0	0	13	45.0
Involved in Criminal Behaviour subsequent to Illicit Drug Use	4	19.0	5	62.5	9	31.0
Illicit Drug Use and Criminal Activity Simultaneous	1	4.5	1	12.5	2	7.0
No History of Illicit Drug Use prior to Imprisonment	3	14.5	2	25.0	5	17.0
Total	21	100.0	8	100.0	29	100.0

illicit drug use. Seven of the eight women interviewed reported that they had not been involved in criminal activity prior to their drug use, while thirteen of the twenty-one men reported that they had. It should be noted that, for two respondents, it was impossible to differentiate which 'came first' - drug use or criminal activity? These two respondents had been involved in drug use and offending activities from a very early age and perceived their drug-using history and criminal activity as being inextricably linked. One was a female respondent, who had started her drug use at the age of eight, and the other was a male respondent, who had begun using drugs at the age of twelve.

Engaged in Offending Behaviour Prior to Illicit Drug Use (n=13)

Thirteen of those offenders with a history of drug use prior to imprisonment reported that they had begun their offending behaviour prior to their drug use. The length of time between engaging in crime and beginning their drug use varied. Two respondents described themselves as 'career criminals', who had become involved in illicit drug use to a limited extent. The majority of respondents in this group, however, had become involved in criminal activity in their early adolescence, and in illicit drug use soon afterwards. These respondents reported that once they had become involved in illicit drug use, their criminal activity escalated. The financial requirements for daily opiate use meant respondents were involved in crimes perceived to be more profitable than those in which they had been involved prior to their opiate use.

Yeah it [heroin use] was on a daily basis, yeah, whatever I could get me hands on, you know. Like it was really when I went on the heroin that I really started getting into the serious crime, you know. But eh, other than that, at first I started off on one quarter [gram of heroin] every day and then I went on to two or three. I had to start stealing and robbing and getting money for it, just robbing cars, after a while doing more serious crime like banks, like to get the money like. I needed it, you know.

Not Engaged in Offending Behaviour Prior to Illicit Drug Use (n=9)

Nine respondents reported that their criminal activity had begun as a direct consequence of their drug use, in order to meet the financial requirements of being an illicit drug user. While drugs other than opiates required finance, it was not generally until respondents had become involved in regular opiate use that criminal activity became part of their daily routine. While respondents may have been employed when they first began their drug use, once they became regular users they had stopped working. Attending work while addicted to heroin was not seen as feasible.

I was after being in a few jobs and I couldn't go to work 'cause I was strung out and I was sick and like, I'd have the gear there beside me in the bed, and basically not going

to work, you lose your job. So you have to get money some way, you couldn't survive like, you couldn't have a habit like on the dole 'cause that wouldn't be a habit like, £60 or £70 a week, so you have to rob then.

These respondents could be termed 'reluctant' criminals, in that their criminal activity was perceived to be a direct response to their need to feed their drug habit. It could be argued that if the financial demands of their drug use were removed they might no longer be involved in crime. These respondents had entered into crimes that they perceived to involve the lowest levels of risk in terms of being arrested. These crimes included small-scale drug dealing and, in the case of some women, prostitution. A move from shoplifting and other forms of larceny to prostitution was seen to offer women a way to earn money while minimising the risk of arrest. As one woman explained:

There's a few nice girls in here, like I am a nice girl and like there's a few girls like meself you know, just caught up in addiction like meself you know. ... Shoplifting was played out, so I went on the game. ... I was sick of shoplifting and getting caught, and just getting watched, and getting chased out of shops and getting thrown off the train, getting stopped everywhere. Like it's not just as easy as going into a shop, like there's more to it than that. ... I think that it's totally different when you go on the needle, you don't care about yourself, you're just thinking about the money, 'where can I get easy money?' So I went over with her [a friend engaged in prostitution] that night and I started working.

The drugs-crime relationship is a complex one and needs to be researched comprehensively in the Irish context. This section has illustrated the diversity of the experiences of the current sample.

3.6 Summary of Main Findings

Twenty-nine prisoners took part in the study. There were twenty-one men and eight women in the sample. Participants ranged in age from nineteen to forty-three. Respondents reported a low level of educational achievement. Furthermore, their employment histories were generally characterised by long periods of unemployment.

Twenty-four respondents had a history of drug use prior to imprisonment; seventeen were continuing to use illicit drugs in prison and seven were not. Five respondents had no history of drug use prior to imprisonment; one of the five had 'experimented' with drugs during his present incarceration, but had since ceased using drugs.

Among those who were engaged in illicit drug use, opiates were the main drug of choice both in the community and while in prison. Cannabis had been the first illicit drug used by most of those with a history of drug use. In the context of early use, cannabis was often used alongside a number of other substances including lysergic acid (LSD), solvents and then ecstasy and benzodiazepines. Twenty-three of those with a history of drug use prior to imprisonment (n=24) had used their first illicit drug by the age of twenty.

Twenty-one respondents (72.5%) had served at least two previous sentences, with many (n=12) having spent multiple periods of time in prison.

Thirteen respondents reported that they had been involved in offending behaviour prior to starting their illicit drug use. Nine reported that they had become involved in offending behaviour as a direct result of their illicit drug use. Two respondents reported that their illicit drug use and involvement in criminal activity had begun simultaneously. Irrespective of when their offending behaviour had begun, respondents with a history of drug use prior to imprisonment perceived their on-going criminal activity to be inextricably linked to their illicit drug use.

CHAPTER 4

PRISON LIFE AND THE ROLE OF DRUGS

4.1 Introduction

Previous studies have shown that Mountjoy Prison is an environment where a large proportion of the population has a history of opiate use (O'Mahony, 1997b; Allwright *et al.*, 1999), most having engaged in daily use right up to the time they entered the prison. The Department of Justice, Equality and Law Reform has estimated that Mountjoy has to cope with detoxifying 1,200 - 1,500 opiate users each year (Department of Justice, Equality and Law Reform, 1999). Based on the argument that environments have significant impacts on human functioning (Moos, 1975), it is important to understand the prison environment from the inmates' perspective, and the role drugs play in shaping this environment. In his commentary on the prison system, O'Mahony has argued that Mountjoy is 'totally dominated by a drugs culture embodied in prisoners' attitudes, values and behaviours' (1997a: 42). This section explores how respondents viewed day-to-day life in the prison and the role drugs played in the prison environment.

Interviews were carried out with respondents in a number of different areas within the Mountjoy Prison Complex (see section 2.4). The experiences of respondents in the different areas of the prison varied. Variations included access to services, cell accommodation, staff-prisoner relationships and prisoner status (remand/convicted). In particular, the extent and nature of drug use were perceived to vary significantly

between areas of the prison. Throughout this chapter, differences between the experiences of respondents in different areas of the prison will be highlighted. Section 4.2 offers an overview of some of the characteristics of prison life, while section 4.3 concentrates on the role drugs play in this environment.

4.2 Day-to-Day Prison Life

Respondents were asked to describe day-to-day life in the prison. A number of features were discussed, including:

- 4.2.1 Living Conditions
- 4.2.2 Daily Routine
- 4.2.3 Prison Atmosphere
- 4.2.4 Relationships

4.2.1 Living Conditions

The general conditions in which respondents were living varied depending on the area of the prison in which they were located. Each area will be considered individually:

- Main Male Prison
- Separation Unit
- Medical Unit
- Training Unit
- Female Prison

Main Male Prison

The general living conditions of the main Male Prison of Mountjoy have been subject to much comment and criticism. The sources of this criticism have ranged from the respondents in O'Mahony's (1997b) study, to a report of the European Committee for the Prevention of Torture (1993) and comments from the Director General of the Irish Prisons Service (*The Irish Times*, 9 August 1999). The key features identified in these reports were the insanitary and overcrowded conditions of the main Male Prison. The main prison is divided into four wings (A, B, C and D), which radiate from a central point ('the circle'). Most cells in the main prison were originally designed for single occupancy, but at the time fieldwork was carried out many housed more than one prisoner. Cells in the main prison have no sanitation facilities and prisoners must engage in the practice of 'slopping out'. In addition, prisoners are required to eat all meals in their cells.

The general living conditions in the main Male Prison received much comment from the current sample. Respondents were unanimous in their condemnation. Much of the criticism focused on the insanitary conditions in the individual cells and the prison overall.

I hate this place, I do. It's manky it is, the prison is, like sanitary is out the window, the jacks [toilet]. You shower once a week, you know what I mean. The cells with the mice and all, like the mice in my gaff I'll tell you man, like I went down last night and I heard the cunts all night, dancing on the floor. ... I'd like to see say right a jacks in your cell for a starter, you know what I mean. Any other prison I been in they at least have a jacks you know, like we need one, like that's one fucked up thing. And eh, showers in the landing, you know what I mean, that's another thing, showers in the landing, showers and that. But eh, you hear so much talk about this dump and they're supposed to be doing it up, you know what I mean, but they should fucking knock it down, bloody knock the place, that's how bad it is.

Respondents also criticised the overcrowding in the prison. At times, cells designed to hold a single prisoner were reported to be accommodating two or three prisoners. Overcrowding was particularly acute for prisoners on remand. Respondents reported how, at times, prisoners were asked to help alleviate overcrowding. When prisoners first entered the prison they were kept in large holding cells ('the Base'), until space became available on a wing; some respondents reported that, at times, prisoners in cells on a wing, with floor space, were requested to take another prisoner into their cells from the Base. A couple of respondents reported that they had either accepted or had been accepted into the cell of another prisoner whom they knew from the community. While prisoners expressed a preference for a single cell, some felt obliged to accept another prisoner to share their cell.

I used to take a few people on the floor, you know, people that were coming in, people that you knew and that rather than them being down in the place over there [the Base]. It's disgraceful for inmates, like a room with 13 or 14 people staying in it like and at night time mattresses on the floors. ... You're just doing the inmate a favour, you know, by getting him the hell out of there and making his first night a little bit more comfortable for one thing, rather than staying in there with a lot of people, you know. It's a sad place, it is truly a sad place.

These conditions were perceived to be dehumanising and added to the stress of being incarcerated. As seen in Chapter 3, drugs had helped respondents cope with problems while in the community and had offered them an escape from reality. The conditions of the main Male Prison were seen to reinforce the perceived benefits of drug use by prisoners.

But the truth of the fact is that it's a shit hole in here, we're all cramped on top of each other, like it's well overcrowded, you know what I mean like. It's a filthy place, the diseases are floating around in the air out there, I mean like when you breathe the air in you might get something, you know what I mean like. Going to the toilets, there's nowhere to go to the toilet decent, do you know what I mean, you know still the slop out, things like that and the cells are in bits. Mice are everywhere, you know what I mean, well our cell, me and [cellmate's name]'s cell, mice are everywhere, you know what I mean like. And if you were in here, you might just want to take something to just get you off that there, like to get you away for a while, course you would, anybody would, you know what I mean.

Overall, the general living conditions within the main Male Prison were seen in particularly negative terms - insanitary, dehumanising and unacceptable.

Separation Unit

The Separation Unit was established in 1983. It was originally used to segregate those suffering from HIV from the rest of the prison population, but now principally houses prisoners who are 'on protection'¹⁶ from others in the main Male Prison. This unit, which offers prisoners both single and double occupancy cells, has twenty-seven cells in total. The three respondents interviewed from the Separation Unit had spent at least some time in the main Male Prison. Respondents felt the general living conditions in the unit were relatively good and they did not attract much comment. Respondents felt their physical living conditions were adequate relative to the main Male Prison.

In the main jail there's a lot more strung out than here, like over here is a lot cleaner. You can have a shower and be clean, over there [main Male Prison] you can have ten showers a week and you still feel scruffy, like the place is that dirty, like the toilets, no-one mopping them, just a mess.

Medical Unit

The Medical Unit was seen to have significantly better living conditions than those of the main Male Prison. The Medical Unit houses prisoners suffering from AIDS and other diseases. In addition, prisoners undergoing the seven-week drug detoxification programme are housed in this area of the prison (see section 6.2.2 for a full description of this programme). Each cell has its own toilet and a wash-basin. Two respondents were housed in the Medical Unit at the time of interview. As with those in the Separation Unit, both had spent time in the main Male Prison and reported that the conditions in the Medical Unit were better than those in the main Male Prison.

¹⁶ Where prisoners are perceived to be under threat from other prisoners, they are moved to a separate area of the prison to ensure their safety.

Training Unit

The Training Unit was built within the confines of the Mountjoy Complex in 1975 but operates as a separate prison. The unit was established to provide skills that would enhance male prisoners' opportunities for employment after release, and to promote re-socialisation and educational opportunities (European Social Fund Evaluation Unit, 1998). The Training Unit is described as a 'semi-open' prison in that the perimeter security to the unit is equivalent to a closed prison but the internal regime is more relaxed (European Social Fund Evaluation Unit, 1998; personal contact, Irish Prisons Service). Prisoners have a significant amount of control over how they manage their own time, they spend less time 'locked up' than inmates of other units in the Mountjoy Complex and generally do not have to be escorted by a prison officer when they move about the unit.

Prisoners can access the Training Unit through the drug treatment programme based in the Medical Unit, as part of a special programme for life-prisoners reaching the end of their sentence, or by making an application to the prison's governor for a transfer. Since 1996 the unit has been a designated drug-free zone and random urinalysis is carried out on all prisoners, irrespective of whether they have a drug-using history or not. Testing positive for prohibited substances means relocation to the main Male Prison.

Respondents in the current study reported that the starkest contrast in living conditions was between the Training Unit and the main Male Prison. All Training Unit prisoners are housed in single cells, which are fully furnished and have windows without bars. Respondents reported positive reactions to the living conditions in this unit. The unit was seen to be clean and the individual cells much more comfortable and with more sanitary conditions than those in the main prison.

Female Prison

At the time fieldwork was carried out, female prisoners were housed in a wing of St Patrick's Institution.¹⁷ Cells were designed for single occupancy and, at the time interviews were carried out, each woman had her own cell. In addition, unlike in the main Male Prison, the women's cells each had their own sanitation facilities. Compared with the main Male Prison, overcrowding was not as common a feature in the women's prison. The privacy this wing offered was seen in favourable terms.

It was only when it got packed that there would be like two in each [cell], like it's not like the men's prison that they double up down there. ... Like I prefer singles, like if

17 Since the completion of fieldwork, the women's prison has been relocated to a new building within Mountjoy Prison Complex.

you're sharing then you'd have to eat with them and all, I don't mind all that, you know what I mean, but like I like going to me cell and I like being on me own.

The expectations for the new female prison (called Dóchas) being built at the time of the study were high. It was hoped that this would improve the general living conditions for prisoners and the facilities available to them.

It's going to be easier to do your jail 'cause you have a telly in your cell. You have a shower in your cell, it's real comfortable.

In summary, the living conditions of prisoners varied depending on the area of the prison in which they were housed. The Training Unit was seen to have the most favourable conditions while the main Male Prison was described in the most negative terms.

4.2.2 Daily Routine

Daily life in the prison was structured around a routine. While the Training Unit varied somewhat, the other areas followed the timetable described below.¹⁸

TIME	ACTIVITY
08.15 am	Unlock, empty chamber pot, get fresh water. Give your name to your Class Officer ¹⁹ if you want to see the Governor, a Chaplain, your Probation and Welfare Officer, the Doctor etc. Collect Breakfast, return to cell.
09.15 am	Unlock, empty basins, make bed, tidy cell, etc. go to place of employment, school, yard or gym.
09.30 am	Governor's Parade (approx. 45 - 90 minutes).
12.15 pm	Return to cell, get fresh water, collect dinner, return to cell.
02.15 pm	Unlock, empty basins, tidy cell, go to place of employment, school, yard or gym.
04.15 pm	Return to cell, get fresh water, collect tea, return to cell.
05.30 pm	Unlock, empty basins, tidy cell, go to recreation.
07.30 pm	Return to cell, get fresh water, collect supper, return to cell. (8.00 pm on Tues).
10.00 pm	Lights out.

18 This timetable is included in a booklet currently being produced for prisoners in Mountjoy by the Mountjoy Prison Probation and Welfare Service.

19 A prisoner's Class Officer is the prison officer in charge of his/her landing.

Prisoners are allowed to mix with other prisoners in the prison's school, gymnasium, workshops, exercise yard, and the recreational area ('the rec') of each prison section. During recreational periods prisoners may participate in a number of sporting activities or watch television or a video. They also have access to a library. All sentenced prisoners are entitled to educational services, although places are limited. As with other services, the range of classes on offer and the number of places available vary between different areas of the prison. The subjects taught include literacy, computers, English, languages, health education, history, sociology, word processing and mathematics. Prisoners can also be facilitated in taking the Junior Certificate, the Leaving Certificate or an Open University course. In addition to education, the opportunity to work while in prison is open to a limited number of sentenced prisoners. Prisoners can work in any of the prison workshops or in the Catering Department of the prison. However, unless proven to be drug-free for a significant period of time, those with a history of drug use are not permitted to work in the Catering Department. The workshops include a metal workshop, fabric workshop, computer workshop, window assembly workshop and carpentry workshop. Access to these varies, depending on the area in which prisoners are housed. The Training Unit has the highest level of availability, followed by the main Male Prison. Prisoners engaged in workshops may be paid IR£10 per week.

Each morning, during Governor's Parade, prisoners have the opportunity to approach the prison governor or his representative with any queries or problems he/she may have. Contact with the outside world is subject to strict rules. Prisoners are allowed one telephone call a day, for a maximum of six minutes, to one of three pre-selected personal numbers and a solicitor. All these telephone calls are monitored and recorded, except for those to either the Samaritans or a solicitor. Letters are also monitored and may be censored. Visiting times at the prison are from 10 am to 12 noon and from 2 pm to 4 pm every day, except Sunday and Christmas Day. During an 'ordinary visit' with friends or family members, prisoners are not allowed physical contact with their visitors. Sentenced prisoners are entitled to one 'ordinary visit' per week for 30 minutes. Those on remand are entitled to an 'ordinary visit' for 15 minutes per day.

The following is a remand prisoner's description of a typical day for him in the main Male Prison.

Like you can have breakfast if you want, I always do 'cause I like a cup of tea and a cigarette first thing in the morning, a 'whore's breakfast' as it's called. And eh, I might just run down, fill the flask, run back up and get back into bed or leave it 'til half nine when they do wake you up. Then at half nine we come down and go to the governor if you want to make a phone call or whatever, and then to the library if you want, if not, you're out in the yard if you're on remand. Then twelve o'clock is fall back in. The food

hasn't been too bad lately for the last few months, like it's started to get better. You go down and queue up for your dinner, bring it up to your cell. As I said there's three of us in the cell so there's no room, you know what I mean, squashed in. Then you might have a sleep. In the afternoon, two o'clock, same rigmarole again to four, like the yard or workshop or wherever you may be, you know. Four o'clock, get your tea, back up to your cell, half five down again, watch a video, play pool, snooker.

Respondents found their daily routine monotonous. While they recognised the need to have the daily activities structured within the prison environment, they felt there was a lack of facilities, especially when they were out of their cells. Even where there were workshops or classes, the places were limited and many reported that prisoners were left with nothing to do. The following woman was hoping that this would change when the new women's prison was opened.

It's very boring. Everyone just walks around, do you know what I mean, all day with nothing to do, it's dead. And like there's only so many that the classes can take and so many, like all the classes are full, like they're just waiting, just for school, do you know what I mean. And some judges recommend that you get an education, you can't, like maybe in the new prison it might sort that out, I don't know.

For those respondents who felt there were no activities in which to participate during the time their cells were unlocked, drug use offered a welcome break from the boredom. Therefore, from their perspective, the monotony of the daily routine was seen to reinforce the value of drug use and to be an important factor motivating their drug use.²⁰

You come in here, you just double up with a guy in the cell or whatever and when the drugs come along like they're heaven sent, you know, like you get out of here for a while. What I mean like it's a shit hole here, it really is, it's a shit hole it is, there's nothing here for anybody, nothing, there's no rehabilitation, no nothing.

It is important to note that respondents in the Training Unit did not see monotony as being such an integral part of prison life. In the Training Unit, prisoners are unlocked from 8 am until 9.30 pm each day. Workshops and the school begin at 9 am and there is a tea break from 11 to 11.30 am. Dinner is served between 1 pm and 2 pm and there is another tea break from 4 pm to 4.30 pm (Mountjoy Prison Probation and Welfare Service, personal contact). Prisoners who had spent time in other areas of the prison found being given more control over their time management took some adjustment when they initially arrived in the Training Unit. An important difference between the

²⁰ See section 5.2.3 for a full discussion on motivations for using drugs within the prison environment.

daily routine in this area of the prison and the main prison is that inmates eat their meals in a communal area. When respondents had spent a number of years eating their meals alone, it could be difficult to adjust to eating in a communal area.

Eh, it was a big change coming from a what they call a 'high security' prison to this, I mean it's a lot more open, it takes a while to get used to that, the dining hall is a big change, 'cause in [other prison] you eat in your cells, so that's a big change. ... You're used to eating on your own, then you're eating with ninety people, the noise level is way up, you get panicky, freaked out of your head for the first week, you know.

In summary, respondents generally found the daily routine monotonous and argued that there were not enough activities for them. Boredom was particularly acute for those on remand, who did not have access to a number of the prison's facilities. Where day-to-day life was characterised by boredom, this was seen to reinforce the benefits of drug use.

4.2.3 Prison Atmosphere

The atmosphere within the prison was described by respondents in broadly negative terms. It was characterised by feelings of isolation and tension. It was felt that tensions were particularly heightened in an environment where there were a large number of prisoners on remand. Being on remand meant that tensions rose for prisoners in relation to pending court cases and uncertainty about their outcome. Overall, the atmosphere was both tense and unpredictable.

This place here is at boiling point, you know what I mean, it's boiling over and it's waiting to explode, you know.

I'm still a bloody nervous wreck, every day is different in here you know, like eh, you don't know what's gonna happen, you know. ... So when you're talking to a person you don't actually know what they're feeling like that day, so you've got to be kind of wary.

At times these tensions overflowed into violence. Individuals were often imprisoned with people they knew from the community, and problems that existed between individuals on the outside might be brought into the prison environment. In some cases this required people to be separated.

I've seen the hardest of guys being put under protection because they were in fear of their lives, 'cause somebody comes in that they've done something on the outside and, eh, em, the staff have got word that there's going to be trouble, they just tell them 'listen it's up

to you, you've got to go underneath [into the Separation Unit] or else you're gonna be, gonna be gone' and eh, it can happen.

As well as tension, an underlying feeling of depression was seen to characterise the atmosphere within the prison. Respondents were removed from their home and family, with those convicted only having one visit per week. Many parents within the sample did not want their children to visit them in prison. This absence of contact with their families was seen as contributing to their feelings of loneliness and isolation within the prison. Those who were in prison for the first time expressed particular feelings of depression about their situation, as the following woman explains:

I felt like I was letting meself down, that I had let me parents down, that I had let me son down, I let everybody down. I thought to meself 'I'm in a mess, I'm strung out to bits, I'm on me way to prison now, can it get any worse than this?' you know what I mean. I really, I felt so sad, so upset, I was very upset coming in, crying and that.

It is important to note that prisoners had to cope with feelings of loneliness and depression within a very stressful atmosphere, where they might not have access to help and support.

Like it's a different world out there, like this is a city within a city in here, you know what I mean, like this place, you know what I mean, it's like a whole different world in here, it's all about survival, surviving every day, you know.

4.2.4 Relationships

Relationships developed within the prison both between prisoners and between prisoners and staff. Prisoners' perceptions of these relationships were explored in the interviews.

Prisoner-Prisoner Relationships

A previous study has established that prisoners in Mountjoy tend to be from a limited number of areas in Dublin that are characterised by relative deprivation (O'Mahony, 1997b). The current study found that prisoners who had been living in Dublin prior to imprisonment tended to come from these same areas. Furthermore, they tended to know each other not only through being members of the same community but also through their drug use. Where relationships had already been established in the community, they were maintained in the prison.

You'd know them [other prisoners] from the drug scene, the scene like, or they could be friends, like I always bump into them in here as well.

Like I know it's not a nice place to see your friends and that, you know what I mean, but like when you see them coming in you're chuffed, you know what I mean, seeing, like I'd be delighted to see them coming in. ... Like I lived out in [north city suburb] so like there's a good few of the lads in here, you know what I mean, from the address I live, so it's alright.

Relationships were based not only on those already established in the community but also on an individual's drug-using status. In general, prisoners tended to select those whom they spent time with based on their drug-using status. For those currently engaged in drug use, companions were generally part of the drug distribution network in which they were involved.²¹ On the other hand, prisoners who were not engaged in drug use tended to spend their time with other non-users. Overall, as in the community, individuals selected a peer group of 'like-minded' individuals. As the following respondent, who had no history of drug use, explained:

I haven't had that much experience with them [drug users] but they're a different, eh, they're not you know, like it's like you probably have your own friends out there [in the community] like, and you wouldn't be with other friends like, so you just stay with your own people sort of, you know.

Another respondent, who was not currently using, explained why he felt that there was a division made between prisoners on the basis of drug-using status. He felt that drug users were particularly stigmatised within the prison setting and attracted a lot of attention from prison staff. He argued that prisoners who were not involved in drug use did not want to be labelled as drug users, and therefore tended not to want to be associated with those who continued to use drugs in the prison.

Most of the people that don't take drugs, don't want to be labelled. They don't want to be seen walking around with a bunch of them that do take drugs because they'll be labelled as well. ... Anybody that's not taking drugs won't have any time for anyone that is, unless they're family or else they grew up with each other and one of them ended up taking drugs and the other one didn't, you know.

Prisoners currently using drugs, and those who were not, reported that drugs were one of the main topics of conversation among prisoners. Accessing them, using them and past experiences of them were talked about on a frequent basis. The following respondent was currently engaged in the use of heroin in the prison:

21 See section 5.3.2 for a full discussion of distribution networks.

It's so negative in there [main Male Prison], you know what I mean, like I'm sitting in there with negative people around the clock, 24 hours, like it's the whole topic of conversation in there. Like you can get no intelligent conversation out of nobody in there, you know. Believe it or not, the whole conversation in there from one end of the day to the other end of the day is drugs, like who's getting drugs in visits, who's not getting visits, ah it'd do your head in.

The divisions in terms of drug-using status were highlighted by the experience of those housed in the Training Unit, which was a designated drug-free area. Respondents generally felt that, owing to the lack of a drug-using culture in this area, there was less differentiation between those prisoners with a history of drug use and those with no history of drug use. In this environment the tensions around drug use were removed. This was seen to encourage mutual respect between prisoners, and removed divisions based on drug-using status. There was a much higher level of interaction between prisoners, irrespective of drug-using history. As the following respondent, who had a history of illicit drug use, explained:

There's two people at my table who have never taken drugs in their life, you know, and they don't take drugs and they're not into taking drugs. But there's an awful lot of people in here and they're sitting with people who are clean, you know, have come through the Medical Unit and all, and that's what it is, they don't hold it against them, you know. Like you wouldn't say 'fuck him, I'm not sitting beside him', because most of them know that once they're here, they're trying to do something for themselves.

Prisoner-Staff Relationships

This study did not aim to examine prisoner-staff relationships in depth and data on this aspect of prison life are limited. Staff were not interviewed and therefore data are restricted to the perceptions of prisoners. While there was a range of different staff in the prison, respondents focused almost exclusively on their relationships with prison officers. Prisoners had daily contact with prison officers, who were perceived to play a key role in their day-to-day experience of prison life.

Respondents had mixed attitudes towards prison officers. A small number held particularly negative attitudes about them and categorised them all as 'being the same', emphasising a 'them' and 'us' relationship between officers and inmates.

I never see anyone behind the blue uniforms, they're all the same to me you know what I mean, eh, we've [prisoners] got this hatred, you know what I mean, towards them.

Overall, however, while the majority of prison officers were viewed in a generally negative way by interviewees, a significant minority were viewed more positively. The following examples demonstrate this:

I don't know how many screws there is but, give or take out of a hundred, I'd say that there would be about thirty screws that would be interested in you, then the seventy, they'd just fuck you in a cell and leave you to rot.

Like there's only a certain few of them that are in here to help people, the rest of them are just in here for the money. There is a certain few officers that is here to help, there's a certain few. ... We're prisoners, we're scum, they're hard workers. That's the way some of them see it.

As with other aspects of prison life there appeared to be variations in the relationship between prison officers and inmates in different areas of the prison. Overall, prison officers tended to be seen as more of a source of support by female respondents than by male respondents. As the following woman explained:

The prison officers, like they work very closely with the prisoners in here [the women's prison], you know. Like a few of them are very nice, you can sit down and talk and they'd have time for you, you know, if you need to talk they'd tell you to come in and sit down and talk to you.

In summary, prisoners had mixed views of prison officers and this was reflected in their relationships with them. While a significant minority were seen in a positive light, prisoners generally maintained a distance between themselves and the prison officers.

4.3 Drugs and the Prison Environment²²

While the previous section has explored the prison environment in a general way, this section explores the role played by drugs in shaping this environment. There was consensus among respondents that drug use had a strong presence in Mountjoy (other than in the Training Unit) and that it impacted on prison life in a number of ways. A number of areas were identified in the course of interviews and respondents' perceptions of them are explored in the following sections:

4.3.1 Visibility of Drug Use

4.3.2 Drugs and the Prison Atmosphere

4.3.3 Impact of Drugs in Prison on Different Categories of Prisoner

²² See Chapter 5 for a full discussion on drug use within the prison setting.

4.3.1 Visibility of Drug Use

All twenty-five respondents with a history of illicit drug use in the current sample had used illicit drugs at some stage while imprisoned. Twenty-three reported that they had used drugs while in prison on their current sentence, and two reported that, while they had used drugs during previous sentences, they had not used since entering prison on the current sentence (see section 5.2.1). The various processes involved in drug use were therefore on-going within the confines of the prison, i.e. accessing, administering and being under the influence of drugs. Respondents highlighted the visibility of these processes in the prison, although there was a lot of variation between different areas in the prison. While it was reported that drug use was not apparent in one area of the prison (the drug-free Training Unit), it was perceived to be particularly acute in others (the main Male Prison and the Female Prison).

The following respondent, who had moved to the Training Unit, described the role drugs had played in shaping his daily experience of prison life while in the main Male Prison. His description was typical of those given by respondents who had spent time in the main Male Prison. He explained why he would not have been able to cease his opiate use while incarcerated in that setting:

Like it would be like asking an alcoholic to sit in a pub all day and not drink, that's what it's like. Because there's drugs everywhere, you know. Like you wake up in the morning and you walk out, and before you even walk out somebody probably comes into you and probably asks for tinfoil to smoke heroin, or somebody will probably come into you and ask you if you've got a works. Or like you walk up to the toilets and go to walk into the toilets and there's two or three people there, banging up in the toilets, like taking heroin in the toilets. Or you're walking by one of the rooms and you can smell heroin cooking in the cell, you know, and there's people walking by you stoned all day. And you can walk down to the rec and sit in the rec and they're coming out of the toilets and they're taking drugs and they're asking you can you get them a works and that, or they're asking you can you get them this or whatever. And they're looking for spoons and they're looking for, you know, things to cook up the gear. But I mean the majority of them over there are on drugs.

The distribution and use of drugs were seen to be a common feature of day-to-day life in the main Male Prison. Both the following respondents had a history of drug use: the first was using opiates in the prison and the second cannabis.

Like say you get a visit, you're back up at four, half five, the amount of people around the cell, it's like a bleeding shop, like the January sales, that's what it would be like. Queuing up for the January sales, it's a joke. ... Like you walk out into the yard on a summer's day, the yard is black, people everywhere, some turning on, rolling joints.

Like I'm in the jail where the drugs are rife and I sit down and play chess in the recreation hall and there's a guy beside me, two guys like, sitting beside me for me to hide them. They're jabbing needles into their neck, they're warming up gear.

However, it is important to note that the main Male Prison was not seen as homogeneous in terms of the visibility of drug use. Respondents reported that the openness of drug use and its associated behaviours varied between the four wings (A, B, C and D) of the prison.

Like the way it is that whole [main male] prison is rampant with the drugs, it's just that on one side of the prison it's behind the door, on the other side it's open, do you know what I mean? That's just the way it is.

Respondents reported important disparities between wings in the overtness of drug use among prisoners. As the following respondents (housed in D-Wing and A-Wing respectively) explained, use was particularly overt in the remand wing (B-Wing) and A-Wing, and more covert in D-Wing.

It's not as bad where I am. You see, there's three or four different wings in the prison and like, they're all like separate jails, they're like four, well two different jails like type of thing. So I'm in one part of the jail and there's not as much heroin at all, and the other part of it is just unreal to be honest with you, like they're out in the yard just banging up, it's crazy.

Like D-wing's completely different, you wouldn't see anybody banging up in the yard. But if you look at A-wing, they're all in the yard and the rec smoking and banging up.

Drug use was also described as being visible within the Female Prison. Unlike in the main Male Prison, women were all housed on the same wing, which meant the situation was the same for all female prisoners.

It's happening in the yard every fucking day, every day that I go out to that yard they're sitting there under that corner, every one of them sharing the same spike.

Only three respondents from the Separation Unit and two from the Medical Unit were interviewed. However, all reported that at least some drug use occurred within these units. It was argued that this use was more covert than in the main Male Prison. The status of the Training Unit as a drug-free wing, monitored by random urinalysis, had implications for both the extent of drug use within this setting and its visibility. None

of those interviewed from this area of the prison (n=4) reported having used illicit drugs while housed in the unit. Furthermore, none reported having witnessed any drug use there. Only one respondent reported that he thought some drug use occurred in this unit. He identified the absence of any visible drug use to be a positive aspect of the Training Unit's environment.

Like this place [the Training Unit] is after doing something big time 'cause like it's totally, well I won't say totally, totally drug-free institution, there's still bits of it floating around but it's not as bad as Mountjoy or Wheatfield, do you know what I mean. So where that [drug use] is being done, it's done behind closed doors. It's not like the main jail like where you're facing it every day in the week.

It may be argued that the respondents above reported drug use as a visible part of prison life because of their drug-using history. However, in each area of the prison those prisoners with no history of use reported similar views to those with a history of use. As with drug users, their accounts varied depending on which area of the prison they were based in. Non-drug-users in the main Male Prison reiterated the view that the visibility of use varied between different wings. As the following non-user reported:

D-wing, where I am at the moment, I haven't seen one person shoot up but I've heard, whereas in C-wing you actually see them. B-wing it's rampant, you see it all the time, blood on the floors, toilet paper with blood, blood on the walls, I don't know how these guys do that, and eh, I just think it's too terrible.

While non-users in the Female Prison reported use was visible on occasion, they did not appear to be exposed to it as frequently as the male prisoners in certain areas.

You see it [drug use] now and again, they'd be out in the yard and they'd be sharing the needle and that. Like now I pass no remarks on it, now if I see it, I see it, if I don't, I don't. ... I can't recall seeing it the first time when I came in, em, they'd smoke joints and all but it's only now that I would see them shooting up and all.

The absence of overt use in the Training Unit was reflected in the experience of the only prisoner interviewed there who had no history of use prior to imprisonment. He had been transferred directly from a prison outside Dublin into the Training Unit and was the only respondent to report that he had not seen any drug use since entering the Mountjoy Prison Complex:

I've still never seen heroin, and I don't want to see it either, thanks very much but no. ... They keep it amongst themselves the one or two that might be into it.

In summary, there were variations in how overt drug use was perceived to be in different areas of the prison. The Training Unit, a designated drug-free wing, was not characterised by drug use. However, the vast majority of inmates were housed in areas where they were regularly exposed to drug use and its associated activities, i.e. distribution, administration and effects of drug use.

4.3.2 Drugs and the Prison Atmosphere

As discussed in section 4.2.3, respondents often considered the prison atmosphere to be tense and unpredictable. While the prison population was made up of a significant proportion of people who were addicted to drugs, respondents tended to focus on the drugs themselves as impacting on the prison's atmosphere. The perceived impact of drugs on the atmosphere was complex and somewhat contradictory. When drugs were available, they were seen to produce a relatively calm environment; when they were in short supply, it was argued that tensions in the prison increased. In an environment where the availability of drugs fluctuated, tensions among those depending on them also fluctuated. This was highlighted by the experience of the following female prisoner.

It's fucking a lot quieter when there's drugs in the prison 'cause everyone is stoned, but when there's no drugs, there's fighting and a lot of tension in the place.

There were suggestions that blocking access to all drugs in the absence of adequate treatment services would have potentially serious consequences.

I think they're happy at certain times that there's drugs in the jail. It keeps the lid on it, it does. Like that's why I can't see this remand place working out, it's supposed to be screened visits and like there'll be 400 people coming in, say 350 of them are addicts and it's screened visits and they're not getting any drugs in on the visits. It's going to flare up there and tensions, they're gonna be at breaking point, whereas in here I think they let it in, like they stop a lot but a certain amount will get in, like when they turn their backs people are getting drugs.

Tensions mounted when drugs were in short supply. Accessing heroin was a priority for many of the respondents. The nature of the distribution networks for heroin in the prison meant prisoners were dependent on other inmates to provide them with drugs. Where 'favours' were not returned and the distribution network failed, this created tension between prisoners.²³

²³ See section 5.3.2 for a full discussion on the distribution process for drugs in the prison.

Like you'd look after people and then they'd get their own visit and you'd look for it, and they'd be after looking after another five or six blokes and there wouldn't be any left. That's when things get rough, that's when there's a lot of assaults on inmates in jail and that.

It was also reported that prisoners who had been seen to get drugs through a visit, had been attacked by other prisoners, who stole the drugs from him/her. This was reported to occur in both the main male and female prisons.

It's a drug haven, it's rampant with drugs. ... It's just like attacking people for heroin, like I seen blokes knocked out in the yard, when they're coming off visits 'cause they have gear and the next person doesn't, you know, so they'll just take it.

By being removed from the drug distribution networks, prisoners felt they were also removed from the associated threat of violence. The following respondent was in the main Male Prison but had ceased his drug use.

I know a lot of people in jail, I don't have any arguments with them or animosity or that, like it'd be 'how'ya, what's the story', everything's a laugh, everything's a slag, you know. And I think the reason for that is, it's good, because if you were involved in drugs, the slightest hitch and they'd turn and stab you in the back, whereas that wouldn't happen with me, so I'm safe that way.

The less volatile atmosphere in the Training Unit was attributed in part to the fact that drug use was not generally perceived to occur there.

They're all sort of in a happy humour over there [the Training Unit] 'cause of the fact they're off drugs, you know. There's none of the fighting, eh, there's no, like you never see fights, you know, the physical fights, like to what you get in the main jail so there's not that paranoia or fear there, you know.

In summary, while the prison population was made up of a significant proportion of people who were addicted to drugs, respondents tended to focus on the drugs themselves as impacting on the prison's atmosphere. Drugs were seen to play a complex role in influencing the day-to-day atmosphere within the prison. While a prison with a number of its population under the influence of drugs was seen to produce a calm atmosphere, when drugs were not available a particularly tense atmosphere was perceived to result. This was highlighted by what respondents perceived to be the fluctuating level of tension in the prison, which depended on the availability of drugs. Other aspects of drug use in the prison also contributed to the overall atmosphere. This

included the ability of users to access drugs: where distribution networks broke down, the tension rose and at times was reported to erupt into violence.

4.3.3 Impact of Drugs in Prison on Different Categories of Prisoner

Despite variations between different areas of the prison, the majority of inmates were imprisoned in an environment where drug use was perceived to be a common feature of day-to-day life. In the course of the interviews, respondents described what they perceived to be the key impact of this on their experience of prison. They argued that the presence of drugs in the prison impacted on the experiences of both those working and those living in the environment. In this section the experiences of those in each of the three groups are considered from the prisoners' perspective:

- Prisoners with a History of Drug Use
- Prisoners with No History of Drug Use
- Prisoners' Perceptions of Impact on Prison Staff

Prisoners with a History of Drug Use (n=25)

Respondents with a history of drug use reported that the presence of drugs in the prison had impacted on their experience of prison in a number of ways. As seen in section 4.2.4, the relationships prisoners established within the prison environment were influenced by drug use. However, the key feature raised by respondents was that the presence of drugs in the prison influenced their decision making around their own drug use. As seen in section 3.3, respondents reported that one of the key attractions of heroin was its physical and psychological numbing effects and its ability to offer an escape from reality. In the context of the prison environment, this 'escape' was a very attractive characteristic.²⁴

Smack, like you get smack in here, you don't give a bollocks, you know what I mean. It takes you away from reality for a while, you know what I mean, or whatever, like that's the way it is here, you know what I mean, you just want to escape.

Respondents argued that seeing other prisoners enjoying the benefits of heroin use reinforced their motivation to use. As the following woman explained:

They'd [other female prisoners] be all skin popping, you'd see a lot of it and it's very hard when you're trying to stay away from it in here, you know, when you're seeing that, especially when your head is screaming for it.

²⁴ See section 5.2.3 for a full discussion on motivations for using drugs within the prison environment.

The following two men were typical of respondents who believed that, in order to cease heroin use, they would have to be removed from an environment where it was a key part of day-to-day life. Both were continuing to use heroin within the prison.

I've never been able to turn me back on it [heroin] it's very hard, very hard, you know what I mean. I think I'd have a better chance if we weren't in this wing [B-Wing] and all, with the drugs and that. ... It is just like it's the willpower you need, but like you can't get that willpower when you're not away from the environment. You have to be away from it and be around people that's not into it.

Respondent: I want to get out of here [main Male Prison].

Interviewer: Why?

Respondent: 'Cause if it's [heroin] not in front of me I won't be as tempted, you know. Like I really do, really do want to give up. I've lost so much because of it.

As discussed in section 4.3.1, drug use was reported to be more covert in the Separation and Medical units than in the main Male Prison. The following respondent argued that an environment in which drug use was not visible was more conducive to remaining off drugs.

I just see that place [the main Male Prison] as a hell hole over there, you know, it's bad, you know, manky, it's [heroin use] the chronic problem that they have over there. ... Like a lot of them [other prisoners in the Separation Unit] are taking them [drugs], but a lot of them are trying to get their heads together as well like. They're not able for it over there, you know, for being in an atmosphere like that, so they come over here, it's not nice you know like.

Overall, the 'drug scene' in all the Dublin-based prisons was seen to discourage prisoners from ceasing their drug use. As one respondent who was currently using heroin explained:

As soon as I'm done in court I'll put in me transfer to Portlaoise [County Laois] or Castlerea [County Roscommon] or somewhere like that, 'cause I have to get out of the Dublin prisons, 'cause the drug scene is too much. No chance of getting anywhere in life if you're around that all the time. That's my reckoning anyway.

In summary, where drug use was visible it was seen to reinforce its perceived benefits. To change their drug-using behaviour, respondents generally felt that they would have to be removed from an environment where drug use was a central aspect of daily life.

Prisoners with No History of Drug Use (n=4)

Four of the prisoners interviewed had no history of drug use. They had all been living outside Dublin prior to imprisonment, in communities where they had not perceived drug use to be particularly prevalent. These respondents reported that they had not been familiar with illicit drug use, and the practices around it, prior to entering Mountjoy. However, once imprisoned in Mountjoy and living in an environment where drugs were a feature of daily life, drug-using activity was something to which they had had to adapt. As the following respondent from the main Male Prison reported, he was faced with drug use and its effects on a daily basis.

Everyday, all day I see them [users], shooting up. I've been offered hundreds of times and I look at them and they just say, 'sorry'. ... Like I've seen them in the toilets and out in the yard, in front of everybody, shooting up dirt, getting sick on poisoned gear. ... People will be rushing around to see if they can find a bit of hash, or if someone's got gear they'll be around him like vultures. So it's yes, I would say everyday all day yeah, because it's in relation to drugs, everything you do in this place.

While initially respondents reported being shocked by the drug use going on in the prison, it was something that they had become accustomed to over time.

I was shocked, I was scared of my life, I was scared. Like one of the girls told me, like I wasn't sure at the beginning what was going on like, you know. But the first time I ever, like I wouldn't even say I saw anything but I heard it going on in the shower. It was two girls, like all I could hear was that [slapping arm] so, oh my God. I had the quickest shower of my life. ... I'm more used to it now, even though I haven't heard it going on any more, well I've heard it going on but I think you get immune to it.

At least initially, these respondents saw injecting drug use and the volatile atmosphere in the prison as posing a potential threat to their welfare, as the following woman explained:

Well it's the needles that I worry about, I don't mind them smoking a joint or whatever but you know I have to look after my health, you know. ... I don't usually argue but in case I did argue with anyone that they'd try and get back at me with it [the syringe], probably silly but anyway.

In summary, even for those four respondents with no history of drug use, drugs were a feature of daily life in Mountjoy. They had very little previous experience and knowledge of drug use but they had to adjust to mixing with those who had. This meant negotiating the often fluctuating atmosphere in the prison.

Prisoners' Perceptions of Impact on Prison Staff

Respondents discussed not only the impact that the presence of drugs had on their experience of prison, but also on the experiences of those working in the prison. It should be borne in mind that findings relate to the perceptions of prisoners rather than the views of prison staff themselves. Respondents' views were almost exclusively related to the perceived experiences of prison officers rather than other prison staff.

The key feature identified by respondents was that the presence of drugs in Mountjoy made it a more stressful working environment for staff. Respondents referred to the increasing prevalence of drug use within the prison, and in particular, the presence of syringes. As the following respondents argued, in such a tense atmosphere syringes could be seen as particularly threatening for prison officers. Prisoners felt that officers feared needle-stick injuries and the risk of contracting HIV or hepatitis. As the following women, the second of whom did not have a history of drug use, explained:

Like they'd [prison officers] be afraid if someone was having a skin-popping, they'd be afraid to walk over 'cause they could say 'get the fuck away or you'll get this in you', like they wouldn't, but that's what they would say. I've seen it happening loads of times, girls in the showers and they do say 'come near me and I'm telling you, I'll put this fucking in you, let me get this [heroin] into me and I'll give it to you'.

The officers don't do anything about it, they're too scared you know, scared. Like there's so many [prisoners] with the virus in here that they're just scared that they'll catch anything.

The potential use of a syringe as a weapon was felt to affect the way prison officers perceived prisoners. Where a prisoner was engaged in injecting behaviour they would be seen as a threat to officers, compared to those who were not using drugs.

'Cause they know then this fella doesn't use heroin, he's more likely not to be violent and this fella is using heroin, cross his path and he may have a syringe in his cell or whatever and cut you up.

The experience of those working in areas of the prison where drug use was a part of day-to-day life was in direct contrast to the experience of those working in the designated drug-free wing (the Training Unit). Officers in the Training Unit were perceived to be working in a much more positive environment. They were removed from an environment in which a volatile atmosphere was combined with the presence of syringes. The following respondent was in the Training Unit.

- Respondent: They're [prison officers] a lot more relaxed you know, they don't go around with as much tension as, you know what I mean, the other officers over in the main jail. Like they're not as stressed out either, they seem a lot more relaxed over here.
- Interviewer: Why do you think that is then?
- Respondent: Because they don't have to worry about smack or stuff, or people with dirty needles or anything, you know. I just know that they are a lot more relaxed.

In summary, respondents reported on how the presence of drugs impacted on the experiences of prison officers with whom they had daily contact. They felt that in areas of the prison where overt drug use occurred, prison officers were working in a volatile environment in which some prisoners had syringes in their possession. It is important to note, however, that none of the respondents reported ever having used a syringe to assault an officer or knowing a prisoner who had done so.

4.4 Summary of Main Findings

Drugs Culture

Other than in the designated drug-free wing of the Training Unit, respondents perceived Mountjoy Prison to be characterised by a drugs culture, manifest in the attitudes and behaviour of prisoners. Irrespective of the drug-using history of prisoners, or their current drug-using status, there was an overall consensus that drug use was an issue they faced on a daily basis.

Living Conditions

Respondents reported variations in living conditions between different areas of the prison. They were particularly critical of the living conditions in the main Male Prison, where the majority of inmates were housed. They described conditions as insanitary and overcrowded. In comparison, respondents reported positive reactions to the living conditions in the Training Unit, where inmates had their own cells and the conditions were perceived to be sanitary.

Daily Routine

The daily routine of prison life was perceived to be extremely monotonous, although the monotony was perceived as less acute in the Training Unit. Where respondents with

a history of illicit drug use were not engaged in structured activities, the boredom experienced was seen to reinforce the perceived positive aspects of illicit drug use.

Visibility of Drug Use

Respondents reported that they saw significant variation between different areas of the prison in terms of the visibility of the activities involved in illicit drug use, i.e. distribution, administration and being under the influence of drugs. While it was reported that drug use was not seen in one area of the prison (Training Unit), it was reported to be particularly acute in others (main Male Prison, Female Prison). Respondents identified drug use as visible, depending on which area of the prison they were housed in, rather than whether they were engaged in illicit drug use in the prison or had a history of illicit drug use.

Drugs and the Prison Atmosphere

Respondents reported that the overall atmosphere of the prison was affected by drug use. In an environment where the availability of drugs fluctuated, tensions among those depending on drugs also fluctuated. This resulted in a volatile atmosphere in most areas of the prison. Respondents argued that drugs impacted on all those in the prison setting, including prisoners with a history of drug use, prisoners with no history of drug use, and prison staff.

Impact of Drugs in Prison on Different Categories of Prisoner

Prisoners with a history of drug use argued that the perceived benefits of drug use were reinforced in the prison environment. Drugs were seen to alleviate some of the problems associated with prison, such as boredom and depression. To stay or become drug free in an environment characterised by a drugs culture was not perceived as feasible by those with a history of drug use.

The prisoners with no history of drug use, who were housed outside the Training Unit (n=4), reported that, at least initially, the presence of drugs made the prison environment more threatening for them.

Respondents felt that the presence of drugs in the prison made for a more threatening working environment for prison officers.

CHAPTER 5

DRUG USE IN THE PRISON ENVIRONMENT

5.1 Introduction

Previous studies have found that a significant proportion of the Irish prison population has a history of illicit drug use, and continue to use drugs while in prison (O'Mahony, 1997b; Allwright *et al.*, 1999; Long *et al.*, 2000). However, little is known about the nature of this use and how individuals organise it within the prison setting. In the course of interviews, respondents were asked to describe how their drug-using behaviour had changed since coming into prison, both on this and previous occasions. In addition, respondents were asked how they organised and managed their use of illicit drugs in the prison and how they adapted their drug-using behaviour to the prison environment.

This chapter falls into two main sections. The first section (5.2) focuses on the impact imprisonment had had on respondents' drug use. It examines whether respondents had ceased their drug use since entering prison on this sentence, or had continued to use drugs. In addition, it explores whether prisoners were initiated into drug use while incarcerated. Finally, it gives an overview of what respondents perceived to be their motivations for either continuing or ceasing their drug use in the prison environment. The second section (5.3) focuses on how those individuals who had continued to use drugs while in prison, organised their use in the prison environment. It explores the types of drugs used, how the distribution process was organised, the quantity and

frequency of use, routes of administration and the associated risk behaviours. The experiences of the respondents during their current and previous sentences are considered.

While respondents reported having used a range of drugs in their lifetime, cannabis and, in particular, heroin were the drugs reported to be most commonly used in the prison setting.

5.2 Impact of Imprisonment on Drug Use

This section explores the impact that respondents perceived imprisonment to have had on their drug-using behaviour. It focuses on four specific issues:

5.2.1 Current Drug-Using Activities

5.2.2 Initiation into Drug Use in Prison

5.2.3 Motivations to Use Drugs in Prison

5.2.4 Motivations to Cease Drug Use while in Prison

5.2.1 Current Drug-Using Activities

In total, twenty-four of the twenty-nine respondents had a history of illicit drug use prior to the current period of imprisonment, and all of them had been opiate users. At the time of interview, respondents could be divided into two broad groups in relation to the impact the current sentence had had on their drug use:

- Prisoners Engaged in On-Going Drug Use within the Prison
- Ceased Drug Use since Entering Prison

Prisoners Engaged in On-Going Drug Use within the Prison (n=17)

Seventeen respondents continued to use illicit drugs in the prison on their current sentence. Of these, thirteen were men and four were women. They varied in relation to both the drugs they were using and the frequency with which they used them. All of those who reported currently using drugs had a history of opiate use prior to imprisonment; eleven continued to use heroin in prison and six used cannabis only. Irrespective of which drugs these respondents used or the frequency with which they used them, it is essential to note the opportunistic nature of this use - accessing drugs was the key. Where respondents could access their drug of choice, they would use it.

Distribution networks existed within the prison, through which access to drugs was negotiated. It is in the context of these networks that the respondents who were

continuing to use drugs are best explored. Respondents fell into three broad groups:

- Part of a distribution network
- Dependent on other prisoners who were part of a distribution network
- Access through personal visits

Part of a distribution network (n=9)

Nine respondents were involved in a distribution network (see section 5.3.2) in the prison. Of the respondents in the study, this group comprised the most regular users of drugs. They received visits through which they were able to access drugs. These respondents then distributed the drugs to certain other inmates who, in turn, would give them drugs when they accessed them. While access was irregular, these respondents reported using illicit drugs within the prison at least once a week. Prior to imprisonment, heroin had been their drug of choice and this continued to be the case.

Interviewer: What would decide whether you would use or not?

Respondent: If there was gear here [laughing], that's it, as simple as that. Like if I got gear in, just say I got gear, I'd look after a few of the girls, then when they get their gear they'd look after us, that's the way it goes.

Dependent on other prisoners who were part of a distribution network (n=3)

The second group of respondents (n=3) were particularly opportunistic in their drug use. They did not receive drugs through visits and were not part of a distribution network. This was either by choice (n=1) or because they did not have anyone in the community who would smuggle drugs to them in the prison (n=2). Therefore, these respondents depended on other prisoners to provide them with drugs. One in this group focused on accessing cannabis rather than heroin. He had ceased his opiate use since entering prison, but continued to smoke cannabis. He did not feel the need to become part of a network and smoked cannabis whenever given it by another inmate. The use of cannabis was not seen by him to be problematic.

Interviewer: Would you buy hash then off other people?

Respondent: No, I wouldn't, as in I wouldn't be mad into it, it'd be only an odd joint here and there and I'd be given that, 'here you go', throw that to you, you know what I mean. I wouldn't go looking for it, I wouldn't try to buy it.

The two other respondents engaged in heroin use whenever possible. Depending on other prisoners to provide heroin, when outside a distribution network, was seen to be

particularly unreliable. The following respondent had only managed to access heroin approximately once every three months since entering prison.

Interviewer: Why don't you use more often?

Respondent: Ah, basically because like me mates could come over to me today and say like 'here's some', and I'll use it, you know. ... Sometimes you look at them and think, 'God I'd love a bit of that now', but what happens is people promise you, like 'I'll have that for you tomorrow', and they're after promising you and saying they'll have it tomorrow, and tomorrow comes and they get a visit and they just go past you. Like they're after promising you but it doesn't matter, like you get up your hopes and that, like it's a prison promise, it doesn't work.

In general, this group used drugs on a less frequent basis than those who were involved in a distribution network.

Access through personal visits (n=5)

Five respondents received drugs through visits, but were not members of a distribution network. These inmates were engaged in the use of cannabis only. Respondents gave different reasons for confining their use to cannabis. The one woman in this group had only recently entered prison and intermittently received small amounts of cannabis. She had not chosen to confine her drug use to cannabis but her visitors would not provide her with heroin. Therefore, she did not have access to heroin or regular access to cannabis, which meant she could not become part of a distribution network. The four male prisoners in this group had used heroin during their current sentence but had stopped since entering prison. They had been involved in distribution networks but had removed themselves from them in an attempt to cease their opiate use. However, they continued to receive cannabis through visits for their own use. The frequency with which this group used cannabis depended on how often it was made available to them - when they had access to cannabis, they used it. These respondents did not perceive cannabis use as problematic.

It's [cannabis] not a problem, you know what I mean, it's not addictive, like it's, I could smoke often, I smoked it for years on the trot and then just stopped. It's not addictive, I don't know why but drink is worse than it.

Ceased Drug Use since Entering Prison (n=7)

Six respondents had ceased their illicit drug use since starting their current sentences, and a seventh respondent, who had been on a maintenance programme immediately

prior to imprisonment, had managed to remain drug free. There appeared to be a clear delineation between the men and women in this group in terms of how they had managed to achieve abstinence. All the men (n=5) were housed in an area other than the main Male Prison: three were in the designated drug-free Training Unit, and two in the Separation Unit. Being removed from the environment of the main Male Prison was perceived to be the most important factor determining abstinence.

It's [Training Unit] not like the main jail, like where you're facing it every day in the week like over there, you know, and that's how you get caught up in it. But over here there's a lot of people that is serious about getting their head together. There's a lot of people from the Medical Unit, and there is a few people that will tell you that when they come over are serious about their addiction and getting themselves together, you know.

The two women had very different reasons for not using drugs while in prison. The first woman had been stable on a methadone maintenance programme immediately prior to imprisonment, which meant she had been in receipt of a stable daily dose of methadone from service providers. She had recently been imprisoned and, at the time of interview, she was being detoxified from methadone. She expressed concerns about the impact this would have on her ability to remain off heroin. This issue is discussed in more detail in Chapter 6. The second woman attributed her drug-free status to the problem of accessing drugs. She did not receive visits and could not get drugs, so was not part of a distribution network. She had not ceased her drug use out of choice.

I'm not using in prison, no. ... Like if I could get gear I would fucking use it, but I don't even get a fucking visit, you know.

In summary, the key feature identified in managing to cease drug use while in prison was being removed from an environment characterised by a drugs culture. The only other way was by not having access to drugs: this had only happened in one case and it was likely it would only stop the respondent temporarily.

5.2.2 Initiation into Drug Use in Prison

The extent to which prisoners were initiated into illicit drug use while incarcerated was also examined. Five respondents fell into this category. Four had previously been involved in the use of illicit drugs but were initiated into the use of heroin while in prison on a previous sentence; the fifth was the only respondent who had first used an illicit substance while in prison.

Initiation into Heroin Use (n=4)

Four male respondents reported that their first-ever use of heroin had been while they were in prison on a previous sentence. At the time, one had been incarcerated in Wheatfield, one in St Patrick's Institution and the other two in the main Male Prison of Mountjoy. Each of these respondents had used illicit drugs other than heroin prior to these periods of imprisonment. Despite the dominance of injecting as the preferred route of administration in the prison (see section 5.3.4), these respondents had all smoked heroin on initiation. While they reported initially experiencing some nausea and vomiting, overall they found it to be a positive experience. Each of the four men reported that other prisoners had given them heroin, but argued that it was given to them as a 'favour' rather than having it 'pushed' on them. Where heroin was in such short supply, it was not seen to be in a user's interest to 'push' heroin on another inmate. The men had seen others using heroin and were curious about its effects.

I was in Patrick's at the time and it seemed to me that everybody else had to be involved with it [heroin], like most inmates were involved in it and I was only curious because of everyone, you know, the curious [sic] did get the better of me, you know. Because I didn't know that heroin would be blocking out all my feelings from me. I was just curious to see what it was like.

While these respondents were initiated into heroin use in the prison setting, they argued that it was not until after release that they became addicted. The nature of heroin use in the prison meant that they were not using regularly enough to become physically dependent. Two of these men were currently using heroin, one was using cannabis and the other was in the designated drug-free Training Unit.

Initiation into Any Illicit Drug Use (n=1)

Only one respondent reported that his first-ever use of any illicit substance had been within the prison setting and this had occurred on his current sentence. He had started his sentence in a prison outside Dublin, where the main drugs of choice were cannabis and stimulants. He used these on a few occasions, but never saw his drug use as problematic. He had since ceased all his drug use. As with the previous group, he did not feel that drugs had been 'pushed' on him but rather that fellow inmates had given them to him as a 'favour'.

I never touched anything before I went in. ... Just the first couple of weeks I was in, it was offered to me left, right and centre, you know, the lads just offering. I just didn't bother, then after a while I was just 'ah sure why not?' It was a new experience. ... Like I knew all the lads, they were mates of mine... like they were offering it to me, you

know, it's up to yourself whether you want to take it or not, you know, it's no big deal about it. They were being nice as they seen it, you know, 'I have some of this, do you want some?', you know. So basically I took one [ecstasy pill], I think I took four in all, you know. I wasn't gone on them now at all.

In summary, initiation into use of an illicit drug while in prison was very rare among this sample. While four respondents reported that they had first used heroin while incarcerated, this had not become habitual use until they returned to the community. In the one case where the first use of any illicit drug had taken place in prison, the respondent had not considered this use to be problematic. He had since ceased all drug use.

5.2.3 Motivations to Use Drugs in Prison

There was consensus among those in this sample who had a history of drug use about the factors motivating their drug use in prison. As will be seen in section 5.3.3, the quantity of drugs being taken by respondents was greatly reduced after incarceration, which highlighted the fact that the motivation to use once in prison had changed from that immediately prior to imprisonment. Respondents cited 'boredom' or 'escape from reality' as motivating their initial drug use (see section 3.3), but over time 'to hold off withdrawals' had become a principal motivation; they no longer experienced the 'high' from their drug use that they had done to begin with. After an initial period in prison, however, physical withdrawals were no longer experienced as a common feature of daily life, and respondents reported reverting to motivations similar to those cited for their initial use. This can be seen in the following respondent's description:

At the start it was more taking it for an escape from reality and then just to get on, keep off the withdrawal symptoms and all, you know. That's the way it was on the outside, but on the inside I think it's just an escape from reality, an escape from jail, an escape from life, things like, you know what I mean.

This concept of an 'escape' was the most commonly-cited motivation for using heroin while in prison. As discussed in Chapter 4, respondents expressed broadly negative attitudes towards the prison environment. The daily routine was seen to be monotonous, and the general atmosphere to be characterised by tension. The use of heroin was seen as an opportunity to escape from this environment, a 'day out' from the reality of prison life.

Like if you go a few days without gear it [prison] just does your head in. But it's different when you take drugs, like take drugs and you're gone on a day out. That's the way it

works in here, it's a brilliant time killer, you know. Like in here, like you take a turn on in here about twelve o'clock in the day and you find that it's two o'clock in the morning, you know what I mean, a day out, that's the way it works.

It's an escape from reality. The gruel of being locked up doesn't seem to be there as much when you take some heroin, and it's out of boredom as well. Like this is one thing that I've noticed about prison as well, I'm saying to meself, you're saying you'll give it up, now I'm saying it kind of knocks you out of this place for the day, everything seems okay again.

In summary, being imprisoned was perceived to be a negative experience and drug use offered prisoners a way of coping with the problems they associated with being in prison. It was a consistent theme in the interviews with those who had used drugs in prison, that drug use offered an 'escape'. Overall, there was a strong consensus about the perceived benefits of using drugs while in prison.

5.2.4 Motivations to Cease Drug Use while in Prison

Some respondents had managed to cease their drug use during this period of incarceration, while others had achieved a period of abstinence during prior sentences. As with those who had managed to cease their drug use during the current sentence, those who reported periods of abstinence during previous sentences also tended either to have been removed from a prison environment characterised by a drugs culture or did not have access to drugs at the time. Respondents cited a number of motivations for abstaining from drugs and referred to a 'cost-benefit' analysis of their situation. They argued that certain costs of their drug use had become unacceptable.

In their most extreme form, the costs of on-going drug use were seen to be life threatening. Some respondents felt they had reached a stage where, if they continued their drug use, it would cost them their lives. The following respondent was in the Training Unit and had managed to cease his drug use since starting the current sentence.

I just got sick of it [using drugs], you know. I don't know, it just broke me down, I just got sick of it. And I said to meself '[respondent's name], you have to stop this', you know, 'this is no fucking life', you know, 'you're gonna, either you're gonna end up being carried out of here in a box, you know because like, you know, you just can't keep going on'. So I just decided meself.

The following respondent expressed the same motivation to cease drug use, although he was continuing to engage in intravenous drug use.

I'm determined to get off it, 100%, I know I am. In my own heart and soul I'm determined to get off it, 'cause the way I look at it now, it's got to the stage now with me if I don't stop it now it's going to kill me. And eh, I'm getting out now and coming back into this place like I've been in this place all me life. I've been in prison all my life, all my teenage years is gone, you know what I mean? I'm twenty-four now, well nearly twenty-four, like all my life is just prison, prison, prison, do you know what I mean. I've barely seen the outside world.

An individual's drug use was also seen to have negative costs for his/her family. These costs were cited as a motivation for attempting to cease drug use while in prison. This was particularly relevant where people had partners and children. Respondents felt that their imprisonment was directly related to their drug use and therefore the reason why they were away from their families. They felt they had a responsibility to their families to try and ensure that they did not return to prison. The following respondent had ceased all illicit drug use since entering prison.

After I seen the kid it just made me start thinking, you know, I said like it just made me start thinking. So I pushed for the Training Unit [i.e. the seven-week detoxification and rehabilitation programme in the Medical Unit], and I got the Training Unit [i.e. the seven-week detoxification and rehabilitation programme in the Medical Unit], and I says 'well this is it', you know, 'I'm gonna have to do it for him and meself, 'cause I don't want him to grow the way I grown up, with all the shit around me', do you know what I mean. And eh, like feeling bitter about the system and all, the way it's operated, and other things that I went through, I didn't want him going through it. Like he might have a better chance than I had.

In addition, a number of respondents reported that after a certain period of time their sentence would be up for judicial review. In many cases, a condition of this review was that a prisoner would address his/her drug use. This was perceived to be another motivation to cease drug use while in prison. Overall, it is important to note that in describing their motivations to cease use, respondents drew on a range of factors.

Like I've been in and out since I was fourteen, fifteen, I'm bored of it, I want to put it all behind me you know. ... This sentence to be honest with you, at the start I was using you know, but with the review coming up it's not just because of the review. It's because I've been in and out all the time and I've started to think what I've done to the family, meself and me family and friends, good friends that I have you know. The older you are, the wiser you are, you know, hopefully this time.

In summary, respondents reported a number of motivations to cease drug use while in prison. The challenge was whether these motivations could be fostered in the prison environment.

5.3 The Nature of Drug Use in Prison

Respondents with a history of opiate use reported that imprisonment had impacted extensively on the nature of their drug use. This section explores the way in which drug use is organised when it continues within the prison setting, focusing in particular on differences from use outside prison. Four main features are identified:

5.3.1 Types of Drugs Used

5.3.2 Distribution Process

5.3.3 Quantity and Frequency of Use

5.3.4 Routes of Heroin Administration and Associated Risk Behaviour

5.3.1 Types of Drugs Used

The types of drugs used in prison reflected those used by the prison population while in the community. Among the current sample, heroin had been the main drug of choice, with extensive cannabis use also being reported. Therefore, demand in Mountjoy focused on accessing heroin and cannabis. The development of access networks around the drugs of choice of a particular prison population was highlighted by the experiences of those who had spent time in prisons in other parts of the country. For example, the following respondent had spent time in another prison where the main drugs of use were the same as those used by clients attending for treatment in that community, i.e. cannabis and stimulants (O'Brien *et al.*, 2000).

Interviewer: What about in [prison outside Dublin], were drugs an issue down there?

Respondent: In comparison to the Dublin jails, no not really. The drugs down there are basically hash, Es, and Es are only in the last couple of years, and bits of speed, acid and tablets, but mainly hash.

Respondents in the current study argued that the effects of heroin and cannabis were more suited to the prison environment than stimulants. Opiates, such as heroin, are described as strong sleep-inducing painkillers, which dull the user's senses, whereas stimulants, such as cocaine and ecstasy, make the user feel more energetic and heighten his/her senses (Corrigan, 1994). As the following respondent argued:

Interviewer: What had you been using before that time, when you went into Wheatfield?

Respondent: Es and coke and all, but when I went down, like they're not a prison drug, you know.

- Interviewer: What do you mean 'they're not a prison drug'?
- Respondent: Like in here you just want to sit down and relax and chill out, you know what I mean. You don't want to be hyped, falling around the place and, eh, yeah all downers, like uppers are not prison drugs.

In summary, twenty-four of this sample had been engaged in daily opiate use prior to imprisonment and also reported regular cannabis use. Consequently, when they continued to use drugs in prison, this was overwhelmingly cannabis and opiate use. Furthermore, the effects of cannabis and heroin were perceived to be more suited to the prison environment than those of stimulants.

5.3.2 Distribution Process

As mentioned in section 2.5, the prison authorities invoked a number of measures to prevent prisoners from accessing drugs and the relevant paraphernalia. These included:

- monitoring all visits (both by prison officers in the visiting hall and a closed-circuit television system);
- prohibiting physical contact between visitors and prisoners during visits;
- internal and external body searches of prisoners suspected of smuggling drugs or paraphernalia into the prison; and
- carrying out searches of cells where it was suspected that drugs or paraphernalia were being kept.

The prohibition on drug use in prison meant respondents had to use specific measures to facilitate the distribution of drugs. According to them, accessing drugs in prison involved two stages - getting drugs into the prison, and then distributing them. The interviews focused on understanding the processes involved in the latter stage.

Stage One

The interviewer did not ask respondents about the methods used for getting drugs into the prison. This was not essential for the current study and it may have been perceived as particularly sensitive among respondents. Respondents did not report staff being involved in the process. Getting drugs into the prison through visits was generally seen to be a difficult task: prison officers observed all visits and sanctions were imposed on any prisoner caught receiving drugs.

The method of payment for drugs received from the community into the prison was an area of interest. Respondents reported that payment was not expected for drugs brought to them while in prison. Family members, partners and peers were the principal suppliers cited. It was reported that drugs were provided as a 'favour' to those in prison rather than in return for any financial payment. There was a custom whereby drug users in prison were 'looked after' by other drug users in the community during their prison term.

They [users in the community] knew what it was like to be in prison without drugs, you know. So when they were outside and they had easy access to money or easy access to drugs, they'd send it up, 'cause they'd know it wouldn't be too long before they'd be locked up, you know.

The physical bulk of drugs was also an issue to be considered at this stage of the process. Because it was less bulky, heroin was perceived to be easier to smuggle into the prison than cannabis.

Now with the visits and that hardly any hash comes into the jail, so it's mostly heroin. 'Cause it's so small, it can be concealed easily, you know, like it's not like a big blob of hash, it's more easier to get in. The visits are very strict anyway, you know.

One respondent suggested that some prisoners not involved in heroin use might smuggle heroin in, to exchange for cannabis. However, the respondents reported only smuggling in the drug that they wished to use.

Stage Two

The second stage, the distribution process, is particularly important in understanding the nature of drug use within the prison setting. It impacts on the quantity of drugs used, the frequency of use and the risk behaviours engaged in by those using drugs in the prison setting.

The principal means of drug distribution in the prison was networks set up between prisoners. Networks were generally established between prisoners who had known each other in the community. Fellow prisoners were often people with whom respondents had mixed outside prison, either through their drug use, their criminal activity or simply because they came from the same community. Distribution was based on a reciprocal arrangement between those who had access to drugs from the community. One person would access drugs by smuggling them into the prison, and then he/she would distribute them within his/her network. Another member of this network would

then access drugs in a similar way and distribute them to the members of this network. As such, members of this group were assured that they would continue to receive drugs from other people's visits, as long as they continued to receive drugs that they could then distribute. As the following man described:

The way you work it is you get your gear in, get a bit of smack, and look after someone one day, you know what I mean, and then they get you back. Like, throw your man a ten bag, give him a ten bag, you know what I mean, and then when you haven't got it, and he'll get it, and he'll come back and give it to you, you know what I mean. That's the way it works.

The same method of distribution was reported within the Female Prison. The following woman was in a distribution network.

There's different people, like there's certain people that I fix up, they'll fix me up, do you know what I mean. ... So just you stay in with your own really, like you fix them up, they fix you up.

At the time of this study, the sale of drugs was not reported to be a common practice in Mountjoy. However, respondents reported having bought drugs for cash in the prison during previous sentences, but felt that there was a misconception among those outside the prison about the sale of drugs in Mountjoy. No explanation was forthcoming for why drugs were no longer sold in the prison.

I've only seen drugs being sold in the jail once or twice and it's not as big as it's made out to be, it's not as big as it's made out to be. It's exaggerated a lot. Em, hash is never sold here, like, 'cause you'd hear about it straight away, and you'd be split up or shifted or stopped straight away [by prison authorities]. Like you often read in papers like reports on Mountjoy Prison and I do be laughing at them.

Rather than being sold for cash, heroin was sometimes accessed by those outside distribution networks either in exchange for favours, or through a bartering system.

Well it's not very easy to buy it [heroin], like it was in '97, it was great 'cash', 'no bother'. Now it's very rarely, very, very rare. I think there hasn't been a person here . . . since I come back in, that they've actually been selling it for cash. But like I know a bloke that might want something in the shop so he'd say, give you ten pound order, twenty pound order or like a needle or whatever he wants, you know, and that way you'll get a bit. Like that's the main way of doing it, unless you get visits or somebody looks after you.

In summary, access to drugs was mainly secured through distribution networks. Membership of these networks depended on whether an individual was receiving drugs from the community. Outside these networks, gaining access to drugs was seen as difficult. Where inmates were either dependent on the goodwill of others or were engaged in a bartering system, they only managed to access drugs on a sporadic basis. The sale of drugs within the prison at the time of the study was uncommon. Overall, access to drugs in the prison was perceived to be exaggerated by the media.

5.3.3 Quantity and Frequency of Use

Imprisonment was perceived to influence the nature of drug use through impacting on the quantity of drugs used and the frequency with which they were used. Before imprisonment, twenty-four respondents had been using illicit opiates on a daily basis, generally administering them on multiple occasions throughout a day. Once in prison, access to heroin was more restricted and only a limited quantity was available. Typically, use decreased from up to three or four times a day to approximately twice a week.

Like it's been a good weekend but a bad weekend, do you know what I mean, 'cause we've had it [heroin] all weekend, you know. But now I'm kicking myself 'cause this morning I wasn't feeling the best, the Mae West, you know, but like I have a bit of withdrawal. I might not have it [heroin] now for another two or three weeks. On average it's usually once a week at least, like either me or a cellmate would get some.

It was felt that there was a perception among the general public that drugs were extensively available within the prison. Respondents argued that this was not the case. In the respondents' experience, while drugs were available in the prison, the quantity was significantly lower than assumed by the general population.

People think it's [Mountjoy] rampant with the gear, but it's not. Probably, like you'll probably find three people like sharing one bag, do you know what I mean?

Prisoners' drug use was generally dictated by whether or not they could access drugs. The amount available in the prison fluctuated. The limited amount available ensured that prisoners did not experience the same physical withdrawals as those experienced in the community.

You kind of get a Mickey Mouse habit in jail, you know, just a Mickey Mouse habit. ... You know you might be lucky, you might get it five days, six days on the trot, you know, and then after that you could be waiting another three or four days, you know. You'd only be after getting back to yourself, you know what I mean, like it wouldn't be as bad as the withdrawal that you'd get from the outside, you know what I mean, 'cause you wouldn't be using as much.

The 'Mickey Mouse' habit referred to above was considered preferable to more frequent use within this particular setting. It was felt that a habit that required using opiates on multiple occasions each day would not be possible to maintain in prison. The withdrawals that would be experienced would also make it more difficult to cope with prison life.

I'd use maybe once a week, like I get it maybe once a week if I'm lucky, once a week, maybe twice a week, when you can get it, you know. But eh, you couldn't use everyday in prison 'cause eh, prison's a bad place for a habit, you know what I mean, because you're not able to support your habit in prison, you know what I mean. Like you'd be going around dying sick, you know what I mean, I'm not into that, eh, it's not a nice place to have a habit.

While the nature of this habit meant respondents did not suffer heavy physical withdrawals, there were still psychological withdrawals to cope with. As the following woman highlighted, learning to cope with the psychological cravings became important.

You're after using so much on the outside, but you're not using that much in here, you know what I mean, you'd only have what, like a twenty bag between three of us, do you know what I mean? Like you'd be a little bit sick [from withdrawals] but you wouldn't be that sick. ... You try not to think about it, try and get on with the gym, with school and not sit around moping, sitting around moping you might as well forget about it or you'll end up fucking killing yourself.

It is important to note that while the quantity of heroin being used was reduced, respondents continued to identify themselves as drug users. For many, while in prison, their daily activities continued to be focused around the lifestyle of a habitual drug user - organising access to drugs, seeking them out, using them.

Like I'd still constantly use, I'd still be actively involved in drug use, do you know what I mean? It's just I wasn't getting as much as I was when I was on the outside, but I was still active in the drug situation inside.

In summary, prisoners adapted their drug use to fit the prison environment. Unreliable access to drugs and the small quantities in which they became available meant multiple daily use was replaced by intermittent use, although where access permitted, respondents reported binges. This reduced intake was considered by respondents to be more suited to the prison environment. While they did not experience the severe physical withdrawals that they associated with their drug use in the community, they continued to have psychological withdrawals and cravings.

5.3.4 Routes of Heroin Administration and Associated Risk Behaviour

Opiates may be administered by a number of different routes. According to data gathered from those in treatment in the Eastern Health Board area²⁵ in 1997 and 1998, of the approximately 80% of the sample who cited heroin as their main drug of use, just over 30% smoked and just under 60% injected it (O'Brien *et al.*, 2000). An important question in the current study was the extent to which being in prison impacted on the route of administration chosen by respondents, and their associated risk behaviour. Respondents identified two main impacts - it had influenced a move from one route to another, e.g. smoking to injecting; and it had influenced the risk behaviours in which they engaged in relation to the spread of blood-borne diseases such as hepatitis and HIV.

Changes in Route of Heroin Administration

Where prisoners had moved from one route of heroin administration to another while in prison, it was generally from smoking to injecting. Most had begun injecting while in the community, and continued to do so while incarcerated. Six of the twenty-four respondents who had ever injected drugs reported that they had moved to injecting drug use while in prison, on either the current or a previous sentence. Despite experience in injecting heroin while in the community, smoking had been the preferred route of administration for two of these respondents (one male and one female) prior to imprisonment. The four others were all male and reported that their first-ever experience of injecting drug use was in prison. While these respondents were already habitual users of illicit drugs in the community, they had not previously engaged in injecting drug use. A more experienced injecting drug user, usually a cellmate, had facilitated each respondent in his/her first experience of injecting drug use.

Irrespective of their injecting drug-using history, these respondents all attributed their move to injecting drug use directly to the nature of drug use in prison. As discussed in section 5.3.3, the actual quantity of drugs available to prisoners was limited and prisoners felt that the drugs they obtained should be used in what they perceived to be the most efficient way. By 'efficient' it was meant that the greatest number of prisoners should be able to use, to its maximum effect, the limited quantity of heroin available. Despite the limited availability of heroin within the prison, the culture of the distribution networks meant that there was an understanding between members of these networks that any heroin accessed would be shared. It was also agreed that efficient use meant injecting heroin. As the following respondent, who had his first experience of injecting drug use within the prison setting, explained:

25 Renamed the Eastern Regional Health Authority.

Like you'd need a good half gram of heroin to smoke, you know, but to shoot it up or have a turn on like a quarter would do you, you know what I'm saying, to get the same buzz as you would with a half gram smoking, you know. Like that's the way people look at smoking heroin in here, that that's the biggest sin you can commit, you know, like 'what are you doing wasting it?', you know what I mean, they do genuinely, you know.

In the prison setting, respondents did not feel they had a choice about the route of administration. Even when prisoners wished to refrain from injecting, they felt obliged to inject to facilitate both their own and other inmates' drug use.

Like if I could get the amount [of heroin] that you'd need to smoke in here, I would smoke it, I wouldn't touch a needle, you know.

I'd rather smoke it [heroin] but if there's not enough I'll fix a few of the girls something. Like I'm going to use [inject] so we can all get something.

In summary, the limited availability of drugs within the prison setting created an environment in which injecting was considered the only acceptable route of administration. Smoking heroin was generally perceived to be wasteful, and where the heroin supply was limited, injecting was perceived as the more efficient route. Prisoners found themselves in a position where they had to manage their drug use in a way that would facilitate the maximum effect from a small amount of drugs.

Risk Behaviours

Mountjoy Prison has been identified as a 'high-risk' environment for the spread of blood-borne diseases through the sharing of injecting equipment (Allwright *et al.*, 1999; Long *et al.*, 2000). The current sample confirmed this view and offered an insight into what creates this 'high-risk' environment.

Unlike in the community, there were no needle exchange programmes in the prison. Clean injecting equipment,²⁶ moreover, was perceived to be harder to access than heroin - it was perceived to be more difficult to smuggle into the prison than heroin and to keep concealed from prison authorities. Therefore, respondents were restricted to using any injecting equipment that became available, irrespective of how many other prisoners might have used it. While most respondents reported having shared injecting equipment to some extent while in the community, all of those who had injected in the prison had shared injecting equipment. The following respondent had never engaged in sharing practices while in the community.

26 Data were collected on injecting equipment in general, rather than addressing individual items of injecting paraphernalia, i.e. filters, spoons, needles etc.

I would never dream of anything like that [sharing injecting equipment] on the outside, I knew I was playing Russian roulette when I was taking the needle off that guy.

Respondents' adaptation of their drug-using activities to the prison setting reduced the quantity and frequency of use, but led to engaging in high-risk sharing practices. Irrespective of the area of the prison in which respondents were housed, where injecting drug use occurred it was perceived to be synonymous with sharing injecting equipment.

It's very unhygienic like that. I think there's genuinely like, three needles. I'm on [wing in main Male Prison] at the moment and I think there's three syringes for the whole wing. ... At least 100 prisoners in there, and that's no joke, at least 100 prisoners for those three needles, you know.

Jaysus, like when I look back at it [using in the main Male Prison] it was ridiculous. The syringes that you'd be using were a disgrace, you know. Like you'd be using works that's after doing thirty-five different people, you know what I mean.

Engaging in such sharing practices was perceived to be something to which a drug user in the prison environment became accustomed. It was reported that, although an individual might not have engaged in risk behaviours while in the community, after a period of time in the prison setting it became an integral part of his/her drug using activities.

I never shared with anyone [on the outside], I always had me own works and everything, you know. Like anyone, I wouldn't give it to no one. Like I wouldn't even use it, even if I was dying sick I wouldn't use after [another person], like I'd go into the [needle exchange programme]. I always had loads on me but like I wouldn't use it after anyone, you know what I mean. ... When I had me first turn on in there [prison], out of me head, I didn't give a bollocks. But the next day, when you think 'oh fuck me, what are you after doing?', you know what I mean. But like it doesn't bother you after a while, you know what I mean.

Respondents argued that if they were going to engage in injecting drug use in the prison, then they would have to engage in risk behaviours. While they initially might have engaged in an evaluation of the risks involved, the nature of drug use in the prison environment meant sharing injecting equipment. Using heroin took priority over the risks involved.

I was dying sick, I didn't give a shite [about sharing], you know, just had to get away from the sickness for half an hour, you know.

The syringes, like you have to stab yourself with them, the spikes are blunt as nails, you know. But you still use them, you know what I mean like, there's no choice.

Even where respondents had tested positive for hepatitis C, they shared injecting equipment in prison. The following respondent had tested positive for HIV, but argued that sharing injecting equipment was an integral part of drug use in the prison environment.

Respondent: You could get ten people using the one syringe in the toilets, like it doesn't really matter in here, they don't look at it that way, health wise, like just blokes dying sick, like that comes first and then probably the worrying comes second.

Interviewer: Is that the way it is for you?

Respondent: With me, it is yeah.

While it was unclear whether respondents were fully aware of the risks involved in sharing injecting equipment, they reported making some attempts to minimise the risks as they perceived them. As in the community, female injecting drug users tended to skin-pop rather than mainline, i.e. inject into a muscle or under the skin, rather than directly into a vein. Some women reported doing so in prison in an attempt to reduce the risks of contracting a blood-borne disease. Furthermore, despite the absence of any formal provision of cleaning fluids, respondents used bleach whenever it could be accessed. There were conflicting reports on the availability of bleach, with some respondents reporting relatively free access to it on an informal and unstructured basis, while others said they had no access. Where bleach was available, it was not specifically designated for use in cleaning injecting equipment but rather was household bleach. Respondents argued that they lacked the information about how to use it effectively and expressed concerns about its efficiency. In an environment where respondents had no access to services that would facilitate them in minimising the risks, there was a fatalistic attitude toward the consequences of sharing on their health.

Like I know meself it's dodgy but like what can you do, you know what I mean, like it's fucking stupid and that but, you have to go someday don't you?

Like I don't care. Like I think about AIDS and that and think 'fuck it', do you know what I mean? At the time, like even I used after people that had AIDS over the years, like in here, and I just wash it out with water and say that's clean, you know what I

mean. And then you'd hear that they died and you just'd think 'Jesus what if I had it?', and then somebody else would come along and there'd be only one needle and you'd say 'fuck it', you'd use it.

In summary, from this sample's perspective, while being in prison involved a reduction in the quantity and frequency with which opiates were used, it also entailed an increase in risk behaviours. The absence of access to clean injecting equipment meant that sharing injecting equipment was perceived to be practically synonymous with opiate use in the prison setting. While the respondents tried to minimise the risks in a number of ways, the covert nature of their use and the absence of appropriate services meant respondents were continuing to engage in high-risk behaviours. The choice that drug users in the community have to minimise the risks entailed by their injecting drug use, through accessing appropriate services, was removed from this group. This aspect of the impact of imprisonment on drug use has serious public health implications.

5.4 Summary of Main Findings

Current Drug-Using Activities

Seventeen respondents were continuing to use illicit drugs while in prison, six reported cannabis use only and eleven reported heroin use (usually combined with cannabis use). Heroin and cannabis were reported to be the drugs most commonly used within the prison setting.

Six respondents (five males and one female) with a history of drug use prior to imprisonment had ceased their drug use since entering prison. A seventh respondent, who had been on a maintenance programme immediately prior to imprisonment but had been detoxified since entering Mountjoy, had managed to remain off illicit drugs since entering the prison.

A key feature identified in managing to cease drug use while in prison was being removed from a setting characterised by a drugs culture. All the male respondents who had ceased their drug use (n=5) were housed outside the main Male Prison. Female prisoners were all housed in the one prison wing. Only one woman, who had been using illicit opiates immediately prior to imprisonment, had managed to cease her illicit opiate use since entering prison. This was because she did not have access to drugs and it was likely that she would abstain only temporarily.

Initiation into Drug Use in Prison

Initiation into drug use in the prison setting was rare. Four respondents reported that they had their first-ever experience of heroin while incarcerated. One respondent reported that his first use of any illicit substance had occurred while in prison; at the time of interview he was no longer engaged in illicit drug use.

Motivations to Use Drugs in Prison

Respondents argued that in the prison environment, drug use offered a way of coping with the problems imprisonment presented. Drug use offered inmates a temporary 'escape' from the prison.

Motivations to Cease Drug Use while in Prison

A number of motivations were cited by respondents for ceasing use while in prison. These included concerns about personal health and family well-being, and attempts to comply with the conditions of a judicial review.

Distribution Process

Respondents reported that, at the time of this study, drugs were not sold for cash in the prison. Respondents reported that drugs were generally distributed in the prison through a reciprocal network system, established between prisoners who had access to drugs from the community. When an inmate received drugs from the community, he/she would distribute them to others in a particular group. When others in this group received drugs from the community, they would distribute them to the same group members. Groups were generally established between inmates who knew each other from the outside community.

Quantity and Frequency of Use

Once imprisoned, those who continued to engage in illicit drug use greatly reduced the quantity of drugs they used, and the frequency with which they used them, when compared to their drug use in the community.

Routes of Heroin Administration and Associated Risk Behaviour

Respondents reported that injecting was the dominant route of heroin administration in the prison. Four respondents engaged in injecting drug use for the first time while in prison. Two others moved from smoking in the community to injecting in prison, but had previous experience of injecting drug use. Most of those injecting had engaged in injecting drug use prior to imprisonment.

Respondents argued that injecting was the preferred route of administration within the prison because of the small quantities of drugs available. Respondents felt that where drugs were available, they should be used in what prisoners perceived to be the most efficient way. This meant using the smallest amount to the largest effect for the most people. In this context, respondents reported that smoking heroin was perceived to be wasteful, whereas injecting was seen as an 'efficient' use of heroin.

Respondents argued that injecting drug use in the prison was synonymous with the sharing of injecting equipment. All of those who had injected heroin while in prison had shared injecting equipment. The advantages of using drugs were seen as outweighing the risks involved in equipment sharing.

Respondents felt that the choice drug users in the community have to minimise the risks entailed by their injecting drug use, through accessing appropriate services, was removed from those who decided to inject while in prison. One respondent, who was HIV-positive, reported that he was continuing to share injecting equipment within the prison.

CHAPTER 6

SERVICE PROVISION

6.1 Introduction

This chapter explores the services available to prisoners at the time the study was carried out, and respondents' perceptions of these services. The commitment to provide services for those in prison based on the principle of equivalence of care (Department of Justice, 1994; Department of Justice, Equality and Law Reform, 1999; Irish Prisons Service, 2000) will mean the introduction of a number of services which were not available in prison when this current study was carried out. In this context, interviews also addressed respondents' perceptions of the services available to drug users in the community and their introduction into the prison setting.

This chapter focuses on participants' perceptions of the services specifically relevant to drug users in the prison and also briefly addresses other healthcare and more general services available to prisoners. It is important to note that this study did not aim to evaluate the services in any way. Three broad categories of services are addressed:

- 6.2 Drug-Related Services
- 6.3 General Healthcare Services
- 6.4 Other Services

Table 6.1 gives an overview of the services that were available to prisoners in Mountjoy Prison at the time fieldwork was carried out (end of 1999).²⁷ Access to services depended on both the area of the prison in which an individual was housed and whether he/she was a remand or sentenced prisoner.

TABLE 6.1
Inventory of Services Available in Mountjoy Prison at the Time of Fieldwork.
 Y=Yes; N=No.†

SERVICE	MAIN MALE PRISON	MEDICAL UNIT	SEPARATION UNIT	TRAINING UNIT	FEMALE PRISON
Probation and Welfare	Y	Y	Y	Y	Y
School	Y*	Y*	Y*	Y	Y
Workshop	Y*	N	N	Y	N
CONNECT ²⁸	Y*	N	N	Y	N
Doctor (medical officer)	Y	Y	Y	Y	Y
Psychologist	Y	Y	Y	Y	Y
Psychiatrist	Y	Y	Y	Y	Y
Dentist	Y	Y	Y	Y	Y
Narcotics Anonymous	Y	N	N	Y	N
Alcoholics Anonymous	Y	Y	Y	Y	Y
Drug Awareness Programme	Y	Y	Y	N	N
Methadone Maintenance	N	Y	N	N	N
Alternatives to Violence Programme	Y	N	N	N	N
Drug Detoxification and Rehabilitation Programmes	Y*	N	N	N	N
Methadone Detoxification	Y	Y	Y	N	Y
Drug-Free Area	N	N	N	Y	N
Needle Exchange	N	N	N	N	N
Cleaning Materials	N	N	N	N	N
One-on-One Counselling ²⁹	N	N	N	N	N

† Source: Personal contact with Mountjoy's Probation and Welfare Service.

* Not available to prisoners on remand.

27 The extensive changes proposed by the Steering Group on Prison Based Drug Treatment Services for drug treatment services in prison (Irish Prisons Service, 2000) are discussed in Chapter 7 of this report.

28 The CONNECT project was established in Mountjoy Prison with the main objective to encourage the (re) integration of offenders in society through employment as a support. It is an action-research project led by the Department of Justice, Equality and Law Reform, and run by the National Training and Development Institute. The project has developed and implemented pilot strategies and systems to fill the gaps identified and to improve the employability of offenders while in custody.

29 One-on-one counselling from a prison-based service provider other than a probation and welfare officer or prison psychologist.

6.2 Drug-Related Services

There was an overall consensus among respondents that there was an urgent need to expand the drug-related services available to drug users in Mountjoy. This related to both the types of services available, and the number of prisoners that could be accommodated by them. Respondents identified a variety of needs that they felt could and should be met in the prison setting. In its broadest terms, this meant offering services to those who wished to cease their drug use while in prison, and minimising the risks for those who were continuing to use drugs. The service programme at the time, in which there was only one comprehensive detoxification and rehabilitation programme for drug users, was perceived to be inadequate.

Like the Medical Unit [where the detoxification and rehabilitation programme is located], there's only the one place that they have throughout Ireland for ordinary inmates of Mountjoy. Like you have the ones that is HIV, mainly HIV, and you might get the odd three or four that are on that maintenance over there, you know. But like the detox when you're not HIV and that, it only takes nine, that's only nine every seven weeks, do you know what I mean? It's not enough, you know, and then they're wondering why inmates are going back out, and they're re-offending, and are going back on the drugs, you know.

The following sections explore respondents' perceptions of those services currently available in Mountjoy, and those which were available to drug users in the community but not in the prison setting (see section 6.2.6).

- 6.2.1 Short-term Detoxification (with Methadone)
- 6.2.2 Drug Detoxification and Rehabilitation Programme
- 6.2.3 Methadone Maintenance Programme
- 6.2.4 Drug-Free Wings
- 6.2.5 Self-Help Groups
- 6.2.6 Needle Exchange and Cleaning Materials
- 6.2.7 Counselling
- 6.2.8 Drug Awareness Programme
- 6.2.9 HIV and Hepatitis-Related Medical Services
- 6.2.10 Alcohol-Related Services

As mentioned in section 6.1, services available in the community but not in prison were explored within the context of the commitment by the prisons service to providing services based on the principle of equivalence of care (Department of Justice, 1994; Department of Justice, Equality and Law Reform, 1999; Irish Prisons Service, 2000).

6.2.1 Short-term Detoxification (with Methadone)

In Mountjoy there is a standard thirteen-day methadone detoxification programme³⁰ offered to all prisoners on committal who are found to test positive for opiates. There is a throughput of an estimated 1,200-1,500 cases per year (Department of Justice, Equality and Law Reform, 1999). At the time fieldwork was carried out, prisoners who may have been stable on a methadone maintenance programme in the community, were generally detoxified upon incarceration.³¹ Melleril³² (25mg) was also offered for the first seven nights of detoxification. Detoxification takes place in all areas of the prison where prisoners are initially held, and has been described as being provided in an 'essentially unstructured and unsupervised fashion, with no follow-up or medium to long term planning' (Department of Justice, Equality and Law Reform, 1999: 4). The programme was the same for each prisoner, irrespective of the quantity of opiates used prior to imprisonment. The doses involved are laid out in an information book for prisoners:³³

The detox programme in Mountjoy Prison is:

Day 1 - 2: 25mls methadone mixture (5mg methadone per 5mls syrup)

Day 3 - 4: 20mls methadone mixture (5mg methadone per 5mls syrup)

Day 5 - 8: 15mls methadone mixture (5mg methadone per 5mls syrup)

Day 9 - 11: 10mls methadone mixture (5mg methadone per 5mls syrup)

Day 12 - 13: 5mls methadone mixture (5mg methadone per 5mls syrup)

Melleril 25mg each night on day 1 - 7 of this programme

All those in the current sample who had been using opiates on a daily basis up until the point of imprisonment, had availed of this short-term detoxification programme. There was consensus among respondents about the programme. Most reported having used illicit opiates on multiple occasions each day prior to imprisonment. Once imprisoned this was reduced to one, relatively low daily dose of methadone for a restricted number of days. Inevitably, respondents had suffered opiate withdrawal symptoms once incarcerated. They described these symptoms as causing them extreme discomfort. Insomnia was reported to be one of the most problematic symptoms, with respondents reporting problems with their sleeping patterns for a period of time after imprisonment. This was perceived to contribute to the mental distress experienced by prisoners upon incarceration.

30 Community-based detoxification programmes tend to offer a programme over a minimum of twenty-one days.

31 Since fieldwork was carried out, all new committals to Mountjoy and prisoners transferring from Cloverhill Prison who are on approved methadone maintenance treatment programmes continue to receive maintenance treatment while in prison.

32 Melleril contains thioridazine, which belongs to the phenothiazine class of drugs. Among other uses, it is used to relieve tension and anxiety.

33 Mountjoy Prison Probation and Welfare Service, in press.

Ah, how to explain it? It's a real empty feeling takes when you come off [opiates], it takes four weeks to sleep, it took me four weeks to sleep. So the bones in your body, in your legs, feel like they're bending when you're standing 'cause your body's not getting rest when it should, in the night like. You go to sleep and your body rests, well, you'd get a little rest but your body wouldn't be getting a proper rest because you weren't sleeping.

The short-term detoxification programme was perceived to be inadequate in meeting the needs of those withdrawing from daily opiate use. It was argued that the quantity of methadone used was too low, and that the detoxification period was too short. Many referred to it as a 'crash course' rather than an effective detoxification programme.

Like when I came in here I was dying sick, in a bad way, gives me phy for two weeks, after the two weeks man I didn't sleep for about three or four weeks after, do you know what I mean, like it was that bad of a habit. They give you a crash course here, a few weeks and a tap on the back, 'yeah you're alright, you're grand', you know what I mean. A load of bollocks it is.

Overall, prisoners felt that as the only service on offer to all drug users entering the prison, this short-term detoxification reflected a general misunderstanding of the nature of opiate addiction by the prison authorities.

I can't see them ever organising it properly here, they haven't got a clue they haven't, they say 'we know what the story is, we understand where you are coming from' but they don't, they couldn't, otherwise they wouldn't be giving a fourteen-day [sic] detox to prisoners.

They give us two weeks detox, what's the logic in that. That doesn't make sense for the life of me, you know. ... It's a major crash course you know, but em, I em, like it doesn't hold you, you know, not a serious drug user, like it doesn't, like it doesn't, you know. I don't know who wrote their detox for them but it was definitely some fascist, you know.

It was felt that, in an environment where this short-term programme was the only service on offer to addicts, it was inevitable that inmates would try to access illicit opiates within the prison.

It [methadone] just helps you with the withdrawals, even two weeks is not enough. Like you can't blame some people going back on it [heroin] in here.

In summary, respondents argued that as the only service available to all heroin users who tested positive for opiates upon entering the prison, the short-term detoxification

programme was not adequate. They argued that it involved too low a dose of methadone, and the period of detoxification was too short.

6.2.2 Drug Detoxification and Rehabilitation Programme

Two drug detoxification and rehabilitation programmes (1 & 2) are run by Mountjoy Prison's Probation and Welfare Service. Both are based in the Medical Unit of the prison. Programme 1 aims to place prisoners in the Training Unit, and Programme 2 aims to place them out in the community. Only prisoners with less than twenty-six months to serve, or with a Circuit Court sentence review date less than twenty-six months away, can apply for either programme. Programme 2 is a six-week programme aimed at prisoners who are nearing their release date. Once participants have completed the six-week programme, they undergo a six-week Drug Treatment Community Release Programme, which aims to prepare them for release (Mountjoy Prison Probation and Welfare Service, in press). None of those in the current study sample reported having been through this programme. The remainder of this section will explore the experiences of those respondents who had participated in Programme 1.

Programme 1 is a seven-week drug detoxification and rehabilitation programme, which is based in the Medical Unit and run by probation and welfare officers. The programme caters for nine male prisoners at a time. There is no equivalent service available to female prisoners. To access the programme, prisoners are interviewed by probation and welfare officers and assessed for suitability. Participation entails an initial, voluntary ten-day methadone detoxification, followed by an intensive rehabilitation programme. A multi-disciplinary team, which includes both medical staff and counsellors from outside agencies, delivers the programme. Participants who remain drug free during the seven-week period are then transferred to the drug-free environment of the Training Unit. Crowley (1998) provided a medical review of this programme, reporting positive results. However, he highlighted the need for an expansion of the programme, both in terms of places and the services offered. In addition, he highlighted the detrimental effects of being returned to the main Male Prison, i.e. to a 'less secure and regulated environment in terms of illicit drugs availability' (Crowley, 1998: 126).

Four members of the current study's sample had been through Programme 1 at some stage: two during their current sentences and two on previous sentences. Both of those who had completed the course on a previous sentence were now in the main Male Prison and reported that they were currently engaged in illicit drug use. The other two respondents were in the drug-free Training Unit and reported having ceased all illicit drug use.

Respondents argued that there were a number of factors influencing the prison authorities' decision as to whom could access the programme. These included the length of time an individual had left to serve, the type of conviction they had been imprisoned for, and the level of motivation to cease illicit drug use that they had displayed. The restrictions on those with a longer sentence to serve were criticised by respondents. As the following respondent, who had not managed to access the programme, explained, he felt that long-term prisoners were in particular need of a comprehensive treatment programme. While those on shorter sentences would be able to access services in the community, he argued that long-term prisoners had no access to services.

I says like 'you're leaving us, all us long-term prisoners here rotting, here rotting, here taking drugs'. I says 'you're letting people who are getting out in three months time, who could go and get their own treatment outside', I says 'they're not gonna be here too long, like it's not gonna make much difference, like we're the ones that are gonna be here for the next few year, we're the ones that are using the drugs, why don't you do something for us?'

Respondents were particularly critical of the fact that it was more difficult for prisoners with a drug-dealing conviction to get accepted onto the treatment programme. It was felt that many drug users had become involved in drug dealing to meet the financial demands of their own use; prohibiting them from accessing treatment was, therefore, contributing to their future recidivism.

But em I think maybe it's a vicious circle that where they won't give [access to the programme] the guys that are in for selling it. The reason they're in for selling it is that they were using it themselves. ... I think the fact that they don't let them over to get counselling over in the Medical Unit [drug detoxification and rehabilitation programme], these guys that are in for selling it, when they get out they're gonna turn back to selling it because their head is strung out, they're strung out in the head. And I think that, pardon but for the want of words, they're pissing against the wind and it's a windy day. I don't know how to explain it, it does seem to be coming back right into their face. That's stupid.

Once prisoners had secured access to the programme, they were moved to the Medical Unit, where they participated in a module of counselling and group therapy. It was identified as an intensive experience, in which participants were required to tackle some difficult psycho-social issues that may not have been addressed previously. However, there was consensus among those who had participated in the programme that it was a positive experience. The following respondent had never accessed treatment in the community.

At first when I went over, you know, when I was still thinking sure I'll give it a go and then the first week was totally new, you know what I mean. You go into the room at ten in the morning and you have two counsellors from [a therapeutic community], and in the afternoon you have two from the [a drug project], then you have Social [Probation and Welfare], you know. So you're there with this stuff pouncing on top of you, about where you're at and things like that. Like after the first week I got it into me head, 'yeah, I'll give this a shot', but as you're going through it you'd be sitting in the room and they give you a topic and you talk about it, and come out of it and feel good.

In addition to the counselling, respondents argued that a positive feature of the programme was that it removed participants from the environment of the main Male Prison. This was an environment in which there was a pervasive drugs culture, and where ceasing drug use was not seen to be feasible. Once on the programme, however, they were removed from this environment to one that was perceived to be conducive to abstinence. The key to this was the programme's position as a gateway to the designated drug-free unit, i.e. the Training Unit, the benefits of which are discussed in section 6.2.4. Overall, the programme offered a supportive environment in which participants could begin to address their drug use and their related problems.

- Interviewer: Would you have been able to come off it [heroin] in the main part of the prison?
- Respondent: No.
- Interviewer: Why not?
- Respondent: I eh, no help there [main Male Prison] like, you know. Like what was I supposed to do? Sit in a padded cell like for one week or two weeks, go through me withdrawals, and then come back out and take all this heavy stuff coming at me, and not know what way to deal with it, you know.

There were, however, two criticisms of the programme. The main criticism, expressed by those who had completed it (n=4), was that it was too short. Moreover, despite having intensive counselling for the seven-week period, once respondents had moved to the Training Unit, they felt that the drug-related services available to them were too limited. Drug use had offered users a way of coping with their problems for a number of years: in order to learn to cope with these problems without drugs, it was felt a longer course was needed.

Like I was here for so long, like there's not a lot you can do here after so long you know. Like there's only two NA [Narcotics Anonymous] meetings a week here and there's only one [therapeutic community] group meeting here as well a week, you know.

In summary, the Drug Detoxification and Rehabilitation Programme was perceived to have been a positive experience for the four respondents who had gone through it. It offered a supportive environment in which participants could begin to address their drug use. However, it was felt that there was a need to open up the programme to more prisoners, and to expand its content.

6.2.3 Methadone Maintenance Programme

Methadone maintenance is available to a limited number of prisoners in Mountjoy, and when the research was carried out, approximately twenty prisoners were on a maintenance programme. At the time of the fieldwork, this service was limited to male prisoners housed in the Medical Unit who were HIV-positive. Since fieldwork was carried out, all new committals to Mountjoy, and prisoners transferring from Cloverhill Prison who are on approved methadone maintenance treatment programmes, continue to receive maintenance treatment while in prison. Consultant psychiatrists from the Drug Treatment Centre, Trinity Court, supervised the programme with a prison doctor. Daily urine samples were taken from the prisoners to identify any illicit drug use.

Respondents held complex views on methadone, and perceived its use in the treatment of opiate addiction as having both advantages and disadvantages for the client. They held some negative perceptions about methadone, among them its perceived effects on clients' teeth³⁴ and the withdrawal symptoms.

Like now I wouldn't be into it, I don't want to be on phy for the rest of me life. It wrecks your teeth, your bones, do you know what I mean? It takes lumps out of you.

As a matter of fact, I think the sickness off the phy is worse than the sickness from heroin, you know what I mean like? 'Cause this phy gets right down deep into your bones and, as bad as the gear is, it's kind of physical effect, it's the same with the phy I suppose, but eh, it's easier to get off it [heroin].

Respondents who had participated in a methadone maintenance programme generally perceived it as an intermediary measure, prior to becoming drug free. Respondents who wanted to cease their illicit opiate use did not want to be dependent on methadone for the rest of their lives, irrespective of its licit status. The following respondent was currently using heroin in the prison:

34 Until 1996 the only form of methadone available in Ireland was Physeptone linctus, which had a high sugar content, which may have had a negative impact on users' teeth. Since 1998 all methadone services now prescribe methadone mixture, which is generally green in colour and has a higher concentration of methadone to syrup. Physeptone linctus has 2mg of methadone per 5mls of syrup, while methadone mixture has 5mg of methadone per 5mls of syrup.

Like don't get me wrong, I don't want to be on drugs for the rest of me life. Like I have a maintenance outside and I don't want to be on that for the rest of me life either, because I sampled the other side of life [being drug free]. And sometimes I can't see meself ever getting out of it, to get there, you know, because there's not enough help in here, there's no help in here.

Overall, methadone was described in positive terms. In particular, methadone maintenance was seen to offer users stability, by preventing withdrawal symptoms from heroin such as insomnia. The stability offered by a maintenance programme was seen to have particular benefits in the prison setting. By being assured of a daily licit dose of methadone, respondents would not need to engage in injecting heroin and the associated risks.³⁵ In addition, a couple of respondents argued that they would be able to remain in an environment, such as the main Male Prison, where drugs play a key role in daily life,³⁶ without relapsing into heroin use.

I talked to a lot of blokes there at the weekend and asked them what do they reckon would they go for a phy programme, 'yeah bloody right, instead of using in here'. Like you're not gonna catch the virus or hepatitis you know. ... 'Cause a detox programme say four months down the line they're finished with it, and they're back in the same environment, you know what I mean. They're walking up the yard watching other blokes coming in fresh off the streets, using in the corner or in the rec or whatever, and straight away you know they want it, you know what I mean, 'great like can I get it off you', back to square one. ... Methadone programme you wouldn't bother with it [heroin], you know what I mean, you're getting your phy, you know what I mean, have a bit of hash, have a couple of joints in the cell at night.

Respondents were particularly critical that, at the time the fieldwork was carried out, there was no continuity of care between the community and prison in relation to methadone maintenance programmes. They argued that where an individual had attained a certain level of stability on a maintenance programme in the community, they should be able to continue on an equivalent programme in prison. The following woman had been on a maintenance programme immediately before being imprisoned.

I think people on gear that outside have a maintenance, when they come into prison they should be kept on their fucking maintenance, and they should be well kept on that maintenance, 'cause it's not fair, you know what I mean.

Only two of the respondents in the current sample were on a methadone maintenance programme in the prison (in the Medical Unit). They both held positive attitudes

35 See section 5.3.4 for a full description of the risk behaviours involved in injecting drug use in the prison environment.

36 See Chapter 4 for a full description of the role of drugs in prison life.

toward the provision of a maintenance programme in the prison, and attributed their abstinence from illicit opiates to their participation in the programme.

The only time I ever stopped using drugs in prison was now this time, . . . because of the fact that I can walk up them stairs, and I can knock on the door and I can go in every morning and get a 100mls, 50mls of green. . . . It keeps me stable, and it keeps the fucking wolves away from the door. It doesn't have me ringing the family and annoying, ask her for a score and you get a score. I come from a big family, and there was always no problem with them, but I've been tormenting the heart of them, threatening them to come up [to the prison] and all, you know. So I'm delighted in that sense, that that's all over, you know.

In summary, while respondents' perceptions of methadone were complex, it was generally felt that the maintenance programme should be expanded in the prison. Respondents argued that it would offer prisoners an opportunity to attain a certain level of stability, which in turn would reduce their risk behaviours. They felt that the prison authorities should at least operate a policy of continuity of care for those entering prison while on a maintenance programme in the community. The introduction of a policy of continuity of care for methadone maintenance clients, which, as mentioned before, was put into practice in Mountjoy during October 2000, is to be welcomed.

6.2.4 Drug-Free Wings

The Training Unit is the only designated drug-free area in the Mountjoy Prison Complex. Male prisoners can access the Training Unit through the Drug Detoxification and Rehabilitation Programme, as part of a special programme for 'life' prisoners nearing the end of their sentence, or by making an application to the prison's governor for a transfer. All prisoners, irrespective of whether they have a drug-using history or not, are required to undergo random urinalysis in the Training Unit in an effort to maintain the drug-free environment. Where a prisoner tests positive for a prohibited substance, he is moved either to another prison or to another area of Mountjoy, generally to the main Male Prison. Random urinalysis was accepted among respondents as a necessary measure to ensure the unit maintained its drug-free status. However, the four respondents interviewed in the Training Unit expressed concerns about the reliability of the urinalysis.

That's the policy like with the urine if there's anything at all in your urine you're sent back [to the main Male Prison] and that's it, you can't argue the point that's the policy, you're just gone. . . . That's what I fear, I fear someone calling me some day and saying your urine's dirty. I haven't been taking drugs, I don't need drugs anymore, like I'm off drugs now thirteen months and I can do without them now.

In another case, the respondent had used illicit drugs on an 'experimental' basis while housed in another prison. He felt that, unlike prisoners who had accessed the Training Unit through the detoxification programme in the Medical Unit, he should not be subject to the random urine testing. As with the other prisoners in the unit, he expressed fears about the reliability of the tests.

Interviewer: Would you have to give urines?

Respondent: Yeah, that's what I mean 'the lotto's on', it could be my number next week, that's the way. I know that sounds a bit paranoid but you see guys being thrown back who you know are clean. Like I think I shouldn't have to give them 'cause I didn't come from the Medical Unit, I don't have a drug history. Like I said, I dabbled a bit here and there but it's no big deal, I mean I still have to do this, take the risk that they fuck up and that's me knocked back for another twelve, eighteen months.

While no independent evidence relating to these perceptions of the validity of the urinalysis was available, the concerns expressed by respondents suggest that assurances are needed as to the reliability of the testing process.

The drug-free environment was seen by respondents as offering those with a history of illicit drug use an opportunity to become drug free. Chapter 4 shows that certain areas of Mountjoy were perceived by respondents to be characterised by a drugs culture. They argued that while they may have been motivated to cease their illicit drug use while in prison, it was not feasible to foster these motivations in an environment dominated by drugs. For example, the following respondent was currently in the main Male Prison, where he was engaged in illicit drug use. While he wanted to cease his use, he felt the only way he would do so would be if he were moved to a drug-free area.

Like we talk to each other about it, he [cellmate] wants to really get off it 'cause he's doing alright. It's just the people that's around us, like I know we can't really blame them but I think if we were on, like I think if there was a wing in here that was drug free, I think a lot of people would be happy, you know, that they'd be given the chance.

Those who had managed to access the Training Unit confirmed this view that a change of environment could facilitate a change in drug-using activity. It was felt that, by being removed from an environment with a drugs culture, prisoners would be provided with the opportunity to cease their drug use.

It's not like the main jail like where you're facing it every day in the week like over there, you know, and that's how you get caught up in it.

Furthermore, respondents with no history of drug use argued that the option to be on a drug-free wing should be offered to all prisoners. They reported that they would prefer to be segregated from those who were continuing to engage in illicit drug use. There were a number of reasons cited for this, which overall reflected a desire to be removed from an environment characterised by a drugs culture. As seen in section 4.3.3, some of these reasons were related to health and safety.

In summary, both those engaged in illicit drug use and those with no history of drug use perceived the provision of a drug-free wing as positive. A drug-free wing was perceived to have particular benefits in fostering motivations to cease drug use among those with a history of illicit drug use. In addition, for those not involved in illicit drug use, a drug-free wing was seen as removing them from an environment dominated by a drugs culture. Therefore, while a drug-free wing may not be considered a 'service' *per se*, it was seen by these respondents as playing an important role in their rehabilitation.

6.2.5 Self-Help Groups

Outside the context of the Drug Detoxification and Rehabilitation Programme, the only structured self-help group accessed by these respondents in relation to their drug use was Narcotics Anonymous (NA). NA developed from the Alcoholics Anonymous movement of the late 1940s, and its programme is based on the Twelve Steps approach. These steps include admitting there is a problem, seeking help, making amends where harm has been done, and working with other drug users who want to recover. It describes itself as 'a non-profit fellowship or society of men and women for whom drugs had become a major problem....recovering addicts who meet regularly to help each other stay clean.'³⁷ The basic structure is an NA group, where addicts come together to discuss their experiences and seek support in an anonymous environment. NA has no professional counsellors. The closest thing to an 'NA counsellor' is the sponsor, an experienced member, who offers informal assistance to a newer member.

Participation in an NA group was seen to present individuals with an opportunity to discuss their problems in a supportive environment. In particular, respondents referred to those who co-ordinated the meetings, or acted as sponsors, as a positive feature of NA. As the following respondent explained, he found it a positive experience to see individuals from a similar background who had succeeded in stopping their drug use.

Most of these people [NA co-ordinators] I started taking drugs with. I probably sold them drugs or bought drugs off them, or probably robbed drugs off them. I've been in

³⁷ Data gathered from Narcotics Anonymous' web site, www.na.org

jail with them, I went to school with some of them, and to see all them coming in here and sitting in a chair in a meeting, and telling me they're clean four or five year, and they're doing great, and telling they have their own little home, and some of them are married and have kids and all, that's fucking great, you know like.

Some respondents reported that their initial contact with NA had been for reasons other than to address their drug use. Some attended to meet with other prisoners, others to alleviate the monotony of daily prison life. However, as the following respondent, who had ceased his illicit drug use, reported, this had served to introduce him to the group. While initially uninterested, he argued that NA offered participants an environment in which motivations to cease use could be fostered.

I went to the meetings for the wrong reasons, because I had to pick something up at the meeting, you know the scams. But like I took a bit of interest in it, you know, but the other half of me was still craving the drugs and that, you know, and I just wanted to get back to the landing, like where I could use the gear. But after a while, like when I went regular over here, I seen him [sponsor] again and like he had a yap with me, you know, and I asked him if he'd be me sponsor and that 'cause he took a lot of interest in me. And like I was curious about how he was doing it, how he was handling himself, you know, how he was dealing with it out there, like a lot of things that a drug addict would have to experience, you know.

A policy of anonymity among groups is core to the activities of NA in the community. A number of respondents commented that in the prison context, anonymity was extremely difficult to maintain. Furthermore, it was felt that confidentiality could not necessarily be maintained in this setting. There was a perception that, were a prisoner to discuss his/her private problems within the group, these would be discussed outside the group, with other members of the prison population. The perceived absence of a confidential and anonymous environment meant participants in the NA meetings could not freely engage in discussing many of the issues relating to their drug use.

You might hear some people talking in the cells later on about what one fella was talking about in the group, and they might be touching on a very personal thing, you know, heavy issue for him, and things that means an awful lot to him. But you'll get another fella in the group laughing and another fella slagging him on the wing that night, you know, which I don't like, I don't like it at all. It should be kept confidential, you know, you can get that an awful lot in prisons, you know, image is a big thing, they like to cash in on people's weaknesses.

In the Female Prison, the problem of maintaining confidentiality was seen to have resulted in meetings no longer being held there.

No, the meetings and all are stopped, they are, there's nothing. Like they used to be here but the girls don't really talk, you know, they just sit there for a cup of tea but they don't really want to stop [using drugs], you know what I mean. Then most girls that want to won't talk 'cause they know it'll go outside the room, do you know what I mean?

Respondents argued that the Training Unit offered a more supportive environment than other areas of the prison for those addressing their drug use, and was therefore a more suitable environment in which to hold NA meetings. The drug-free environment was perceived to be one in which the ethos of confidentiality within a NA group could be respected. As the following man explained, comparing his experiences in the main Male Prison and the Training Unit:

[In the main Male Prison] the meetings, they bring in a couple of packet of smokes and throw them on the table, you know, that's what they go up for, you know. And people that are trying to get into it are afraid to share at meetings 'cause they know that when they go back downstairs they're like 'you'd want to hear what he was saying', and this, and that. But here you won't hear anything back from anyone. ... Like it's kind of a rule [in the Training Unit] that what you hear here and what you say here, you know like, when you leave here that stays here, like you'll never say something to somebody outside.

Where respondents were involved in an NA group, they were critical about the restrictions on telephone calls. While they were permitted to call the Samaritans at any time, they were not permitted to call their NA sponsor, unless as one of their designated personal calls.

In summary, where respondents attended NA meetings regularly, they had found it to be a positive experience. They felt they could relate to others in the group and that it provided an environment of support. However, all of those with positive experiences of NA were in the Training Unit. Outside the Training Unit it was felt that a group process based on a premise of confidentiality and anonymity was not compatible with the prison environment.

6.2.6 Needle Exchange and Cleaning Materials

An examination of the issues surrounding injecting practices within the prison has already been given in section 5.3.4. Respondents generally argued that injecting drug use in prison was synonymous with sharing of injecting equipment. The prison did not provide prisoners with either new syringes or cleaning materials. In an environment where blood-borne-diseases, in particular hepatitis C, have been found to be prevalent among injecting drug users,³⁸ respondents expressed concerns about the risks of sharing

38 Allwright *et al.* (1999) found the following prevalence rates among a national sample of prisoners who reported a history of injecting drug use (n=509): HIV 3.5%, hepatitis B 18.5%, hepatitis C 81.3%.

injecting equipment. As a result, many discussed the provision of needle exchange programmes and cleaning materials in the context of drug-related services. There was strong consensus that the issue of sharing injecting equipment in the prison needed to be addressed by the prison authorities.

'Cause the way I look at it they know the prisoners are using drugs, you know what I mean, to beat the band, and they know they're spreading diseases, do you know what I mean, left, right and centre. So why not, like to stop spreading diseases, give them whatever they want, that's one way of looking at it.

Needle Exchange

In Ireland, needle exchange programmes have been available to drug users in the community, albeit initially on a limited basis, since 1989. Drug-using respondents were, therefore, coming from a community in which they could access clean injecting equipment, to prison where this service was not available. They had to adapt their injecting behaviour to a situation where access to clean injecting equipment was extremely limited. Respondents argued that they should be able to protect themselves, and those with whom they had contact in the wider community, from the risk of HIV and hepatitis infection. As the following respondent explained, irrespective of the measures taken by the prison authorities, it was perceived that injecting drug use would continue in the prison setting.

My experience is they'd want to get a needle exchange. No matter what they do out there there's still going to be needles in jail, going around. And then they have people with the virus, ... like a bloke walks out the gate and then they're with a bird and then the bird is with ten different blokes, it's just mad you know and that's not a lie. Like I've been studying the virus I've done courses and that's my opinion. Anyway, they have a serious problem.

Overall, respondents were pessimistic about the probability that the prison authorities would introduce a needle exchange programme. Their views reflected the complexities involved: while they argued that the current situation, in which prisoners were engaged in high-risk behaviours, was unacceptable, they also recognised the difficulties inherent in introducing a needle exchange into the prison setting. The reasons cited were diverse and included a perception that to provide a needle exchange would imply that the authorities sanctioned drug use in the prison. In addition, respondents felt that prison staff might perceive a needle exchange as a threat to their safety. The following respondent was HIV-positive and reported that he had contracted it through his needle sharing practices in the prison.

I think that if they provided needles, eh, I don't know, like if they gave you the needles they're more or less helping you on the way to use drugs, but the other way they'd be saving lives, so I'd say 'yeah, they should give the needles', which they wouldn't 'cause they could be used to take them hostages or whatever. I don't know which way they could deal with that, I don't see a solution to that because I think there's gonna be drugs here always, like it's just the way this prison is run, it's drugs. And the prisoners, like it keeps them quiet, and I don't know how they're gonna get around that, stopping that, I can't see a solution.

Respondents recognised the dilemma prison authorities faced on this issue. While arguing that they should consider introducing a needle exchange, they also acknowledged that the fears of prison staff, that the needles would be used as weapons, would preclude its introduction. As the following respondent remarked, while prison officers generally did not want to see diseases being spread among prisoners, they would have felt threatened were syringes to be readily available.

Eh, I reckon the actual idea they'd [prison officers] agree with, like they don't want to see a person dying anymore. They know what it's like in here, you're locked up, you know what I mean, some of us have problems, a lot of us have drug problems, personal problems, whatever the case may be, and the only way the people are gonna deal with them is through drugs. But then they have to look at themselves, they're gonna be at risk with so many needles around, so we can see it from their point of view as well.

While respondents recognised the fears of prison staff, they also pointed out that syringes were already present in the prison. If prisoners were going to use syringes as weapons, it would happen irrespective of whether they were being exchanged or not.

I think they should give out needles over there [main Male Prison], 'cause they're never gonna stop them using them, but they're afraid that if they start giving out needles they're gonna start using them as weapons. ... I mean why should they use them as weapons just because they start exchanging for them? I mean they haven't used them as weapons before, maybe, maybe they have. Like I believe there was one or two of them that used them, people trying to escape from courts and that, but they could have had them, they could have brought them with them, you know.

In summary, respondents identified a number of complexities inherent in the introduction of a needle exchange into the prison. While respondents felt that those who continue to engage in injecting drug use within the prison should not be exposed to the risk of HIV and hepatitis infection, they also recognised the concerns of the prison authorities. Respondents argued that while syringes may present a possible threat, they were already in the prison and to provide clean syringes would not necessarily mean an increase in their use as weapons.

Cleaning Materials

An alternative to a needle exchange was the provision of materials for cleaning injecting equipment. At the time this study was carried out, there were no formal mechanisms for making bleach available to prisoners. However, some managed to access household bleach on an informal and sporadic basis and used it to clean their injecting equipment. But respondents expressed concerns about the effectiveness of bleach in protecting them from contracting HIV and/or hepatitis, and similar concerns have been expressed by medical professionals.³⁹ There was particular concern about its effectiveness in preventing the spread of hepatitis C.

You see in here like, bleach doesn't work for, eh, like bleach will kill the virus itself, it'll kill HIV but it won't kill hepatitis. I don't know about B and A but it won't kill the C 'cause it's bleeding, it's [hepatitis] like a grease it is, you know. Like you can even notice it on the barrels blokes will use in here, you know, it'll look greasy, you know what I mean. So you can't kill that 'cause it's much stronger than HIV, like it spreads more easier.

Unlike needle exchanges, respondents did not identify any hurdles to providing cleaning equipment in the prison. They identified a need for education and information about the effectiveness of using a substance such as bleach in cleaning injecting equipment.

6.2.7 Counselling

Prisoners have access to counselling through the Probation and Welfare Service, and the Prison Psychologist Service. However, respondents identified the absence of a dedicated addiction counsellor within the prison as a significant gap in service provision.

A number of problems with the current system were identified. While respondents perceived probation and welfare officers to be accessible, they also noted their heavy workload. It was argued that while probation and welfare officers were a good source of support, they were not in a position to provide adequate support to the high proportion of prisoners who required a counselling service.

I did a bit of counselling off the probation officer, but it's not like everyone can get it like, 'cause there's only one officer to two wings so [he/she] wouldn't be able to counsel everyone that wanted it, you know, like I see [him/her] every week.

³⁹ Crowley (1999) has pointed out that cleaning injecting equipment with bleach may be sufficient to limit HIV spread, but it is unsatisfactory in limiting the spread of hepatitis.

Three respondents reported that they had been able to access an addiction counsellor while in the prison. In all cases the counsellors came from outside agencies, one of which was a therapeutic community-based service. However, respondents reported that there had been a lack of continuity in the services. While they may have had one or two sessions with the counsellor, contact had then ceased. The length of time respondents were required to wait between requesting contact with a counsellor and accessing the service was also identified as a problem. Respondents argued that, when a prisoner reached a crisis point, they should have immediate access to a counsellor.

Interviewer: What about any other services here, like counsellors?

Respondent: [Laughter]

Interviewer: Why are you laughing?

Respondent: Counsellors? I don't think so. They just throw you in the pad or send you to the block, there's no such thing as a counsellor here you know.

Interviewer: Even if you make a request to see one?

Respondent: No good, like even if you did you'd be waiting two or three months and by that time you'd be fucking running around the yard, you know what I mean?

Counselling was seen as a source of support for prisoners. Where respondents might be trying to cease their illicit opiate use, they felt they needed on-going support. This need was particularly acute among those currently housed in the main male and female prisons.

I just want someone to come up from there [outside agency] to talk to, like I am trying to stay away from it and trying to get this heroin out of me bloody head, you know.

One-to-one counselling was seen to be the best means of getting support. As mentioned in section 6.2.5, group support, such as NA, was perceived to present problems surrounding confidentiality.

One-to-one counsellor I think for starters anyway, instead of a big group of us. 'Cause fellas won't talk in front of the other fellas, you know what I mean, they're embarrassed like, 'cause I'm not gonna talk with all the fellas sitting there, you know what I mean. If you open up like they could start laughing, you know what I mean, I wouldn't be able to do that. Eh, one-to-one counselling I'd say would be alright yeah.

In summary, respondents identified a need for one-to-one counselling within the prison. At the time fieldwork was carried out, service provision in this area was perceived to be inadequate.

6.2.8 Drug Awareness Programme

The Mountjoy Prison Probation and Welfare Service has developed a Drug Awareness Programme. This is a four-week programme, with one session per week. The principal aim is to educate participants about drug use and the associated risks. It is aimed at all prisoners with a history of drug use, including those who have ceased using, and those who are continuing to use in the prison.

As with other services in the prison, respondents noted the waiting lists for this programme. Respondents gave a number of reasons for wanting to access the programme. The certificate awarded at the end was seen to be beneficial where prisoners had a judicial review coming up. In addition, participation broke the monotony of day-to-day life. More importantly, however, respondents were motivated to educate themselves about their drug use and the associated risks.

I think there's eh nine of us in it [Drug Awareness Programme], they do an awful lot of talking in the first week about drugs, about heroin, where it originated from, and where it came into the country, and talking about all that stuff. And then the down side to it, and eh, then what it mainly leads to, the diseases and how you catch them from that, and about clean works and that, and what information we had about it. They wanted to see what we knew, whether we had information ourselves. I think it's just to see how well educated we were on the downside of it and that. It's very interesting it is, because like it's after teaching me a few things.

It was reported that the information was delivered in an accessible manner. Respondents cited the information on hepatitis and other blood-borne diseases as a particularly interesting aspect of the programme. For those continuing to engage in drug use in the prison, it heightened their awareness of the risks they might be taking. The following respondent had tested positive for hepatitis C.

I done the Drugs Awareness Programme and they did a session on hepatitis which was very, very good now. I didn't know, I didn't know half the things about hepatitis so it sort of opened me eyes, like I was a bit wiser, you know, knowing that I had it and what happens and that. But he sort of explained it in detail, you know, and it was good. Like I would like some more courses like that, you know. Like I would say that it would help, like it mightn't help me, it could help the next person or the person after that, like someone who mightn't have it, you know, make them more aware and stop them using. But I would like to see more of those sorts of things like, you know.

In summary, where respondents had taken part in the Drug Awareness Programme, they had found it beneficial. By engaging those who were continuing to use while in prison, the programme was effective in getting information directly to those most at risk of contracting/spreading blood-borne diseases. Information was given in a way that was seen as accessible and was immediately relevant to the prison population.

6.2.9 HIV and Hepatitis-Related Medical Services

As discussed in section 5.3.4, prisoners who were continuing to use illicit drugs in the prison were engaging in high-risk activities as regards HIV and hepatitis infection. Within this population, blood-borne diseases presented a number of service needs. The following profile describes the self-reported prevalence of hepatitis and HIV among the respondents and their testing histories (n=29):

- three reported that they had tested positive for both HIV and hepatitis C;
- eight had tested positive for at least one strain of hepatitis, with hepatitis C being the strain most commonly referred to;
- four with a history of injecting drug use reported that they had never been tested for either HIV or hepatitis;
- only two respondents with a history of drug use had tested negative for both HIV and hepatitis, and had not engaged in any risk behaviour since;
- four had tested negative at some stage for at least one of the infections, but had continued to engage in risk behaviours, and at the time of interview were unsure of their status;
- five respondents, who had never engaged in injecting drug use (four were non-drug-users), had never been tested; and
- three respondents did not report their status.

This profile suggests a range of healthcare needs among this sample in relation to hepatitis and HIV. Overall, respondents reported a lack of information on many of the aspects of HIV and, in particular, hepatitis.⁴⁰ The information gap related to methods of transmission, treatments, vaccines and testing. There was, moreover, a negative perception of being tested for HIV or hepatitis in the prison. Breaches of confidentiality and the tactless delivery of test results by some medical officers were referred to. While none of the respondents had personally experienced either of these, the prison environment was not perceived to be suitable for testing.

⁴⁰ While the Drug Awareness Programme discussed in section 6.2.8 was being run in the prison, only a limited number of prisoners had managed to access it at the time of interview.

Like I know a 20 year old junkie that was here, like he was a good friend of mine actually, and he went down to get the result, it usually takes two weeks, and he went down to the doctor, he went in and [he/she] was like 'oh yeah here they are', gave them back to him, like he had it, and just told to get out then. Like this is like a professional doctor getting paid, do you know what I mean? And like a 20 year old could have gone and hung himself, like he should have been given counselling, been talked to about it, like that's supposed to be a professional doctor up there, you know.

Unlike the rest of the sample, the following respondent had used the prison services to facilitate regular testing. She had a good rapport with the medical officer and had been careful to ensure she was tested regularly. She had been working in prostitution and was also an intravenous drug user. Through the dissemination of information by the doctor, she had been given the opportunity to make an informed decision about being tested on a regular basis.

Like the doctor explained to me that if there was anything in my body that it can take it a long time for it to come up. So something that isn't detected now, it could be detected in three more months, and if it's not detected then, it could be detected in another three months. So it's six months and I'll get the all clear, you know. Mostly when you're first tested for them you are in the clear, you don't have anything. I'm happy to do that 'cause I put meself at risk.

None of those with HIV were receiving treatment for their positive status (n=3). Two of them were housed in the Medical Unit, and one in the main Male Prison. While both in the Medical Unit had been offered treatment,⁴¹ both reported that through consultation with the prison doctors it had been found that they were not at a stage where they required the treatment. The option, however, was open to them and they felt they could change their mind at any time. The third respondent had not approached the prison medical services in relation to his HIV status.

Treatment provision for hepatitis was not perceived to be readily available to prisoners. Only two respondents, who had been diagnosed with hepatitis C, had received a course of Interferon.⁴² In both cases the treatment had been effective. It was unclear

41 Highly active anti-retroviral therapy (HAART), a multi-drug treatment regime, which involves the use of protease inhibitors, is offered to prisoners who are HIV positive, where the treatment is considered appropriate.

42 Interferon is one of the drugs currently used in the anti-viral treatment for chronic hepatitis C. Where deemed the appropriate treatment, Interferon is generally prescribed at a dose of three million units, three times weekly, for six to twelve months. The treatment is administered by way of injection, with most patients learning to self-administer the Interferon. Overall, only about one in five people who take Interferon for hepatitis C has a sustained response (Department of Health and Children, 1998). It should be noted that Interferon is reported as often having unpleasant side-effects, including flu-like symptoms, fever, nausea, muscle and joint pains etc., which are similar to those associated with withdrawal symptoms from opiates.

what the reasons were for the other respondents' not having undergone treatment, although the on-going drug-using activity of many would have prohibited them from being accepted into a treatment programme.

There appeared to be little knowledge among the respondents of the availability of a vaccine for both hepatitis A and hepatitis B. Only three respondents, including two in the Female Prison, reported that they had received these vaccinations. Where this service had been accessed, it was seen in positive terms and the individuals involved argued that the prison was an appropriate setting in which to complete the course of injections. While some were aware that vaccines existed, a number of problems were perceived in trying to access them. Waiting lists and a lack of information were the key hurdles identified. The experience of the following respondent, who had no history of drug use, suggests that individuals in certain areas of the prison needed to be persistent if they were to secure a vaccination.

I asked [the doctor] from March to June for a hepatitis injection and [he/she] said 'when it's time for you to get it, you will get it', and I said to [him/her] 'meanwhile I could catch hepatitis?' and [he/she] says 'well that's not my problem, go figure', very nice. Then I got one injection in June and I got one injection in July and now I get a boost in October.

Where respondents had not been tested, they generally assumed that if they had engaged in intravenous drug use for a period of time, they would be hepatitis-C-positive - a particularly common assumption among those who had engaged in injecting drug use in the prison.

I haven't been tested for hepatitis, it's only the virus [HIV] I've been tested for that. So I reckon I have, like I reckon I have hep C, like the figures say 95% have that.

In summary, this sample had particular needs in relation to HIV and hepatitis. They argued that there was not enough information available on either infection, and that the services available to prisoners needed to be improved.

6.2.10 Alcohol-Related Services

While the focus of this study was on illicit drug use, respondents also reported a need for alcohol-related services. Two respondents with no history of illicit drug use described themselves as alcoholics. In both cases they attributed their imprisonment to their alcohol use. For one of these respondents it was his first period of imprisonment, while the other respondent had been incarcerated on five previous occasions. One of

these two respondents was particularly critical of the emphasis within the prison on illicit drug use. This prisoner felt that those who did not have problems with illicit drugs were generally ignored within the prison.

Em there are very few people who are in here who are alcoholics, there are a few old people who are wasted really, who don't want to stop drinking. Anyway at the moment I think I'm the only one who is an alcoholic who is in recovery, and because of that [the small number of alcoholics and large proportion of prisoners with a history of illicit drug use] they put all their attention towards the drug addicts, em, and they sort of just blanked alcoholics out, you know. It's like even the drug addicts see alcoholics as, they don't like alcoholics. Like they can't understand why they just can't stop drinking, I mean 'what's the big deal', you know, 'you're just an alco' or whatever.

The Alcoholics Anonymous (AA) meetings held in each part of the prison were seen as the main source of support for people with drinking problems. However, both respondents reported similar problems to those discussed around Narcotics Anonymous in relation to confidentiality and anonymity (see section 6.2.5). These respondents' experiences suggest that while there is a need to address the problem of illicit drug use among prisoners, there is also a need to develop services that will address some prisoners' problematic use of alcohol. While these respondents did not engage in illicit drug use, their use of a licit substance was problematic and needed to be addressed.

6.3 General Healthcare Services

This section briefly explores the general healthcare services that respondents had accessed in Mountjoy Prison. This current study focused on drug-related services, but it was felt that the general healthcare services in the prison, which might have implications for drug users' health, should also be addressed. The following discussion gives an overview of the issues raised by respondents. Only a number of the healthcare services available to prisoners are covered.

6.3.1 Doctor/Medical Officer Services

6.3.2 Mental Health Services

From the respondents' perspective, a common feature of the healthcare services in Mountjoy was that there were problems with accessing them. The main hurdle was the perceived waiting list for each service.

If you want to see, like say the circumstance that you wanted to see a psychiatrist yeah, you have to put your name down for the doctor and Jaysus Christ you'd be waiting 'til fucking God knows when. Same with the dentist, if you put your name down for the dentist you'd be waiting yonks, you know what I mean. Like you'd be waiting ages to see anybody like that, you know.

6.3.1 Doctor/Medical Officer Services

There is a commitment that all prisoners will be seen by a doctor (the medical officer) 'as soon as possible' after they are committed to prison. Upon entering the prison all prisoners are entitled to see a medical officer upon request. The doctor is present in the prison every day and can also be called in an emergency. In order to be seen by a doctor, a prisoner must first approach their Class Officer, that is the prison officer in charge of their landing (Mountjoy Prison Probation and Welfare Service, in press).

Respondents differed in their views of the service provided by medical officers. They reported that their experiences had varied depending on which doctor they had seen. Some doctors were perceived to be accessible and effective in providing a service to prisoners; others were seen to be both inaccessible and ineffective in meeting the needs of inmates. Therefore, the views expressed generally related to individual doctors rather than medical officers as a group.

You see it's all different doctors, it could be a different doctor every day of the week and some of them are all right, some of them aren't.

On balance, the prison doctors with whom respondents had negative experiences attracted most comment. Respondents felt that a number of doctors employed in the prison, at the time the study was carried out, held negative attitudes about the prison population. As the following respondent, who had no history of drug use, explained:

[He/she]'s a pig, [he/she] really is a pig. [He/She] shouldn't even be allowed to have the licence to practise as a doctor because [he/she] has no sympathy, [he/she] paints everyone with the same brush, 'you're all criminals', we're all drug abusers. And [he/she] has no time for us and I have no time for this person, no time. And eh, the Hippocratic oath probably means nothing to [him/her]. ... We're all criminals and we shouldn't be allowed to live as far as [he/she]'s concerned.

The negative attitude of some of the prison's doctors was seen to have a negative impact on prisoners' well-being. Where a medical officer was perceived to hold negative

attitudes about prisoners, respondents had refrained from attending him/her. They argued that at times the medical needs of prisoners went unaddressed.

Interviewer: Do you go to see [him/her] [medical officer] at all?

Respondent: Well to be honest personally I wouldn't bother. Like I have a murmur on me heart and there about four or five months ago I had a pain in me chest and went in and 'ah you're alright, go on' you know, fucking sad, you know. You can't argue with [him/her], you know, they're the authority, you can't argue with them. ... Like it's just [he/she]'s here for the money and they pay [him/her] and that's it, you know.

In direct contrast were those who reported having had a positive experience with a medical officer. These respondents felt that these service providers effectively met their medical needs. The following respondent highlighted the variation in experiences.

Like there's two doctors here and they're brilliant. Like you go in with anything at all and they give you attention, you know. They check everything out for you, but like over there [a particular prison area] they sat behind a desk with two officers on each side of them and two standing at each side of the door, and you walked in, 'what's wrong with you? Ah yeah it's only whatever', 'okay I'll give you this' or 'give you that' or 'get out' or whatever, you know.

In summary, respondents reported diversity in the quality of service medical officers provided. Where medical officers were seen to hold negative attitudes about prisoners, respondents were reluctant to approach them for care. This may have serious implications for the health of prisoners.

6.3.2 Mental Health Services

Respondents reported a variety of mental health problems. These included periods of anxiety, depression and insomnia. Respondents also reported both suicide attempts and suicidal ideation. Some participants were dealing with the effects of past sexual and physical abuse, which in one case had been expressed through self-mutilation.

I've had a lot of suicide attempts, you know what I mean. I've been trying to kill meself since I was a kid.

Both psychologists and psychiatrists were available to prisoners to help them cope with these problems.⁴³

Respondents' perceptions of these services and the extent to which their needs were met were not examined in-depth in the current study. The lack of in-depth data gathered on the mental health services does not reflect on the importance or need for these services.⁴⁴ Rather, it reflects the limitations of this exploratory study, which focused on drug use and drug-related services.

Psychological Service

Clinical psychologists provide a service to inmates within both the male and female prisons. They hold a number of clinics every week. As with the medical officer, prisoners must request an appointment through their Class Officer.

Only two of those in the current sample (one male and one female) reported attending a prison psychologist, and both had found their experiences positive. They had been sexually abused as children and felt that the psychologist had been supportive in helping them cope with the problems they had experienced as a consequence.

Psychiatric Service

A psychiatric service is available to all prisoners. Prisoners may access the psychiatrist if it is ordered or recommended by the Court. Otherwise, prisoners must be referred to the psychiatrist through the medical officer. The process of referral and the waiting time involved was commented on by a number of respondents.

What you've got to do is put your name down to see the doctor, so you wait a couple of days to see the doctor and you go in and see the doctor and say 'I wanna see the psychiatrist', and [he/she] puts you down for the psychiatrist and then another two weeks and you see the psychiatrist.

Eleven respondents reported being prescribed either sleeping tablets or anti-depressants from a psychiatrist at some time while incarcerated, either on their current or previous sentences. Perceptions of the psychiatric services were not examined in detail with respondents, and reports were mixed. For example, one respondent, who reported having manic depression, said that medication had been made available immediately

⁴³ Probation and welfare officers also offered counselling services.

⁴⁴ In their study of the health of Irish prisoners, Hannon, Kelleher & Friel (2000) found that, using the GHQ-12 instrument, 48% of male and 75% of female prisoners were 'cases', i.e. they may be significantly in need of psychiatric treatment.

upon coming into the prison. This respondent had never had any problems with accessing the necessary medication through the prison's psychiatric services.

Others were more critical of the psychiatric services. Respondents with a history of opiate use reported suffering from problems sleeping once imprisoned, and many reported that they had approached the psychiatrist in an attempt to receive medication that would help them sleep. Some had been refused medication and others had been given a prescription for sleeping tablets. Where a prescription was given, medicines were dispensed by a member of prison staff on a daily basis and a store was not left in the prisoner's possession. From the perspective of these prisoners, this medication was delivered in an *ad hoc* manner. As the following respondent reported, he had received sleeping medication but had not been consulted when the prescription had ceased.

I was having a bit of difficulty sleeping and I got down to see [the psychiatrist] and I got Zimovane for three weeks and that, and then I was just cut, just cut like. Like I wasn't called down to see how I was before I was cut. So like they don't bleeding care about the welfare of prisoners or whatever like, you know.

The process through which respondents need to be referred by their medical officer to the psychiatric services needs to be considered in the context of how some of these officers were perceived by respondents (see section 6.3.1). Where negative attitudes were held toward medical officers, prisoners may have been reluctant to approach them to seek a referral on to the psychiatric services. In addition, the delay involved in accessing a psychiatrist may have been particularly significant where respondents were in a crisis and may have been experiencing suicidal feelings.

6.4 Other Services

There were a number of services available to prisoners other than those related to drug use and health. These included education and training-based programmes, and programmes oriented toward an individual's release. Owing to the limitations of this study, neither prisoners' uptake nor their perceptions of these services were examined in depth. However, respondents identified some of these services as playing a role in reducing the risk of recidivism, both in relation to drug use and criminal activity.

As seen in section 3.2, fifteen of the twenty-nine respondents had left school before the age of fifteen, and twenty-two had left the education system with no formal qualifications. In addition, many had limited employment experience and had

generally been working in unskilled manual positions. Prison offered sentenced prisoners an opportunity to return to education and training. For some, this meant taking literacy classes, while for others it was an opportunity to obtain formal qualifications.

I didn't want to leave prison not knowing anything, there are some good facilities around in Mountjoy, there's some very good teachers. ... They're sound and I just felt that if I gave them my time, they would give me their time, which they eventually did. As I said, I went on to sit my Junior and Leaving Cert and I passed my Junior flying and I got a couple of B's in my Leaving Cert, I was happy.

Respondents argued that the provision of training and education programmes had an important role to play in offering them an opportunity to 'break the cycle' of recidivism. By leaving prison with qualifications, they felt they would be in a better position to cease both their criminal activity and drug use.

Like the reason I want to get over there [Training Unit] is more or less to try and break the circle, you know what I mean, of being in and out, in and out, in and out all the time. I think like, as I said I've been in and out all the time but this time I'm starting to do something, like not going back to square one and all.

In addition to education and training, respondents identified the need for improved service provision relating to release. They felt there was a need to prepare prisoners for their return to the community and to provide them with on-going support after release. As the following respondent explained, more comprehensive pre- and post-release services might help prevent the current pattern of recidivism apparent in the system.

You're seeing the same faces coming back in again in the next two weeks, like all because they're after getting out and they're just going back to drugs like. I mean if they get the people ready, if they prepare them for going out, like for what's outside, I reckon that'd be great, now not saying but in my opinion, it would reduce the amount of people coming into prison, you know.

While these services were seen to have an important role to play in the rehabilitation of prisoners, access to them was perceived to be restricted. As with drug-related services, respondents associated these services with long waiting lists and, in some cases, restrictive selection criteria.

There's only so many that the classes can take and so many, like all the classes are full, like they're just waiting just for school, do you know what I mean. And some judges recommend that you get an education, you can't like.

In summary, these comments suggest that services other than those aimed directly at drug users should be seen to have an impact on the rehabilitation of prisoners with a history of drug use. By providing prisoners with an alternative to their lifestyle prior to imprisonment, respondents felt they might break the cycle of recidivism.

6.5 Summary of Main Findings

Drug-Related Services

Respondents argued that there was an urgent need to expand the services available to drug users in Mountjoy. This related to both the types of services available, and the number of prisoners who could be accommodated by the services.

Short-term Detoxification (with Methadone)

All those respondents who had been engaged in opiate use up until the point of imprisonment, had accessed the voluntary thirteen-day detoxification programme upon entering prison. This was perceived by respondents to be too short and to involve too low a dose of methadone. Respondents reported experiencing severe withdrawal symptoms, which had not been alleviated by this programme. They argued that this detoxification reflected a general misunderstanding on the part of the prison authorities about the nature of opiate addiction.

Drug Detoxification and Rehabilitation Programme

Those who had managed to access the seven-week Drug Detoxification and Rehabilitation Programme (n=4) reported that it had helped them cease their illicit drug use. However, two respondents had done the programme on a previous sentence and had since relapsed into drug use. On completion of this programme, participants had been transferred to the designated drug-free Training Unit. Transferral to the Training Unit was seen as a particularly positive feature of the programme.

Methadone Maintenance Programme

The situation at the time of the fieldwork, whereby only those who were HIV-positive, were offered a methadone maintenance programme, was criticised by respondents. It was felt that the methadone maintenance programme should be expanded in the prison. Respondents argued that participation in a methadone maintenance programme would help prisoners to remain off illicit opiates while in prison.

Furthermore, it was reported that it would reduce the level of risk activity engaged in by prisoners.

Respondents were particularly critical when those on a maintenance programme in the community were required to detoxify upon imprisonment. However, since October 2000, prisoners who have been on a recognised maintenance programme in the community are no longer required to detoxify upon imprisonment.

Drug-Free Wings

Removal from an environment characterised by a drugs culture to a designated drug-free wing was seen by respondents as particularly effective in facilitating those who wanted to remain drug free while in prison. Respondents argued that all prisoners should have the choice of serving their sentence in a drug-free wing.

Self-Help Groups

Self-help groups, based on principles of confidentiality and anonymity, were generally perceived to be incompatible with the prison setting, except in the Training Unit.

Needle Exchange and Cleaning Materials

Respondents recognised the complexities involved in introducing a needle exchange programme into the prison. While they argued that the problem of extensive sharing of injecting equipment in the prison needed to be addressed, they also recognised the concerns of staff and prisoners for their safety. However, it was felt that if clean injecting equipment were provided to inmates, this would not necessarily present a greater threat to staff or prisoners than was already present in the prison.

Respondents did not perceive any significant obstacles to the provision of cleaning materials for injecting equipment in the prison. While some cleaning materials were available in an *ad hoc* manner, respondents expressed concerns about their effectiveness in preventing the spread of HIV and hepatitis.

Counselling

Respondents identified the absence of a specialised addiction counsellor as a major gap in service provision.

Drug Awareness Programme

Respondents who had accessed the Drug Awareness Programme run by the Probation

and Welfare Service reported that it was effective in delivering relevant information in a non-judgemental and accessible manner.

HIV and Hepatitis-Related Services

Three respondents reported that they were HIV-positive and a further eight had tested positive for at least one strain of hepatitis. A further eight were unsure of their status but had been engaged in high-risk behaviours within the prison setting.

Respondents reported a lack of information on many aspects of HIV and, in particular, hepatitis. This related to methods of transmission, treatments, vaccines and testing. Prison was seen by respondents as a suitable environment in which to receive treatment and/or vaccination.

Alcohol-Related Services

A need for alcohol-related services was identified by the sample. Two respondents, who reported no history of illicit drug use, described themselves as alcoholics. In both cases, they attributed their imprisonment to their alcohol use.

Healthcare Services

Respondents differed in their views on the service provided by medical officers. They reported that their experiences had varied depending on which doctor they had seen. Some medical officers were seen to be accessible and effective in providing a service to prisoners; others were seen to be both inaccessible and ineffective in meeting the needs of inmates.

Respondents reported experiencing a range of mental health problems. These included periods of anxiety, depression and insomnia, which at times had manifested themselves in suicide attempts and suicidal ideation. Some were also coping with the effects of sexual and physical abuse. Some respondents had accessed both psychiatrists and psychologists within the prison to help them address these problems.

Other Services

In addition to specifically drug-related services, respondents identified education and training programmes as playing a role in reducing the risk of recidivism, both in relation to drug use and criminal activity.

CHAPTER 7

MAIN FINDINGS AND DISCUSSION

7.1 Introduction

As an exploratory piece of research, this study provides an initial examination of the issues faced by a sample of prisoners (n=29) in one of Ireland's prisons in relation to drug use. It examines various aspects of drug use among prisoners and the impact prison has on an individual's experience of drug use. While the study has its limitations,⁴⁵ the findings should serve as an important starting point for a more comprehensive examination of drug use in Irish prisons. This chapter presents a summary of the main findings, and discusses them in the context of findings from research carried out in Ireland and other European countries. The sections correspond to the chapters of the report:⁴⁶

- 7.2 Sample Profile
- 7.3 Prison Life and the Role of Drugs
- 7.4 Drug Use in the Prison Environment
- 7.5 Service Provision

In conclusion, in section 7.6, the implications of the study's main findings are discussed.

⁴⁵ The non-random sampling strategy used, the small sample size and the limitation to one prison means that the findings here cannot be extrapolated to the Irish prison population as a whole. See section 2.2.

⁴⁶ As in the preceding chapters, the experiences of both those prisoners with a history of drug use and those with no history of using drugs are discussed.

7.2 Sample Profile

7.2.1 Socio-Economic Profile

The current study sample (n=29)⁴⁷ was characterised by high levels of unemployment, low levels of educational achievement and a history of contact with the criminal justice system (see sections 3.2 & 3.4). A similar socio-demographic profile has been found for Mountjoy's prison population in previous studies (Carmody & McEvoy, 1996; O'Mahony, 1997b). The more comprehensive study was that carried out by O'Mahony (1997b), but it did not include data on the female prison population. As with the current study sample, O'Mahony found that, of his sample (n=108), half had left school before the age of fifteen. High rates of unemployment and a low level of educational achievement were also found in O'Mahony's sample, with only one quarter ever having sat a public examination. Furthermore, both the current and O'Mahony's study have found that prisoners tend to come from areas of Dublin characterised by social and economic deprivation.

7.2.2 Drug-Using Career and Criminal History

The current study explored, albeit to a very limited extent, the drug-using careers of respondents (see section 3.3) and the types of criminal behaviour in which they had been involved (see section 3.4). The perceptions that respondents had of their drug use had changed over time. At least initially, drug use was seen by these respondents as a source of pleasure and meeting certain needs. However, once respondents developed a 'habit', they began to require opiates to avoid experiencing withdrawals. Once addicted, the quantity of drugs a user required increased, along with the associated financial demands. This meant either becoming involved in criminal activity for the first time, or escalating it to meet the financial requirements of an opiate habit, while also minimising the risk of detection (see section 3.5). The extensive criminal history of many in the current sample was similar to that found among O'Mahony's (1997b) sample. Furthermore, the experiences of the current sample reinforced the link in Ireland between illicit opiate use and criminal activity identified elsewhere (O'Mahony, 1993; McCullagh, 1996). An in-depth exploration of the drugs-crime relationship was beyond the scope of this study, but warrants further attention.

⁴⁷ Twenty-four of the twenty-nine participants had a history of drug use prior to the current period of imprisonment, and five had not used drugs prior to the current period of imprisonment. One of the five who had not used drugs prior to imprisonment had 'experimented' with ecstasy and cannabis during his present incarceration, but had since ceased using drugs.

7.3 Prison Life and the Role of Drugs

7.3.1 The Social Climate of Mountjoy Prison

While quantitative studies have provided important information about Mountjoy Prison and its population (O'Mahony, 1997b), little is known about the 'personality' or social climate of the prison. By using qualitative methods, this study explored the social climate of Mountjoy and the role drugs played in shaping it (see Chapter 4). Goffman (1961) described prison as a type of 'total institution'. 'Total institutions' are characterised by their all-encompassing character, in which individuals are cut off from social interaction with the outside world. Furthermore, Goffman argued that such institutions are organised along a split between a 'large managed group' (inmates) and a 'small supervisory staff' (prison staff). He argued that each of these groups tends to 'conceive of the other in terms of narrow hostile stereotypes' (Goffman, 1961: 7). In addition, these institutions 'strip' inmates of their extra-institutional roles by, among other things, removing their authority to do even the simplest things on individual initiative. This 'stripping' requires those incarcerated to engage in some personal reorganisation so as to establish new roles that will give meaning to their lives within this environment. Associated with this re-organisation is the development of a sub- or counter-culture among inmates (Moos, 1975). A 'total institution', then, may be seen as an environment in which inmates develop their own sub-culture, which shapes their behaviour and values.

O'Mahony argued that Mountjoy is 'dominated by a drugs culture embodied in prisoners' attitudes, values and behaviours (O'Mahony, 1997a: 42). Within the limitations of an exploratory study, the evidence presented in the current research suggests support for O'Mahony's (1997a) argument. However, it is not suggested that the 'drugs culture' that appears to exist in Mountjoy exists solely as a consequence of the 'stripping down' function of the 'total institution'. Rather, it must be seen in the context of the drugs culture, of which a large proportion of inmates were a part prior to incarceration.

7.3.2 Impact of 'Drugs Culture' on Drug Use

The findings suggest that there is a pervasive drugs culture within Mountjoy, although this appears to be more acute in some areas of the prison than in others. Drugs were reported to play an important role in shaping many aspects of the prison environment. In addition, a number of aspects of the prison environment itself were reported by this sample to reinforce the value of drug use and its dominant role in shaping day-to-day life in the prison. Drug use offered respondents a way of coping with the problems

presented by a prison environment, which was seen to be characterised by insanitary living conditions, monotony, boredom, depression, stress and tensions. Respondents reported that the social affiliations they had formed in the prison tended to be based around an individual's drug-using status, and that for drug-using inmates, interaction with other prisoners was often centred around drugs. The impact of being in a social environment characterised by a drugs culture was seen to have particular implications where an individual might be considering ceasing his or her drug use. Respondents argued that, despite motivations to cease their illicit drug use, it was generally not perceived to be feasible to foster these in an atmosphere dominated by drugs. The findings suggest that where prison presented individuals with particularly negative experiences and problems, the benefits rather than the costs of drug use were reinforced.

7.3.3 'Silent Accommodation' of Non-Drug-Users

While those respondents in the sample who had no history of illicit drug use ($n=4$) did not report feeling pressured into using drugs, drug use was seen to shape their daily experiences within the prison. At least in the initial stages of imprisonment, it was seen as making the environment more threatening. It may be argued that this was the case until they became accustomed to the dominant culture among prisoners, which was based around drug use. While these prisoners may have been able to remove themselves from the various activities involved in using drugs, they felt it was assumed that they would give 'silent accommodation' (O'Mahony, 1997a) to the activities going on around them. The concept of giving 'silent accommodation' to the drugs culture of prisoners was used by O'Mahony in arguing that there was now a 'working balance between the objectives of prison management and those of the oppositional drugs-oriented culture of the prisoners' (1997a: 42). This was seen by O'Mahony as a form of 'compromise' between a prison environment where many prisoners lived a drugs-dominated life, and one where prison authorities could claim an ordered prison world was maintained. From the perspective of those in the current study sample who had no history of illicit drug use, it would appear that prisoners with no history of drug use may have to accommodate a drugs-oriented culture during their time in Mountjoy.

7.3.4 Impact of 'Drugs Culture' on Prison Atmosphere

In the current study respondents proposed that the presence of drugs in the prison may have given the impression of a stable environment (see section 4.3.2). However, the climate was seen to fluctuate, depending on the availability of drugs. When drugs were available, the atmosphere was described by respondents as calm and seemingly ordered, but when there were problems in accessing drugs, tensions arose. Overall, drug use was

seen by both drug users and non-users in this sample as contributing to the volatile nature of the environment.

In conclusion, study participants' experiences of prison appeared to vary, depending on whether they were housed in an area of the prison where a drugs culture was seen to exist. In areas of the prison where drugs were not perceived to be an important part of the prisoners' culture (in the Training Unit), social affiliation was not based on drug-using activities, the atmosphere was more relaxed and 'staying clean' was generally perceived to be a feasible option. In contrast, where a prisoner was living in a social climate characterised by a drugs culture, this might influence his/her decisions around his/her daily life and drug-using activities.

The social climate within which an individual functions may have an important impact on his [sic] attitudes and moods, his behaviour, his health and overall sense of well-being, and his social, personal, and intellectual development. (Moos, 1975: 8)

7.4 Drug Use in the Prison Environment

As in other European countries,⁴⁸ a significant proportion of Ireland's prison population has been found to have had a history of drug use prior to imprisonment. Allwright *et al.* (1999) found that 52% of their national sample (n=1,205) had a history of opiate use, and O'Mahony (1997b) found that 66% of his sample (n=108) of the Mountjoy Male Prison population had a history of opiate use. Within the current sample (n=29), twenty-four respondents reported a history of illicit drug use prior to imprisonment, while five⁴⁹ had not used drugs prior to imprisonment. Research has also shown that in Ireland and throughout Europe, many drug users continue to engage in illicit drug use while incarcerated (Bird, Gore, Cameron, Ross & Goldberg, 1995; Haastrecht *et al.*, 1997, cited in EMCDDA 1998; Keene, 1997; Edgar & O'Donnell, 1998; Strang, Heuston, Gossop, Green & Madden, 1998; Allwright *et al.*, 1999). Research carried out to date has tended to focus on concerns surrounding risk behaviours in the context of HIV and other blood-borne diseases. The current study raises a number of issues that warrant discussion, including the impact of imprisonment on the drug-using behaviour of inmates, the nature of illicit drug use in prison and the associated risk behaviours.

⁴⁸ See Appendix 4.

⁴⁹ One of the five who had not used drugs prior to imprisonment had 'experimented' with ecstasy and cannabis during his current incarceration, but he had since ceased using drugs.

7.4.1 The Impact of Imprisonment on Drug Use

Imprisonment was perceived to impact on the respondents' illicit drug use in a number of ways. In the broadest sense, some continued their illicit drug use once imprisoned (n=17) and others ceased their use (n=7) (see section 5.2.1). It is important to note that, when looking at the continuation or cessation of drug use in prison, the findings of the current study suggest that it was not necessarily the sentence a prisoner had received that had the impact on drug use, but a combination of factors. Accessing drugs was a big factor, and the particular environment of the prison also appeared to impact on what respondents perceived to be an individual's chances of ceasing use while in prison. While respondents may have reported a motivation to abstain, doing so was generally perceived only to be feasible once removed from areas of the prison where a strong drugs culture existed. In order to foster motivations to cease use, respondents felt that they would need to have the option of being in a drug-free wing.

The overall consensus among respondents in relation to what motivated their drug use while in prison highlights the complexity of the problem facing prison authorities. The ability of heroin and other drugs to offer a 'day out' from the general living conditions, the monotony and the pressures of prison life was perceived as a key element in motivating members of this sample to continue their drug use while in prison (see section 5.2.3).

7.4.2 The Prison Habit

The drug-using activity which members of this sample engaged in in the prison, was found to be of a particular nature when compared to that which occurred in the community (see section 5.3.3). This is consistent with the findings of studies elsewhere. Strang *et al.* (1998) found that users reported less use of any one of a range of drugs while imprisoned, compared to when they were in the community. However, Strang *et al.* (1998) did not address changes in either the frequency of use or the quantity of drugs used. In the current study, where respondents continued to use drugs in the prison, the quantity of drugs used and the frequency with which respondents used them, were reported to have reduced greatly in comparison to community-based patterns of use. Consequently, after the initial period of imprisonment, the physical symptoms of a user's addiction were reported to diminish, while the psychological cravings persisted. As highlighted by at least one practitioner in the Irish prison service (Crowley, 1999), the absence of severe physical symptoms may present service providers with an important opportunity for intervention with this population.

7.4.3 Initiation into Drug Use within the Prison Setting

Initiation into use is an important aspect to consider in addressing the question of what impact being in prison has on an individual's drug use. Overall, research carried out in other European countries has found little evidence of prisoners' being initiated into their first-ever use of any illicit substance while in prison, although it has been cited as an issue of concern (Uchtenhagen, in Nelles & Fuhrer, 1997). Only one respondent in the current sample reported that he had been initiated into his first-ever use of an illicit drug while imprisoned. He had used cannabis and ecstasy on what he perceived to be an 'experimental' basis. However, research elsewhere has found that prisoners are initiated into the use of an illicit drug that they had not used prior to imprisonment. In Strang *et al.*'s (1998) study, a significant proportion of the sample reported 'first use in prison' of an injectable drug. Twenty per cent cited heroin, 8% crack cocaine and 7% amphetamines as first being used during a period of incarceration. All of those (n=4) in the current study who reported a transition to a new illicit drug in the prison setting had moved to heroin (see section 5.2.2).

It is argued that one of a range of mediating variables may influence changes in patterns of drug use in prisons, including prison policy. In the United Kingdom, it has been suggested that the introduction of mandatory drug testing has influenced the decision of prisoners to move from cannabis to heroin, because of the relatively longer half-life of cannabis (Gore, Bird & Ross, 1996). No testing policy was in place in the prisons where the four respondents in the current study had first experienced heroin. They reported a more opportunistic factor influencing their move to heroin: when respondents had been in an environment where others were engaged in heroin use and they themselves were already involved in the use of some illicit substance, to experiment with smoking heroin was perceived to be a logical choice. Where individuals had used drugs to help them cope with life in the community, they may have wanted to use drugs to help them cope with being in prison - where heroin was the drug available, they engaged in its use. This finding suggests that initiation into the use of heroin in prison may best be considered in the overall social context in which prisoners are based, rather than as a direct consequence of a particular prison policy.

7.4.4 Initiation into Injecting Drug Use

The impact of imprisonment on the routes of administration used by prisoners and the risk behaviours they engage in, have been the focus of most of the research literature in the area of drug use among prisoners (Strang *et al.*, 1998; Hughes, 1999). In a study of injecting practices in two Scottish prisons it was found that the percentage of injectors who had started to inject while in prison was 6% in one, and 25% in the other (Gore *et al.*, 1995). From their findings, Gore *et al.* (1995) argued that initiation into

injecting drug use while incarcerated had serious implications for the transmission of blood-borne viruses. In turn, they felt that prison authorities needed to understand 'how initiation occurs and to support non-injectors, particularly those never imprisoned before, so that they can avoid starting to inject inside' (Gore *et al.*, 1995: 1135). Gaining an insight into the risk factors in the context of an Irish prison was an important aspect of the current study. It was found that, where a change occurred in the route of administration used in the prison (n=6), this was from smoking to injecting heroin (see section 5.3.4).

Among a national sample of Irish prisoners, Allwright *et al.* (1999) found that 20.5% (n=104) of those who had a history of injecting opiate use (n=506) had first injected while incarcerated,⁵⁰ demonstrating that changes in routes of administration occur to a significant extent in the Irish prison setting. The current sample offered some insights into what factors may influence a prisoner's decision to begin injecting while in prison. In the community, economic motivations and the perception that a better 'buzz' is got from injecting opiates are two of a number of factors identified as influencing initiation into injecting drug use (Stillwell, Hunt, Taylor & Griffiths, 1999). A similar explanation was found among the current study sample. The nature of the setting meant that only small amounts of heroin were available to prisoners. As a result, respondents reported that they felt obliged to use heroin in the most efficient way possible: it was perceived that a smaller quantity of heroin needed to be injected, as opposed to smoked, to get the same effect. In addition, the manner in which drugs were distributed in the prison, through reciprocal distribution networks, meant that there was pressure to ensure that as many members as possible of a network would be accommodated. Stillwell *et al.* (1999) highlighted the 'socially transmitted nature of injecting drug use within using and peer networks' in the community (Stillwell *et al.*, 1999: 458). The findings from the current study suggest that this may also influence initiation into injecting drug use in the prison setting.

7.4.5 Sharing Injecting Equipment

While there is extensive evidence that the overall rate of injecting behaviour is reduced by incarceration (Haastrecht *et al.*, 1997, cited in EMCDDA 1998; Strang *et al.*, 1998), research has found that where it does occur, prisoners engage in a higher level of risk behaviour than prior to imprisonment (Keene, 1997; Strang *et al.*, 1998;

50 A media misinterpretation of data collected in Irish prisons by Allwright *et al.* (1999) gave a false impression of the extent to which initiation into illicit drug use within the prison setting happens in Ireland. A headline in *The Irish Times* (1999) reported that 20% of prisoners had claimed that they had begun their drug use while in prison. In fact, this referred to the percentage of prisoners who had a history of injecting drug use and reported that they had first injected drugs while in prison.

Crowley, 1999).⁵¹ Where individuals inject in a prison setting they may not have access to the harm minimisation services available outside, and therefore there is going to be an increased risk of the spread of blood-borne viruses among this population. Furthermore, it is argued that the nature of the prison setting means drug use is covert and that this will have detrimental consequences for safe injecting practices (Taylor *et al.*, 1995; Dolan in Nelles *et al.*, 1997; Fuhrer *et al.* in Nelles, Fuhrer, Hisbrunner & Harding, 1998).

In the Irish context, Allwright *et al.* (1999) found that of those injecting drug users in their sample (n=506/1,205), only 24.4% reported that they had never shared any injecting equipment while in prison. In the same study, prisoners with a history of injecting drug use displayed prevalence rates of 3.5% for HIV, 18.5% for hepatitis B and 81.3% for hepatitis C. Thus, the risk of infection through sharing practices in prison should be considered high. Respondents in the current study reported that, where injecting drug use occurred in the prison, it was generally perceived to be synonymous with the sharing of injecting equipment (see section 5.3.4). Unlike in the community, where needle exchange services provide users with the opportunity to minimise the risks associated with injecting, prisoners did not have access to any such service. There was no structured access to either cleaning fluids or clean injecting equipment.

In his study of drug injectors' perceptions of HIV risk behaviour, Hughes (1999) found that users have particular concepts of 'cleanliness' and 'dirtiness', which can be seen to influence their decision making around risk behaviour. His study considered both those injecting in prison and in the community. In addition to general physical appearance, Hughes found that one of the factors that contributed to a perception of 'cleanliness' was the extent to which people were known to the particular user. In the context of the current study, this appeared to influence the sharing behaviour of some respondents. They were prepared to share with either a cellmate or a peer whom they knew from the community and regarded as 'all right'. Being 'all right' was not based on any knowledge of either hepatitis or HIV status, but rather social distance.

Within the current sample, once the decision had been made to inject drugs, the single most important reason for taking risks by sharing injecting equipment, was the lack of access to clean injecting equipment. In the prison setting the motivation to use heroin, when it could be accessed, outweighed concerns about the risks entailed (see section 5.3.4). While at times prisoners tried to minimise risks by washing syringes out with

51 Crowley's (1999) review of prisoners (N=187) in the Drug Detoxification and Rehabilitation Programme in Mountjoy Prison found that 60% of prisoners reported needle sharing 'pre-prison' but this increased to 98% when in prison.

water, or bleach where available (see section 6.2.6), they engaged in risks each time they injected. Furthermore, those who reported having been initiated into injecting drug use in the prison (n=4), reported that another prisoner had injected them until they learned the technique for themselves - an activity found in studies elsewhere to have implications for sharing injecting equipment. Respondents portrayed injecting drug use in the prison setting as fundamentally 'dirty'. However, in an environment where there was no access to clean injecting equipment, they engaged in risky injecting behaviour (see section 5.3.4).

7.5 Service Provision

7.5.1 Equivalence of Care?

Equivalence of care, and provision for continuity of care, have been identified among the objectives of the prison medical services in Ireland, which include drug-related services (Department of Justice, 1994; Department of Justice, Equality and Law Reform, 1999). The principle of 'equivalence of care' means that services provided to prisoners should be equal to those that the state provides for the general community (Levy, 1997). Both the World Health Organisation (1987; 1993) and the Council of Europe (1988; 1993) have produced international guidelines for the prevention of the spread of HIV/AIDS in the prison population. These are based on the principle that prisoners have the same rights to non-discriminatory health prevention, care and psycho-social support as they would in the community (O'Brien & Stevens, 1997). Furthermore, the European Union Action Plan on Drugs 2000 - 2004 (Council of the European Union, 2000) calls for member states to intensify their efforts to provide measures to reduce health-related damage in prisons. However, evidence suggests that general health care provision in many European prisons does not meet these requirements, let alone the care of a special needs group such as drug users (Reed & Lyne, 1997). While most prisons may offer drug users some services, the principle of equivalence of care is not commonly realised (O'Brien *et al.*, 1997).

The respondents in the current study came from communities in which a wide range of services were available to drug users. These services included methadone maintenance, counselling, therapeutic communities and needle exchanges. Once imprisoned, the services available to them were limited. The findings of this study highlight the 'inequivalence' of care which, respondents argued, continued to exist in the Irish prison system when they were imprisoned (see Chapter 6).

Since the fieldwork for this study was carried out, a report of the Steering Group on Prison Based Drug Treatment Services has been published (Irish Prisons Service, 2000) and it has received government approval. In this report it is argued that 'the Prisons Service must replicate in the prison to the maximum extent feasible the level of medical and other supports available in the community' (Irish Prisons Service, 2000: 1). The challenge remains for the Irish Prisons Service to translate this policy into practice.

7.5.2 Substitution Programmes

While substitution programmes play a central role in community-based opiate treatment services in Ireland, at the time fieldwork was carried out their role remained limited in the prison context. Where requested, methadone was used for the detoxification of opiate-using prisoners upon imprisonment (see section 6.2.1). However, the use of methadone on a maintenance basis was much more restricted (see section 6.2.3). It was not clear to respondents who were housed outside the Medical Unit, why methadone was provided for drug users in the community, but was not available to them in prison. This was particularly unclear where those who were on a maintenance programme in the community, were forced to detoxify once imprisoned. In other countries, prison-based maintenance programmes have been found to have positive outcomes. Evaluations have found that where a methadone maintenance programme has been introduced into a prison, there have been reductions in the overall incidence of injecting, the sharing of injecting equipment (Dolan, Hall & Wodak 1996; Boguna, 1997, cited in O'Brien *et al.*, 1997) and the number of overdoses among prisoners on the programme (Boguna, 1997, cited in O'Brien *et al.*, 1997).

In the current study, only those who were HIV-positive had access to a methadone maintenance programme. At the time fieldwork was carried out, methadone maintenance was not available to prisoners who had not yet tested positive for HIV, and therefore could not be used to minimise the risks that they might become infected. Furthermore, a prisoner's hepatitis status did not have any impact on his/her ability to access a maintenance programme. While respondents in the current study had mixed views about methadone, they suggested that the introduction of a maintenance programme would help address the on-going use of illicit drugs and the associated risk behaviours in the prison. By being provided with a guaranteed daily dose of methadone, it was felt that prisoners' needs to engage in illicit opiate use might be removed. Respondents who were on a maintenance programme in the prison (n=2) had ceased their illicit opiate use.

It should be noted, however, that since the fieldwork was carried out, methadone maintenance has been made available to a wider cohort of prisoners in Mountjoy

Prison. Now, where a prisoner committed to Mountjoy or transferred from Cloverhill Prison has been on an approved maintenance programme, in either the community or Cloverhill, he/she is entitled to continue to receive this treatment while in prison (Irish Prisons Service, 2001). This development is to be welcomed. However, it should also be noted that maintenance treatment continues to be initiated within the prison only for those who are HIV-positive.

7.5.3 Self-Help Groups and Counselling

The experiences of the current sample suggest that group programmes based on principles of confidentiality and anonymity may not be suitable for the prison setting (see section 6.2.5). By its nature, the prison is an environment in which anonymity is extremely difficult to maintain. Furthermore, study participants who had attended group meetings, such as Narcotics Anonymous (NA), reported that, in many cases, confidentiality had not been respected. In contrast to other areas of Mountjoy, the Training Unit was perceived to have some characteristics of an environment in which confidentiality was respected and peer support was encouraged. In the areas of the prison where a drugs culture was perceived by respondents to exist, it was argued that it was not possible to deliver a service such as NA effectively. One-to-one counselling, on the other hand, was perceived to be an effective way of delivering support: confidentiality could be assured, and prisoners could address issues of particular concern to them. The absence of a dedicated addiction counsellor was identified by the respondents in this sample as a major gap in service provision (see section 6.2.7). When proposals to appoint eight professionally-qualified Health Authority drug counsellors to the Mountjoy Prison Complex (Irish Prisons Service, 2000) are put into practice, this will bridge this gap in services.

7.5.4 Drug-Free Wings

The experiences of the current study sample were similar to those of prison populations elsewhere, where evidence suggests that incarceration may mean daily interaction with the drug scene (Bird *et al.*, 1995; Keene, 1997; Edgar *et al.*, 1998; Strang *et al.*, 1998). Removal from this drug scene was seen by respondents to be crucial if a prisoner were to address his/her drug use effectively. The development of drug-free areas in prisons has been identified elsewhere as effective in helping users to remain drug free while in prison. A pilot project, carried out in Austria and initially involving twenty-one inmates, invited drug users to volunteer to remain abstinent and to agree to give urine samples for testing on a regular basis. Prisoners were kept in a drug-free wing where, in return for remaining drug free, they were granted certain privileges. After an initial period, the programme was expanded to involve about half the prison's 300 inmates.

An evaluation found that the programme had had positive effects on prisoners' well-being and their living conditions (Schweinschwaller, 1997, cited in EMCDDA, 1998). Those in the current study who had been moved from the main Male Prison to the designated drug-free Training Unit (n=3) reported similar positive outcomes. Furthermore, respondents in other areas of the prison argued that this facility should be extended and all prisoners should have the option of serving their sentence in a drug-free area (see section 6.2.4). In this context, current plans (Irish Prisons Service, 2000) to provide a wing in the main Male Prison which would be free of illicit drugs, should help drug users remain drug free in the prison setting.

7.5.5 Needle Exchange Programmes

The adoption by some criminal justice systems and individual prisons in Europe of the principle of equivalence of care has meant the introduction into the prison setting of some controversial harm-reduction strategies. It is known that one of the principal routes of HIV and hepatitis infection is through the sharing of injecting equipment. As discussed in section 7.4.5, injecting drug use within the prison setting has been found to involve significant risk behaviours. Throughout Europe, community-based needle exchange programmes have been introduced for drug users, in an attempt to curb the spread of HIV and other blood-borne diseases. However, proposals to introduce needle exchanges in prisons have raised a number of objections. Opposition has been on the grounds that syringes may be used by prisoners as weapons against other prisoners or against prison staff, and that their provision may encourage drug use (O'Brien *et al.*, 1997; Nelles *et al.*, 1998). The respondents in the current sample expressed similar reasons for why they felt a needle exchange would not be introduced into the prison setting (see section 6.2.6). However, it is argued by some commentators that these objections are similar to those used in the debate surrounding the introduction of needle exchanges in the general community in the late 1980s (Maddow, cited in O'Brien *et al.*, 1997).

Where needle exchange programmes have been introduced into the prison setting, they have been found to have a positive impact on reducing needle-sharing practices among injecting drug users. The first-ever pilot programme of an official needle exchange in prison was carried out in a Swiss prison in 1994 (Nelles, 1996). Despite initial resistance, the service was made available to inmates as part of a more comprehensive programme, following the Swiss government's commitment to providing equivalence of care for prisoners. In their evaluation of the programme, Nelles *et al.*, (1998) found that the experience of syringe distribution in prison was 'entirely positive' (Nelles *et al.*, 1998: 271). No security problems were reported and there was no evidence of an increase in drug use among prisoners. Overall, it was found that syringe sharing among

inmates virtually disappeared. Nelles *et al.* (1998) argued that these findings demonstrate needle exchanges as effective harm-reduction strategies within the prison setting, as well as in the general community. Further pilot programmes have been carried out in both male and female prisons in Germany and Spain (Stover, 1997). Early results from these programmes are reported to be 'encouraging' (Merino, in PHARE, 1999). It should be noted, however, that all these programmes have been located in relatively small prisons, which may have an impact on outcomes. In their review of European prison services, O'Brien *et al.* (1997) concluded that, if needle exchanges in prison were to become more widespread, they would probably be confined to smaller prisons, in which discipline problems were less acute.

The current study sample expressed pessimism about the possibility of a needle exchange being introduced into the Mountjoy Prison Complex (see section 6.2.6). While they identified a need for the problem of sharing injecting equipment to be addressed, they did not see that this would be dealt with through the provision of a needle exchange. It was felt that the perceived negative attitudes of prison staff toward this option would preclude its introduction. The provision of a needle exchange programme for Irish prisons is not currently being considered by the Irish Prisons Service.

7.5.6 Cleaning Materials

The findings in relation to the effectiveness of cleaning materials in preventing the spread of blood-borne diseases have been mixed. Where provided, it has been found that cleaning materials are used by prisoners for the purpose of cleaning injecting equipment (Bird *et al.*, 1997). However, anecdotal evidence suggests that, owing to the covert nature of drug use within the prison setting, prisoners are unable to ensure that they use sterilising agents effectively (O'Brien *et al.*, 1997). More important, however, is the fact that, while the correct use of cleaning materials may be effective in preventing the spread of HIV,⁵² they are generally unsatisfactory in preventing the spread of hepatitis (Crowley, 1999).

There was confusion among respondents in the current study sample as to the effectiveness of cleaning materials in protecting them from the spread of HIV and hepatitis (see section 6.2.6). Household bleach was only sporadically available and was not provided specifically for the purpose of cleaning injecting equipment. While respondents recognised the complexities involved in introducing a needle-exchange programme into the prison setting, they generally saw no obstacles to the provision of

52 A study carried out by Taylor *et al.* (1995) reported that one prisoner, who had become infected with HIV while in prison, claimed he had always cleaned the needle and syringe with bleach prior to injecting.

cleaning materials and the relevant information about their use. It would appear to be important for any provision of cleaning materials to be accompanied by a comprehensive education programme on their correct use and their limitations.

7.5.7 HIV and Hepatitis-Related Medical Services

Drug-related infectious diseases (HIV and hepatitis) have been found to be prevalent among Irish prisoners with a history of injecting drug use (Allwright *et al.*, 1999; Long *et al.*, 2000). Over 80% of a national sample of prisoners with a history of injecting drug use (n=506) tested positive for hepatitis C, and 3.5% for HIV (Allwright *et al.*, 1999). In the current study sample, eleven respondents reported that they had tested positive for hepatitis and three for HIV (see section 6.2.9). Furthermore, eight respondents did not know their current status but were at risk of being infected. Of further concern was the fact that only three respondents reported having received a vaccine for both hepatitis A and B. The prevalence of infectious diseases among this population points to a need for appropriate treatment and vaccination services to be provided in the prison setting.

Respondents in the current sample who were HIV positive (n=3) reported that they had access to relevant treatment services, although one respondent had not approached the prison medical services in relation to his HIV-positive status. On the other hand, treatment provision for hepatitis C and vaccination for hepatitis A and B were not perceived by respondents to be readily available in the prison (see section 6.2.9). While the findings suggest that prison may provide an ideal opportunity for inmates to receive either treatment for hepatitis C or vaccination for hepatitis A and B, they also suggest that this opportunity is not currently being exploited. The acknowledgement by the Steering Group on Prison Based Drug Treatment Services, that such prisoners may be 'ideally placed' (Irish Prisons Service, 2000: 12) to avail of new treatment programmes for hepatitis C, is to be welcomed. However, it would appear that a policy of routine vaccinations, for those who wish to avail of them, also needs to be implemented.

7.5.8 Further Rehabilitative Needs

Respondents identified services other than those specifically aimed at their drug use as having an impact on their drug use (see section 6.4). Respondents argued that a wide range of services, including education and training, needed to be provided if motivations to cease illicit drug use were to be fostered and the level of recidivism minimised. Most had a long history of unemployment and low levels of educational achievement. Where prisoners had managed to access education and training programmes in the prison, these were perceived to play a dual role of alleviating the

boredom of imprisonment, and preparing an individual for an alternative lifestyle on release. In this context, the suggestion by the Steering Group on Prison Based Drug Treatment Services, that there is a need to address the 'multi-factorial causes of drug misuse and offending behaviour' (Irish Prisons Service, 2000: 1), shows a recognition of the complex nature of the problem.

7.5.9 Beyond Equivalence of Care

O'Brien *et al.*'s (1997) review of the services available to prisoners throughout Europe presented an alternative to the 'equivalence of care' approach in the delivery of prison-based drug treatment services. They particularly focused on harm-reduction strategies. The authors argued that there is a need to recognise that prisons are not equivalent to community-based service environments. By their nature, prisons seek to control inmates' physical activities, in particular prohibiting their involvement in illicit activities such as drug use. This is in contrast to the role of harm-reduction programmes in the community, which are provided on the premise that, although the use of drugs may be illicit, some people will continue to use them. The role of the services is to minimise the harm that users may cause themselves while engaging in this drug use, as well as to protect the health of the general public. This is in contrast to the 'controlling' role of the prison. Furthermore, as discussed throughout this report and elsewhere, incarceration may mean daily interaction with the drug scene (Bird *et al.*, 1995; Keene, 1997; Edgar *et al.*, 1998; Strang *et al.*, 1998). Therefore, prisoners are not necessarily in the same position as those attempting to access services in the general community.

Consequently, O'Brien *et al.* (1997) argued that services should be designed specifically for the prison environment. They recommended that prisons should base their services on those found to be effective in other prison settings in Europe, rather than solely on those provided outside the prison setting in their own country (O'Brien *et al.*, 1997). It is worth noting that the European Union Action Plan on Drugs 2000 - 2004 (Council of the European Union, 2000) calls for member states to share best practice on issues such as treatment facilities within the penal system. The findings of the current study suggest that a policy of developing services within the prison, specifically for the prison, should be supported. Since fieldwork was carried out, the Steering Group on Prison Based Drug Treatment Services has stated in its policy proposals that 'a range of interventions specific to prisoners within the context of prison needs to be developed' (Irish Prisons Service, 2000: 9).

7.6 Implications of Main Findings

This was an exploratory study, carried out with a small number of respondents in just one of the country's prisons. The findings cannot be extrapolated to the wider Irish prison population. However, within its limitations, the study has highlighted the complex nature of the issue of drug use among prisoners. The social and criminal background of prisoners, their drug-using history, the social environment of the prison and the lack of appropriate services all combine to present a particular challenge to the prison authorities. In this section the implications of the study's findings, which should be considered by all those involved in addressing the issue of drug use among prisoners, are discussed.

7.6.1 Drugs-Crime Relationship

The question of why such a significant proportion of the Irish prison population is made up of people with a history of drug use needs to be explored. The socio-demographic profile of the current sample reflects the findings of other studies, which indicate that the prison population is characterised by social and economic disadvantage. It has also been recognised that problematic drug use is concentrated in areas of social and economic deprivation. In this context, the high rates of recidivism among the current study's sample, and the relationship identified by respondents between their drug use and criminal activity, suggest that a more in-depth examination of the drugs-crime relationship at the user level is needed. While respondents argued that their drug use and criminal activity were directly related, a sizeable proportion (n=13) reported that they had been involved in some form of offending behaviour prior to starting their drug use (see section 3.5). As identified elsewhere (Parker *et al.*, 1999), the relationship between drug use and criminal activity is extremely complex. It would appear that comprehensive research needs to be carried out on the relationship between drug use and criminal activity in Ireland, leading to an appropriate response on both a policy and a practice level.

7.6.2 The Drugs Culture

Throughout this study, the socio-cultural environment of the prison was perceived to impact on the individual's experience of prison and decision making around his/her drug use. The findings from this study strongly suggest that areas of Mountjoy Prison, other than the designated drug-free Training Unit, are characterised by a drugs culture (see Chapter 4). However, not all prisoners have a history of drug use and not all those with a history of drug use continue to use within the prison, yet the majority of prisoners appear to be housed in an environment dominated by a drugs culture. The findings suggest that this drugs culture, which was reported to impact on the day-to-

day life of the prison and reinforce the value of drug use, should be taken into account in developing policies and services related to drug use among prisoners. Furthermore, the needs of prisoners with no history of drug use, who are currently housed in areas of the prison where there is a drugs culture, need to be addressed. The Steering Group on Prison Based Drug Treatment Services recognised that there is a need to change 'the inmate culture in some of the [Irish] prisons vis-à-vis drug misuse' (Irish Prisons Service, 2000: 2). However, the challenge remains as to how a change in this culture can be brought about.

The findings of this study suggest that, irrespective of a prisoner's drug-using history, where a drugs culture is found to exist in a prison, those who do not wish to be in an environment dominated by such a culture, should be offered the opportunity to serve their sentence in a designated drug-free area. Proposals by the Irish Prisons Service (2000) to provide such areas in Mountjoy are to be welcomed.

7.6.3 Services for the Prison Environment

The findings from the current study highlight the particular nature of the prison environment and suggest a need for those responsible for providing services to look beyond the principle of equivalence of care. It would appear that services need to be tailored to the prison setting and the particular nature of this environment recognised. Policy makers and service providers need to examine what services have proved effective in the care of drug users in prisons elsewhere, and engage in a programme of piloting and evaluating services within the context of Irish prisons. The report of the Steering Group on Prison Based Drug Treatment Services (Irish Prisons Service, 2000) emphasised a 'new treatment ethos' for relevant institutions. The provision of services based on the principle of equivalence of care, while also recognising the need for a range of interventions specific to the prison environment, has also been proposed in the Irish Prisons Service report (2000). However, the challenge of translating these policies into practice remains for those working in Ireland's prison service.

7.6.4 Two-Strand Drug-Treatment Service Programme

The findings in relation to service provision indicate that services for drug users in the prison environment may best be provided following two separate strands. The first strand would be to foster any motivations that prisoners may have to cease their drug use. Offering prisoners appropriate support and a suitable environment in which to foster their motivations would be central to achieving this cessation. The provision of a drug-free area in the Training Unit of Mountjoy was perceived in particularly positive terms by respondents. Throughout the study, respondents contrasted the designated drug-free area with the main Male Prison, and generally argued that they felt becoming

drug free was dependent on being removed from an environment characterised by a drugs culture (see section 6.2.4).

The second strand of services would address the needs of those who continue to engage in illicit drug use in the prison, and would help minimise the risks to these prisoners' health (see section 5.3.4). This would require an innovative approach to service development that could tackle the complex issues involved.

In relation to strand one, the reduction in the quantity of drugs respondents reported using once imprisoned, suggests that imprisonment may provide an important opportunity in which to foster an individual's motivations to cease his or her illicit drug use (see section 5.3.3). However, in the experience of this sample, while prisoners may not experience physical withdrawals on a daily basis, they must still cope with the psychological withdrawals in an environment that is seen to reinforce the perceived benefits of illicit drug use. These findings suggest that strand one of a service programme would need to address both the physical and psychological aspects of drug use. Such a programme could include a range of services, including access to a drug-free area, substitution services and one-to-one counselling.

While some prisoners may wish to abstain from drugs once imprisoned and services should be developed to foster their motivations, other prisoners may continue to use illicit drugs. Respondents in the current sample reported that heroin use in the prison was heavily associated with injecting drug use, and that injecting drug use in the prison setting was generally perceived to be synonymous with sharing injecting equipment. These findings raise issues of particular concern for public health. It is in this context that the second strand of drug treatment service provision is discussed. Some respondents in the sample continued to share injecting equipment, despite the risk of spreading drug-related infectious diseases (see section 5.3.4). In at least one case, a respondent, who reported he was HIV-positive, was continuing to share injecting equipment with other prisoners. As has been argued in the past (Allwright *et al.*, 1999; Crowley, 1999), this situation needs to be addressed as a matter of urgency.

The provision of a comprehensive drug-treatment service programme is likely to reduce the number of prisoners engaging in injecting drug use in the prison setting, and the measures necessary to eliminate and reduce this use should be explored. Included may be an exploration of measures that would encourage a change in apparent prison drug-using culture away from injecting drug use. However, where people continue to engage in injecting drug use in the prison setting, the public health issues arising suggest that the feasibility of providing access to clean injecting equipment should be explored. Initially, however, it would be essential to explore the attitudes of both prisoners and

prison staff to the measures that would be involved in providing such services. Furthermore, it would be important to draw on the experiences of other European prison systems where such measures have been introduced (see section 7.5.5).

In the interim, measures that may go some way towards addressing the concerns of respondents in this study's sample, would include intensive education about blood-borne diseases and their spread; the expansion of the methadone maintenance programme; and the introduction of cleaning materials on a formal basis, while ensuring prisoners were aware of their limitations in preventing the spread of blood-borne diseases.

7.6.5 Collaborative Approach to Service Development

The findings from this study show that the respondents were aware of, and sensitive to, the complexities involved in providing appropriate services within the prison setting. This suggests that a collaborative approach to service development between prison authorities, staff and inmates could be valuable. This would see the involvement of both staff and inmates in the development of a service profile, and would be effective in meeting the needs of all those in the prison environment. In its report, the Steering Group on Prison Based Drug Treatment Services recognised that drug misuse in prisons must be undertaken in a 'co-operative and co-ordinated way' with a variety of groups and organisations, including prisoners (Irish Prisons Service, 2000: 1).

7.6.6 Peer Networks

Respondents in the current study reported that peer networks were well established in the prison. It was reported that they played a role in initiating users into the use of both new drugs and new routes of administration. These networks could be used for peer education purposes, particularly in relation to educating prisoners about sharing practices and the associated risks. This, however, would need to be complemented by providing inmates with access to services through which they could minimise the risks associated with injecting drug use. Peer education could also be used to disseminate information among prisoners on the services available to them in the prison, and to provide feedback to the prison authorities on how services are perceived by prisoners. This would reinforce a collaborative approach to developing an effective service programme.

7.6.7 Evaluation

As with drug-related services in the community, on-going programme evaluations should be carried out in the prison to ensure that the services are meeting the needs of the clients and that any emerging needs are identified and addressed. This would

require a commitment on the part of the prison authorities to the on-going evaluation of services within the prison setting. The role of evaluation in the development of drug-treatment services in the prison has been emphasised by the Steering Group on Prison Based Drug Treatment Services (Irish Prisons Service, 2000).

7.6.8 Further Research Needs

To date, with only a few exceptions (O'Mahony, 1997b; Allwright *et al.*, 1999; Long *et al.*, 2000), there has been little information available to guide policy and practice in the area of drug use among prisoners in Ireland. It is essential that policy and service developments be made on a sound knowledge base. While the current study is limited, it offers an important perspective on the situation in Mountjoy Prison and has highlighted the need for further research.

On a general basis, there is a need for routine data on prisoners to be collected, so that trends and changes in the prison population can be monitored. The lack of routine statistics on those in custody should be addressed.⁵³ Furthermore, the prison services should encourage and facilitate the collection of data for the National Drug Treatment Reporting System. This reporting system will provide important epidemiological information on those prisoners who access drug treatment in the prison, and could be used to identify trends over time, as well as changes in patterns of drug use.

Routine data collection needs to be complemented by special surveys, which would provide more detailed information on sub-groups and specific issues of particular concern. Some of the areas in need of further research, which arise from the current study are:

- the extent to which a drugs culture exists in other Irish prisons, the perceived impact of different prison environments on prisoners' drug-using behaviour and their overall experience of prison;
- the drugs-crime relationship in the Irish context;
- the extent to which drug users change their drug-using behaviour in the prison setting and the nature of these changes;
- the risk behaviours engaged in by those using illicit drugs in the prison setting, the context in which these occur and how they compare to those in the community;
- the processes surrounding initiation into injecting drug use, with a particular focus on initiation in the prison setting;

⁵³ The last Annual Report on Prisons and Places of Detention was for the year 1994 (Department of Justice, Equality and Law Reform, 1998).

- perceptions and knowledge among prisoners of the health risks involved in sharing injecting equipment;
- on-going monitoring and evaluation of prison-based drug treatment and healthcare services; and
- prison officers' perceptions of the drug situation within the prison and their attitudes toward a comprehensive service provision profile.

7.7 Summary of Implications of Main Findings

Drugs Culture

The findings from this study suggest that policies and services related to drug use among prisoners should take account of the drugs culture identified in the prison setting. It would appear that irrespective of their drug-using history, prisoners who do not wish to serve their sentence in a prison environment dominated by a drugs culture, need to be offered the alternative of serving their sentence in a designated drug-free area.

Services for the Prison Setting

Findings from the study highlight the particular nature of the prison environment and suggest that policy makers and service providers need to develop a service programme that recognises the specific nature of this setting. This would appear to support the concept that new services should be developed on the basis of examples of best practice, i.e. services that have proved effective in the care of drug users in prisons elsewhere.

Two-Strand Drug Treatment Service Programme

The findings indicate that services for drug users in the prison environment may best be provided on a two-strand basis. The first strand would be to foster any motivations that prisoners may have to cease their drug use. The reduction in the quantity of drugs being used by participants once imprisoned, suggests that imprisonment may provide an important opportunity to foster an individual's motivations to cease his or her illicit drug use. The second strand would be to address the needs of those who continue to engage in illicit drug use within the prison, minimising the risks to these prisoners' health, and in the longer term, that of the wider community.

Collaborative Approach to Service Development

The findings from this study indicate that prisoners are aware of, and sensitive to, the complexities involved in providing appropriate drug-treatment services in the prison setting. This suggests that a collaborative approach to service development between prison authorities, staff and inmates could be both valuable and feasible.

Peer Networks

Respondents in the study reported that peer networks were well established in the prison setting. These networks could be used for peer education purposes.

Evaluation

On-going evaluations of prison-based drug-treatment services could be carried out to ensure that the services are meeting the needs of the clients and that any emerging needs can be identified and addressed.

Further Research Needs

Decisions on the development of policies and services in the area of drug use among prisoners need to be made on a sound knowledge base, which does not currently exist in Ireland. There is a need for the on-going collection of routine epidemiological data on prisoners, complemented by special studies, which could provide more detailed information on subgroups and issues of particular interest.

APPENDIX 1:

DRUG CLASSIFICATION⁵⁴

Heroin and Other Opiate Type Drugs

Heroin

(street/non-medical use)
heroin, diamorphine ('smack', 'junk', 'horse')

Opium and morphine

(street/non-medical use)
morphine ('Napps', MST)
opium
home-made concoction from opium poppies or poppy straw
('Poppy tea', 'Kompot' etc.)
other (specified) form of opium or morphine or derivative

Codeine

(street/non-medical use)
unspecified codeine or codeine derivative
codeine linctus (cough mixture)
hydrocodeine
dihydrocodeine (DF118, Paracodin)
other (specified) form of codeine or derivative

Synthetic opiates

(street/non-medical use)
unspecified synthetic opiate

⁵⁴ Source: Moran, R., O'Brien, M. & Duff, P. (1997) Treated Drug Misuse in Ireland: National report 1996. Dublin: The Health Research Board. Appendix F: 57-58.

dextromoramide (Palfium)
dextropropoxyphene (Distalgesic)
dipipanone (Diconal, 'dike')
methadone (Physeptone, 'phy')
pethidine
other (specified) synthetic opiate

Opiate agonist-antagonists

(street/non-medical)
unspecified agonist-antagonist
buprenorphine (Buprex)
pentazoncine (Fortral)
other (specified) opiate agonist-antagonist

Substitute opiates/opioids

(used as part of drug-treatment programme)
unspecified opiate substitute
methadone
codeine/dihydrocodeine etc.
buprenorphine
heroin

Other (specified) opiate-type drug

Cocaine, Amphetamine and Other Stimulants

Unspecified stimulant

Cocaine

unspecified cocaine ('coke')
cocaine hydrochloride
freebase cocaine (includes 'crack')
other (specified) form of cocaine (e.g. coca paste)

Amphetamines

unspecified amphetamine ('speed', 'uppers')
amphetamine sulphate ('sulph', 'whizz')
dexamphetamine
methylamphetamine (smokable - 'ice', 'crystal meth')
other (specified) form of amphetamine

Other central nervous system stimulants

unspecified other stimulants (not cocaine/amphetamine)
methylphenidate (Ritalin, Rubifen)
phenmetrazine (Preludin)
ephedrine, norephedrine, pseudoephedrine
other (specified) stimulants

MDMA

MethyleneDioxyMethAmphetamine - MDMA (ecstasy)

Other (specified) central nervous system stimulant**Hypnotics and Sedatives****Unspecified hypnotic/sedative-type drug barbiturates and other hypnotics****Barbiturates and other hypnotics**

unspecified hypnotic
barbiturates
methaqualone (Mandrax)
glutethimide (Doriden)
chlormethiazole (Heminevrin)
other (specified hypnotic, excluding benzodiazepines)

Benzodiazepines

unspecified benzodiazepine ('benzos')
diazepam (Valium, Anxicalm)
flurazepam (Dalmane)
flunitrazepam (Rohypnol)
lorazepam (Ativan)
oxazepam (Serenid)
nitrazepam (Mogadon)
temazepam (Euphynpos, Normison)
other (specified) benzodiazepine

Major tranquillisers

unspecified major tranquillisers

Other (specified) sedative/anxiolytic, excluding benzodiazepines**Hallucinogens****Unspecified hallucinogenic substances****Manufactured drugs**

unspecified manufactured drug ('designer' drug)
lysergic acid (LSD, 'acid')
phencyclidine (PCP, 'angel dust')
other (specified) manufactured hallucinogen or 'designer' drug

Mushrooms and other plants and derivatives

unspecified mushrooms ('liberty caps', 'magic mushrooms')
Amanita Muscaria
psilocybin
other (specified) hallucinogenic plant

Other (specified) hallucinogenic substance (mescaline)**Volatile Inhalants****Unspecified volatile inhalants**

glue
butane
solvents
petrol
nitrites

Other (specified) volatile inhalants**Cannabis**

Unspecified cannabis ('pot', 'joint', 'dope', 'blow', 'draw')

Cannabis

herbal (marijuana, 'grass')
resin (hashish, 'hash')
oil

APPENDIX 2:

CONFIDENTIALITY FORM⁵⁵



‘DRUG USE AMONG PRISONERS’

My name is Lucy Dillon. I am carrying out research on a project called 'Drug Use among Prisoners'. It aims to look at the experiences of prisoners in relation to drug use.

I would like to talk to you about a range of issues affecting you, including your experience of prison, the impact it has had on your drug use and your perceptions of the services available to you.

I work for the Drug Misuse Research Division of the Health Research Board and I can be contacted at 73 Lower Baggot Street, Dublin 2, or by telephone at 6761176 extension 165.

Thank you for agreeing to take part in the project. Before we start I would like to emphasise that:

- Your participation is entirely voluntary;
- The interview is totally confidential. No member of the prison staff will be told of anything that you discuss with me.

The interview will be kept strictly confidential and will be available only to members of the research team. I would also like to emphasise that we have nothing to do with the prison and its staff and nothing that is said in the interview will be repeated to them under any circumstances.

Excerpts from the interview may be made part of the final research report, but under no circumstances will your name or any identifying characteristics be included in the report.

Any notes or recordings taken during the interview will only be used for this research and will be destroyed once the project is completed.

Thank you again for agreeing to take part.

Lucy Dillon
Researcher

⁵⁵ See section 2.5 for a description of how this form was presented and agreed.

APPENDIX 3:

DRUG USE AMONG PRISONERS - INTERVIEW GUIDE⁵⁶

Prisoners with a History of Drug Use

Base data

- Age
- Relationship status
- Parents
- Number of brothers/sisters
- Family background, e.g. employment
- Family history of drug use
- Place and area of residence
- Type of housing
- Parental status: number and age of children, current childcare arrangements
- Educational history
- Employment history

Drug-using history

- Age of first drug use
- Progression of drug use: types of drugs and routes of administration
- Lifestyle as a user
- Methods of finding finances
- Past treatment experiences

⁵⁶ See section 2.8 for a discussion of how this interview guide was used.

- Contacts with services
- Perceptions of impact of treatment on use
- Perceptions of programmes

Pathway to prison

- Criminal activity
- Initial involvement in crime
- Motivation for crime
- Previous convictions
- Drug use during prior sentences
- Length of time after prior release to resume drug use
- Referral to programmes as part of release
- Current status (remand, convicted)
- Current conviction
- Length of sentence (have served/to serve)

Experience of prison

- Drug use immediately prior to prison
- Impact of imprisonment
- Initial contact with professional, i.e. prison doctor: stage and perceptions of contact
- Typical day in prison
- Participation in programmes, e.g. education, training
- Access rules around programmes
- Sharing cell: general conditions in prison
- Drug use within prison
- Sources of supply while in prison
- Perceptions of drug use in prison, e.g. what is mainly used
- Networks within prison
- Perceptions of availability of drugs within the prison
- Relationship between users and non-users
- Perceptions of staff view in prison
- Function of drug use in prison
- Changes in drug-using pattern while in prison
- Methods of payment: accrue debts, barter etc.
- General presence of a 'drugs culture' in prison

Drug-related services

- Services on offer: including counselling, detox etc.
- Uptake of services
- Perception of selection procedures for treatment programmes
- Perceptions of services within prison
- Counselling availability and uptake
- Perceptions of changes required in services:
Ranging from need for needle exchange programmes to training schemes
- Preferred form of treatment: availability
- Prison staff attitudes toward drug use
- Continuity of care

Health (physical and psychological)

- Access to health services, physical and psychological
- Service providers' attitudes toward prisoners
- Risk behaviours
- HIV and hepatitis status
- Current prescription drugs

Perceptions of future

- Further rehabilitative needs
- Drug use after release
- Perception of concept of Drug Courts offering alternatives to prison, e.g. Coolmine

Prisoners with no History of Drug Use**Base data**

- Age
- Relationship status
- Parents
- Number of brothers/sisters
- Drug use among family
- Place and area of residence
- Type of housing

- Children
- Educational history
- Employment history

Criminal history

- Previous convictions
- Motivation for crime
- Current conviction
- Current status (remand, convicted)

Drugs

- Drug use ever
- Alcohol use
- Attitudes toward drugs
- Knowledge about drugs

Health status

- Availability of services
- Use of services
- General health status

Experience of prison

- Daily activities in prison
- Participation on programmes
- Perception of selection criteria for programmes, e.g. training, education
- Perceptions of drug use within prison
- Extent to which drugs are being used
- Perceptions of 'drugs culture'
- Impact of drug use on nature of their imprisonment
- Experiences with users
- Coping strategies used
- Health status
- Uptake of services
- Accessibility of services including training and educational opportunities

APPENDIX 4:

DRUG USERS AMONG PRISONERS IN THE EU

Country	Definition	% of drug users in Prison Population	Year	Methodological Comments
Belgium	People reporting having used illicit drugs	42	1993	Survey in 1 prison (n=1,627)
Denmark	Drug abusers: those having used euphoriant regularly in the six months prior to imprisonment	36	1997	Nationwide survey
	Heavy drug abusers: those who habitually use substances other than cannabis	19	1997	Nationwide survey
Germany	Drug users in prison (based on positive urine samples)	5-26	1995	Survey in 1 German <i>Land</i> (n=5,771)
	Drug users in prison (based on information given by key persons)	60	1996	Survey in 1 prison based on reports of pre-selected prisoners (n=16), doctor, pastor(s)
	Hard drug users (based on information given by key persons)	10	1996	Survey in 1 prison based on reports of pre-selected key prisoners (n=16), doctor, pastor(s)
	Soft drug users (based on information given by key persons)	50	1996	Survey in 1 prison based on reports of pre-selected key prisoners (n=16), doctor, pastor(s)
Greece	Injecting drug users	31	1995	Survey in 1 prison (n=183)
Spain	Women reporting lifetime use (alcohol included)	70	1998	Survey in 18 prisons (n=356)
	Women reporting having used several times a day (alcohol included)	35	1998	Survey in 18 prisons (n=356)
	People reporting to be drug users	56	1998	Survey in 62 prisons (n=1,011)
	People whose frequency of heroin and/or cocaine use in the past two years is at least once a week for a minimum of one month	54	1994	Nationwide survey in 25% of all prisons among people entering prison (n=1,541)
France	People reporting regular use of an illicit drugs in the 12 months prior to imprisonment	33	1997	Nationwide survey among 86% of those entering prison (n=8,728)
	People reporting illicit drug use within the 12 months prior to imprisonment	43	1997	Survey in 4 prisons (n=1,212)
	People reporting lifetime IV drug use	23	1996	Survey in 1 prison (n=574)
Ireland	Regular heroin users	35	1997	Estimated in 1 prison
	People with a history of heroin abuse	70	1997	Estimated in 1 prison
	People reporting heroin use while in prison	42	1996	Survey in 1 male prison (n=108)
	People reporting ever having used heroin or cannabis	Heroin: 66 Cannabis: 89	1996	Survey in 1 male prison (n=108)

DRUG USE AMONG PRISONERS

AN EXPLORATORY STUDY

Country	Definition	% of drug users in Prison Population	Year	Methodological Comments
Netherlands	People judged by a clinical psychologist to have drug addiction problems	29	1997	Survey in 1 prison (n=528)
	People reporting drug abuse or drug dependence within the last month	14	1997	Survey in 1 prison (n=135)
	People judged to be drug addicts according to 2 criteria (at least 2 months of regular use within the past two years; and a severity score of over three in the EuropASI drug section)	44	1997	Survey in 1 prison (n=319)
Austria	IV drug users	15	1996	Estimated by experts
	People reporting having used illicit drugs	72	1994	Survey in 1 prison focusing on those convicted under the Narcotic Drug Act (n=307)
Finland	People reporting having used drugs	31	1995	Survey in 4 prisons
Sweden	People having used drugs IV or on a daily (or almost daily) basis within the 12 months prior to imprisonment	44	1997	Nationwide survey (n=3,616)
U.K.	Prisoners testing positive for drugs during random mandatory drug testing	19	1998	Nationwide survey among 10% of prisoners (n=10,340)
England & Wales	People reporting use of drugs in the 12 months prior to imprisonment	68	1994	Nationwide survey (n=1,000)
	Men entering prison reporting a history of injecting drug use	29	1996	Survey in 1 prison
	Men entering prison reporting a history of injecting drug use	15	1995	Survey in 3 prisons
Scotland	Men reporting a history of injecting drug use	32	1991-96	Survey in 6 male prisons (n=2,256)
	Women reporting a history of injecting drug use	43	1991-96	Survey in 1 female prison (n=127)
	Young offenders reporting a history of injecting drug use	18	1991-96	Survey in 2 young offenders' institutions (n=556)

Source: EMCDDA, 1999:59

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